2021

NATIONAL EMERGENCY ACTION PLAN

POLIO ERADICATION

INITIATIVE, AFGHANISTAN

List of acronyms

AFP	Acute flaccid paralysis
AGE	Anti-government elements
AHS	Afghanistan Health Survey
ARCS	Afghan Red Crescent Society
BPHS	Basic package of health services
COVID-19	Coronavirus Disease 2019
CVDPV	Circulating vaccine Derived Poliovirus
CWG	Communication working group
CDC	Centre for Disease Control
CS	Cluster Supervisor
DDM	Direct Disbursement Mechanism
DoRR	Department of Refugees and Repatriation
DPO	District Polio Officer
GCMU	Grant and Service Contracts Management Unit
EOC	Emergency Operations Centre
ES	Environmental Sampling
FLW	Front-line worker
GPEI	Global Polio Eradication Initiative
HRD	High risk district
HRMP	High risk mobile population
HR	High risk
H2H	House to House
HF	Health Facility
IAG	Islamic Advisory Group
ICM	Intra-campaign monitor/monitoring
IDPs	Internally Displaced Persons
IFA	Information for Action
IMB	Independent Monitoring Board
ICN	Immunization and Communication Network
IOM	International Organization for Migration
IPC	Inter-personal communication
ICN	Immunization communication network
IEC	Information, Education, Communication
IHR	International Health Regulation
IPV	Inactivated polio vaccine
KAP	Knowledge Attitude Practices
KP	Khyber Pakhtunkhwa
LQAS	Lot Quality Assurance Sampling
MCV	Measles Containing Vaccine
MNCH	Maternal New-born and Child Health
MoU	Memorandum of Understanding
MHT	Mobile health team
NDSR	Nation Disease Surveillance Response

List of acronyms

NEOC	National Emergency Operations Centre
NIAG	National Islamic Advisory Group
NGO	Non-governmental organization
NEAP	National Emergency Action Plan
NID	National Immunization Days
nOPV2	Novel Oral Polio Vaccine
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OPV	Oral polio vaccine
PCM	Post-campaign monitoring
PEI	Polio Eradication Initiative
PEMT	Provincial EPI Management Team
POB	Polio Oversight Board
PTT	Permanent Transit Team
REOC	Regional Emergency Operations Centre
RI	Routine Immunization
REMT	Regional EPI Management team
RRL	Regional Reference Laboratory
SIA	Supplementary immunization activity
SARS COV-2	Sever Acute Respiratory Syndrome COVID - 2
SM	Social Mobilizer
SNID	Subnational Immunization Days
SOPs	Standard operating procedures
SIADS	Short Interval Additional Dose Strategy
SWG	Strategy Working Group
S2S	Site to Site
TD	Tetanus Diphtheria
TAG	Technical Advisory Group
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VMWG	Vaccine Management Working Group
VHRD	Very high-risk district
PHC	Primary Health Care
PMU	Program Management Unit
PIRI	Periodic Intensification of Routine Immunization
POB	Polio Oversight Board
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
WASH	Water Sanitation Hygiene
WHE	World Health Emergencies
WHO	World Health Organization
WPV	Wild poliovirus

Contents

Section 1:

Epidemiology and Situational Overview

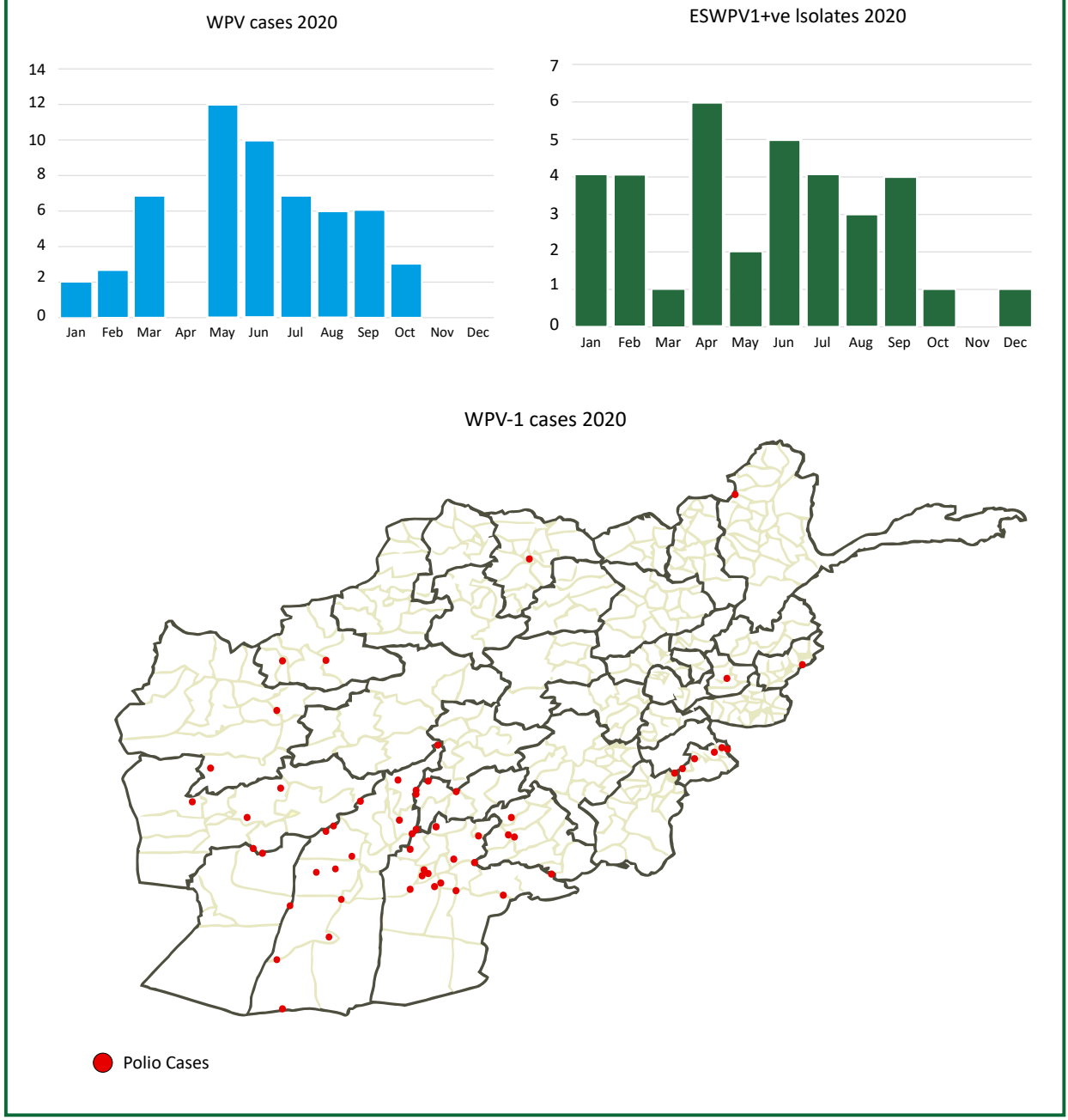
The year 2020 was a challenging year for Afghanistan's polio eradication programme since consistent access to all the children in the country remained hindered, mainly for reasons beyond the programme's control. The ban on house to house vaccination that was imposed in May 2018 became more stringent in April 2019 with its imposition everywhere. This led to no vaccination campaigns from April to July 2019 (no vaccination campaigns for over 4 months). Moreover, the COVID-19 associated adjustment of priorities in 2020 led to a pause in SIAs from March to June 2020. This did not only result in further intensification and geographical spread of WPV-1 but also the same for cVDPV2 since the response vaccination campaigns could not be immediately implemented following cVDPV2 importation from Pakistan. Polio Surveillance activities generally went on uninterrupted, however a dip in the reported AFP cases was observed from April to July 2020. It is important to note that routine immunization activities were also significantly impacted by the pandemic.

The number of cases and infected districts have been on the rise since 2018. The number of infected districts (based on polio cases reporting) increased from 14 in 2018, to 20 in 2019 and 38 in 2020. Similarly, the number of cases also increased from 21 in 2018, to 29 in 2019 and 56 in 2020. Regarding environmental samples, the number of WPV-1 positive environmental samples decreased in 2020 to 35 compared to 56 in 2019. In 2020, 303 cVDPV2 cases were reported from 96 districts of 24 provinces of Afghanistan (as of 14 February 2021).

It is important to note that during 2020, wild poliovirus transmission in Afghanistan spread from South, Southeast and East regions to North and Northeast regions of the country. Ongoing transmission in the South region is due to indigenous local transmission. During the second half of 2020, WPV-1 transmission started to appear outside the known reservoir regions and polio cases were reported from South East (6), West (8) and one case each from North region and Badakhshan province. The majority of the polio cases in 2020 (44, 79%) were reported from the areas with ban on house-to-house vaccination since May 2018. The force of WPV-1 infection was lower in the East region during 2020 (2 polio cases & 4 positive environmental samples compared to 2 and 13 in 2019, respectively) where access for house-to-house vaccination was relatively better during 2019 and 2020. Eastern region is part of the Northern cross border corridor involving bordering areas of Afghanistan and Pakistan.

Genomic sequence analysis of poliovirus isolates identified multiple episodes of cross-border transmission in Afghanistan from Pakistan during 2019–2020 and with sustained local transmission as well. During January 2019 to December 2020, 17 (20%) of 85 WPV1 cases and 14 (16%) of 90 WPV1 positive environmental isolates in Afghanistan had closest genetic links to earlier WPV1 and environmental isolates from Pakistan; the remaining WPV1 cases and isolates were most closely linked to cases and isolates from within Afghanistan. During January 2019 to December 2020, four genetic clusters (viruses sharing ≥95% sequence identity) were detected among AFP cases. Close to 70% of cVDPV2 cases reported in 2020 were genetically linked to cVDPV2 transmission in Pakistan (mostly GB-1 cVDPV2 emergence) which originated in Gilgit-Baltistan, Pakistan. The remaining 69 cases were classified as a new Afghanistan emergence (AFG-NGR-1) and 1 from AFG-HLD.

FIgure 1: Situation Summary, 2020



South Region:

In 2020, 38 polio cases were reported from the region, including 16 from Hilmand, 14 from Kandahar, 4 from Uruzgan, 3 from Zabul and 1 from Nimroz province. There were eight infected districts in Hilmand province (Nad-e-Ali, Sangin, Nawzad, Washer, Kajaki, Baghran, Reg, Deh-e- Shu), eight infected districts in Kandahar province (Kandahar, Zherey, Panjwai, Shahwalikot, Spinboldak, Nesh, Ghorak, Maruf), two infected districts in Uruzgan province (Tirinkot, Shaheed-e-Hassas), three infected districts in Zabul (Qalat, Arghandab, Mizan) and one infected district in Nimroz province(Khashrod district).

The local transmission in Kandahar city continued during the course of the year, mainly represented by the positive environmental samples while three polio cases were reported with onset of paralysis in June, August, and September 2020. It is noted that more than three quarters of the cases were reported from the areas with no house-to-house vaccination since May 2018. Persistent WPV-1 positive environmental samples were reported in 2020 from the Kandahar province (mainly the city) during 2020, representing local transmission in the province. Among the 24 WPV1 positive isolates from Kandahar and Hilmand (as of December 2020), 4 samples from Kandahar had closest genetic linkage with ongoing WPV-1 transmission in Quetta and Khuzdar districts of Baluchistan, Pakistan.

As of end January 2021, the South Region has reported 140 cases of cVDPV2 and 53 environmental samples positive for cVDPV2 in 2020, most of them from the areas inaccessible for house to house vaccination campaigns.

East Region

In 2020, two polio cases were reported from the region, one each from Kunar and Laghman provinces (Shigal Wa Shultan and Mehterlam districts). The WPV-1 case in Kunar province was reported from an area inaccessible for polio campaigns and with closest genetic linkage with a WPV1 positive environment sample in the Southern Khyber Pakhtunkhwa province (D.I.Khan district) of Pakistan. The intensity of WPV-1 transmission seemingly declined in the East region during 2020; as indicated by the lower number of polio cases (6 in 2018, 2 in 2019, 2 in 2020) and positive environmental samples (24 in 2018, 13 in 2019, 4 in 2020). It is pertinent to mention that eastern region could conduct house to house vaccination in the majority of the areas during the second half of 2019 and 2020.As of end January 2021, the East Region has reported 70 cases of cVDPV2 and 65 environmental samples positive for cVDPV2 in 2020. It is important to note that following the mOPV2 (two) and tOPV (one) response vaccination campaigns, the cVDPV2 transmission is seemingly curbing down in the accessible areas; however, the risk of ongoing transmission in some population pockets as well as further importation from Pakistan and from within Afghanistan remains significant.

Outside endemic zones

The WPV-1 transmission started to significantly appear in late 2019 in the non-reservoir regions / provinces (two WPV-1 cases from the South-East Region, four from the West Region, one from North-East Region during Q-4 2019), that continued in 2020 due to ongoing inaccessibility in some pockets as well as the suspension of some SIAs due to COVID-19 pandemic. Almost all the polio cases in these regions represent new viral introductions from the endemic areas. WPV-1 was also detected in the environmental samples collected from outside the South and East Regions during 2020. These include 4 samples reported from Hirat and 1 each from Khost, Kunduz and Kabul provinces. In 2020, among the 56 polio cases reported; 8 polio cases are reported from West region, 6 from Southeast region and 1 each case from Badakhshan and North region.It is important to mention that the population immunity is declining due to inability to implement house to house campaigns in a significant part of the country, leading to inconsistent access to almost 45% of the target population aged less the five years. Polio cases from non-reservoir areas of the country during 2020, represent the risk of further intensification and geographical spread of WPV-1 transmission over the coming months.In regards to cVDPV2 transmission, a total of 93 cVDPV2 cases have been reported in 2020 from the regions other than South and East regions (as per reports in end January 2021). These include 30 cVDPV2 cases from West region, 7 from the North Region, 5 from the Northeast Region and 17 from the Central Region. It is important to note that the cohort of vulnerable children to type-2 polioviruses is significantly large, given more than four years' interval since the switch and low IPV coverage in high risk areas.

Section 2:
Progress on NEAP 2020

In 2020, the Afghanistan polio programme had to adapt the operations according to varying state of security and access while responding to twin outbreaks of wild poliovirus type 1 and circulating vaccine-derived poliovirus type 2. The programme also had to adjust its planning and implementation processes as per the unprecedented situation of the COVID-19 pandemic. Transmission in the northern and southern epidemiological corridors continued and spread of WPV-1 from endemic areas infected the previously polio-free areas in West, North, and Northeast regions of Afghanistan. Significant inaccessibility for SIAs remained the primary reason for intensification and geographical spread of the WPV-1. In addition, the explosive cVDPV2 outbreak resulting from spill from the adjoining areas of Pakistan to the Eastern region in January 2021, significantly spread initially to North-Eastern region and later to other regions, including to the inaccessible areas of the South Region. Due to the COVID-19 pandemic emergency, vaccination response to the cVDPV2 outbreak could not be mounted for almost six months, leading to significant geographical spread to several regions of the country. It is pertinent to mention that the cVDPV2 importation from Pakistan to Afghanistan occurred almost four years after the tOPV-bOPV switch and hence with low population immunity against the type-2 poliovirus.

The programme placed extensive efforts to improve the SIA quality in the accessible areas, while maintaining access dialogue at all levels. COVID-19 had an extensive impact on the polio eradication interventions, especially on the supplementary Immunization Activities. The SIAs for polio eradication were halted for 5 months (from

March to July 2020), together with disruptions in health services and routine immunization, particularly EPI outreach services. The programme also faces disruptions to AFP/ES sample shipment to the Regional Reference Polio Laboratory due to closure of border with Pakistan; this was later resolved in coordination with the Pakistan polio eradication team. A significant number of PEI staff were infected with SARS COV-19 while performing their duties. The immunity gap existing due to continuous bans on polio campaigns has been further enhanced due to COVID-19, lead disruption

in the polio campaigns. However, PEI's support for COVID-19 response in AGE areas is an opportunity for better humanitarian access.

The AFP surveillance network, while supporting the COVID-19 surveillance, reported 62,578 suspected COVID-19 cases, out of which 9,105 were confirmed as COVID-19. The entire AFP surveillance network was trained on COVID-19, including 117,000 medical doctors and paramedics as well as 219,000 community influencers (as per National EOC / PEI information available on 31 December 2020). Polio community networks were utilized to engage the communities and orient them on preventive measures for COVID-19 during and outside the SIAs.
In general, two out of the eight objectives set in the NEAP 2020 were met, five were partially met and the one main objective to stop transmission was not met.

#	Goal/Objective in NEAP 2020	Status
Objective 1	To stop ongoing WPV-1 transmission in the South and East regions	Not achieved
Objective 2	To rapidly and effectively respond to any introduction of WPV\/VDPVs and/or emergence of VDPVs (particularly VDPV type-2) in the currently polio free areas of Afghanistan, ensuring no secondary cases following any importation	Partially Achieved (due to COVID-19)
Objective 3	To maintain a scenario-based approach to rapidly adjust to any possible/anticipated access and programmatic situations	Achieved
Objective 4	To improve community acceptance and demand for vaccination and address vaccine refusals through effective and locally appropriate communication strategies	Partially achieved
Objective 5	Maintain effective access dialogue in coordination with all the national and international partners aiming to have access for house-to-house polio campaigns across the country	Partially achieved
Objective 6	To achieve and maintain high population immunity among HRMPs	Partially Achieved
Objective 7	To enhance program quality with focus on high-risk provinces/districts to uniformly reduce missed children to less than 3% at the sub-provincial level (especially in the accessible areas). Special emphasis will be laid on effectively reaching the new-born and infants	Partially achieved
Objective 8	To maintain sensitive and high-quality surveillance for polioviruses, across the country with consideration for possible expansion of environmental surveillance, as per feasibility	Achieved

It is important to recall that the AGE's ban on vaccination was mostly limited to high-risk provinces of the South region (with active polio transmission) in 2018. Since the beginning of 2019, the ban has been gradually expanding, initially to other parts of the South region, then to South East region and finally to everywhere in April 2019. After a complete cessation of vaccination campaigns (due to ban) from April to July 2019, the vaccination gradually resumed in the accessible areas in August 2019 and onwards.

Towards end September 2019, the AGEs partially lifted the ban on polio campaigns; and house to house campaigns resumed in parts of the country. House to house campaigns continued to be banned in the AGE areas and only health facility-based vaccination was allowed. The three campaigns implemented during the last quarter of 2019 (one nationwide and two sub-national rounds), could not reach the areas in the South region with ongoing intense WPV-1 transmission. As per the reported administrative data, the health facility-based campaigns could reach a maximum of 20% of targeted children (the least being 3% in some high-risk areas of south region) in 2019.

This low coverage is mainly due to challenges such as very few health facilities in some districts, difficult terrain, long distances, and lack of motivation among communities to walk extended distances for only polio vaccination. There has been no significant improvement in the access situation since late 2019 and more than 35% of the children aged less than five years cannot be reached through house to house campaigns.

The Technical Advisory Group (TAG) for Polio Eradication in Afghanistan endorsed three NIDs and five SNIDs for 2020 in February 2020. The programme implemented one NID and SNID each, before the COVID-19 pandemic hit Afghanistan. Following the Polio Oversight Board (POB) recommendation in March 2020, all polio vaccination activities were temporarily paused for 5 months from March-July 2020 to prevent the potential risk of SARS COV-19 transmission associated with SIAs.

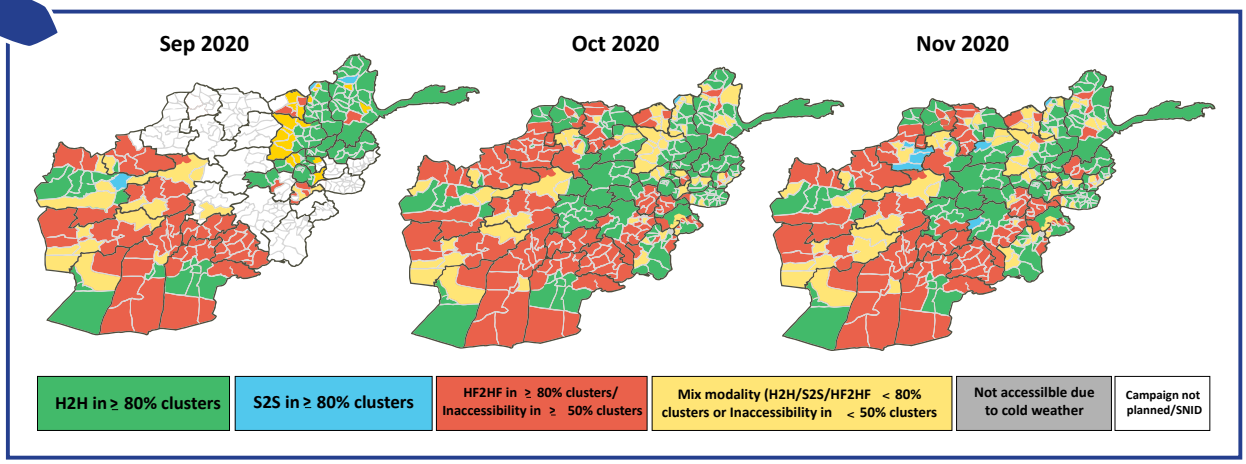
After a careful assessment and thorough risk-benefit analysis led by the Government of

Afghanistan and supported by the GPEI, the programme resumed polio SIAs with the implementation of vaccination response to cVDPV2 in the East region in July 2020, using mOPV2. The programme had to reschedule the entire polio campaign calendar and as the cVDPV2 outbreak was a new epidemiological development, the revised calendar had to balance the types of vaccines (bOPV, mOPV2, tOPV, mOPV1) to be used for various campaigns implemented during 2020, after resumption. Following the restart of SIAs in July 2020, three case response campaigns were implemented using mOPV2, in the areas with cVDPV2 circulation, and one case response campaign was implemented in Kandahar (Dand) and Panjwayi districts with mOPV1 with ongoing transmission of WPV1. In addition, two NIDs (October and November 2020) and one SNID (September 2020) were implemented during the remaining part of the year. All these SIAs utilized a mix of vaccines as per the evolving epidemiology; the September SNIDs were implemented using a mix mOP1 and mOPV2 round while the October and November NIDs utilized a mix of bOPV and tOPV.

Activity / vaccine type	Total Target Population and Target population by vaccine type				
	Total	bOPV	mOPV2	tOPV	mOPV1
Sep. SNIDs	6,180,290	-	3,185,091	-	2,995,199
Oct. NIDs	9,999,227	5,093,984	-	4,905,243	-
Nov. NIDs	9,999,227	4,286,831	-	5,712,396	-

SIA implementation in the environment of the COVID-19 pandemic was an unprecedented scenario for the programme, requiring thorough planning, training and significant strategic shifts to minimize the risk of enhancing the COVID-19 transmission. The campaigns were implemented while exercising adequate preventive and mitigation measures. SOPs were developed for resuming SIAs in the background of the COVID- 19 pandemic. Face masks and sanitizers were distributed to all polio workers including vaccinators, cluster supervisors, district coordinators and monitors (ICM, LQAS, PCM, out of house FM surveyors). Use of face masks, maintaining hand hygiene and social distancing were ensured to the extent possible during training and operations. The training process had to be revised at all levels and the participants were distributed in a way to ensure reasonable number per session to mitigate the COVID-19 risk (the number training sessions had to be increased). Complementary vaccination activities resumed in September 2020 at international borders with all-age vaccination at Torkham and Spin Boldak border crossings.

FIgure 2: Campaign Implementation Modality by district; Sep – Nov 2020



Around 40% of the target population in the country could not be reached with campaigns by house to house strategy in 2020. Importantly, more than 50% of the target population in the South and West Regions could not be reached through house to house campaigns. The East and South East regions could implement house to house to campaigns for around 85% and 60% of the target population, respectively.

The WPV-1 transmission in 2020 is owing to large immunity gaps in access-compromised areas of the country with limited vaccination response capacity particularly in areas with health facility-based campaigns.

The programme continued to maintain a scenario-based approach in 2020, to be able to adapt to the evolving access and security situations. This approach was endorsed by the TAG, under which different strategies and interventions are appropriately devised according to their weightage in a given access / security scenario (please see the matrix below). It is important to mention that the implementation of a number of activities in the scenarios 2 and 3 need the agreement of the AGEs and their implementation is also linked to the availability of resources.

Adjusting NEAP Implementation as per Access - Scenario Based Plannning

+ signindicates program focus on an activity in the given scenario

Strategies	Scenario-1; H2H ban Lifts	Scenario-2; Sit to site/ health facility Strategy	Scenario-3; Ban Persists
OPV SIAs	+++	+++	
IPV/OPV SIAs	+	+	+
Permanent transit teams (PTTs)*	+	++	+++
Enhanced EPI in HR areas + expanded age group for IPV/OPV + Integrated outreach	+	++	+++
Multi antigen EPI campaign including IPV/ OPV	++	++	+++
Polio Plus / incentivized community engagement	+	++	+++
Boosting Surveillance	+++	+++	+++

Clustering of refusals in the South and Southeast regions is potentially contributing to already-diluted population immunity due to campaign quality and inaccessibility. This available surveillance data on vaccination status of AFP cases is indicating this population immunity gap, particularly in the South Region, in areas where house to house campaigns have not be implemented for significant period.

During 2020, the programme continued its efforts to address vaccine acceptance issues through a wide variety of community engagement and social mobilization activities. Dedicated regional plans were developed, polio branded promotional products (including baby blankets, soaps, hygiene kits) were utilized, necessary repositioning of ICNs was carried out, as well as partnerships with the local authorities were developed. Further details are available in the section on Communication.

During 2020, the programme carried out several interventions, on one hand to improve the quality of vaccination campaigns in the accessible areas, and on the other hand to maximize the reach to children in the inaccessible areas (with no house-to-house campaign).

The interventions in the accessible areas of South Region had a special focus on Kandahar city. Staff / FLWs management increased efforts to recruit more females in Kandahar and Helmand (3 female DPOs (KDH city), 90 CS (Kandahar-41, Nimroz-26, Helmand-23) 82 SMs, 11 vaccinators in Kandahar / Helmand / Nimroz). Females in ICN staff increased from 18% in January 2020 to 43% in September 2020. Teams with at least one female increased in the period from Jan-Oct 2020 from 32% to 64% in Kandahar city, 22% to 33% in Lashkargah, and 26% to 32% in Nahr e Saraj. A specific data-driven action plan for Kandahar & high-risk districts of Helmand was developed and implemented. Expansion of modified re-visit strategy to maximize coverage of missed children was piloted in Kandahar city and the strategy extended to all 25 clusters of Loyawala. The extended revisit / catch-up strategy (2 days missed children follow up instead of one day) was expanded after a successful pilot conducted in late 2019 / early 2020 in Kandahar city (additional 15% children reached). The number of clusters with extended revisit / catch-up increased from 12 in February 2020 to 105 clusters in November 2020 in Kandahar city. As per the available data, the modified catch-up strategy helped

reach more than 5% additional missed children compared with a conventional catch-up approach.

After concerted efforts, the programme could improve the female participation as vaccination volunteers during the campaigns in the South Region. Overall, there was a 22% increase in the teams with at least one female in the South Region (currently 45% teams with female), with 18% increase in Lashkargah (currently 40% teams with female) and 50% increase in Kandahar city (currently 70% teams with female).

Interventions in inaccessible areas include enhanced accountability linked with performance appraisal leading to removal of under-performing staff / contractors since Jan 2020. Technical support is being extended by the field PEI staff to the BPHS+ for the monitoring of the health facilities and reporting of issues relevant to immunization. A survey was conducted for 8 health facilities in the AGE areas to improve the infrastructure and health services as well as response activities in COVID-19 by WHO & UNICEF aiming to build confidence for possible future gains on access. In most parts of the country, resumption of PTTs took place from October 2020, together with a rationalization exercise and focusing the PTTs on inaccessible areas. Other inventions in inaccessible areas include implementation of multi-antigen campaigns in the South Region (Uruzgan, Zabul) with the target age increased to children aged less than 5 years) instead of children aged 2 years). An Integrated Services Plan is being followed up for feasible implementation to address immunity gaps in the inaccessible areas, particularly in the focus districts.

The programme has decided to vaccinate all <5 years children visiting the health facilities across the country by the available vaccinators in the health facilities. In addition, 320 female Social Mobilizer/Vaccinators were recruited in all the health facilities of the East region to vaccinate all visiting children less than 5 years of age with OPV and missed EPI doses for other antigens.

The programme continues to maintain dialogue process with AGEs at local, provincial, and higher levels to ensure programme neutrality for polio eradication and supporting humanitarian activities. As a result, the programme was able to perform house-to-house vaccination in the majority areas of the East region and some high-risk areas of the South. The programme calls upon all polio eradication and international partners to play their part to improve access for house-to-house polio vaccination campaigns everywhere in the country. The program will continue to look for every possible opportunity to vaccinate, in the event of continuation of ban.

In addition to the ongoing dialogue on access, the programme continues to implement contingency measures to reach as many children as possible from the areas with no house-to-house vaccination, including:

- Primary Health Centers establishment: 23 and 15 in Kandahar during 2019 and 2020 respectively; 30 in Helmand and 4 in Uruzgan (BPHS plus) targeting RI (target age for OPV in RI raised to under five years). The Afghanistan polio program appreciates the ongoing efforts of the NGOs to maximize vaccination of the children in the areas currently inaccessible for house to house polio vaccination campaigns.
- Mobile health teams deployed in Kandahar (72) and Helmand (3)
- IPV + OPV SIAs
- A state of preparedness is being maintained to implement 3 consecutive H2H SIAs as soon as access gained
- Establishment of 53 new health facilities in white areas with capacity of cold chain and vaccinators for fixed and outreach in Kandahar and Helmand provinces

Section 3:
Key Challenges and Risks

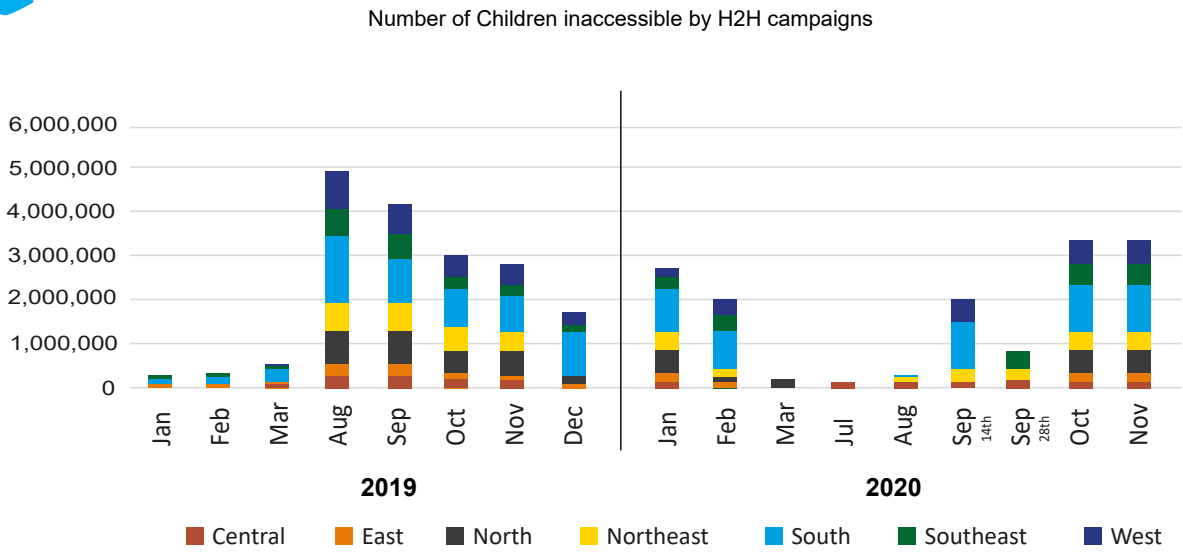
The programme has identified the following significant challenges / risks to stopping polio transmission in Afghanistan:

1. Inaccessibility and inability to perform house to house campaigns
2. Sub optimal campaign quality
3. Refusals
4. High Population Mobility
5. Chronically low Routine Immunization coverage in the polio high risk provinces
6. Continued COVID-19 Pandemic

1. Inaccessibility / Inability to perform house to house vaccination

As described earlier, the number of inaccessible children continued to increase significantly since May 2018. This has been due to a continued ban on the house-to-house strategy in most parts of the Southern region due to security concerns of the AGE. During the course of 2019, the program faced a complete ban on vaccination for approximately 6 months, that was partially lifted in late September 2019, barring the AGE controlled areas. In 2020, the ban continued in the AGE areas, expanded to a few areas in other regions (like North, North East, Central). It is important to note that the critical areas in the South Region are now under the ban on vaccination for nearly three years (around one million children), leading to significant drop in the population immunity and significantly heightened risk of further intensification and geographical spread of the wild poliovirus as well as cVDPV2. Currently, more than three million children are inaccessible in all the regions of the country. This risk is further topped up by the COVID-19 related disruption in SIAs for almost 5 months during 2020. Though the programme is maintaining dialogue at local, regional and global levels, there is immense need to intensify neutral negotiations with AGEs at all these levels and exploring possible additional channels for this purpose.

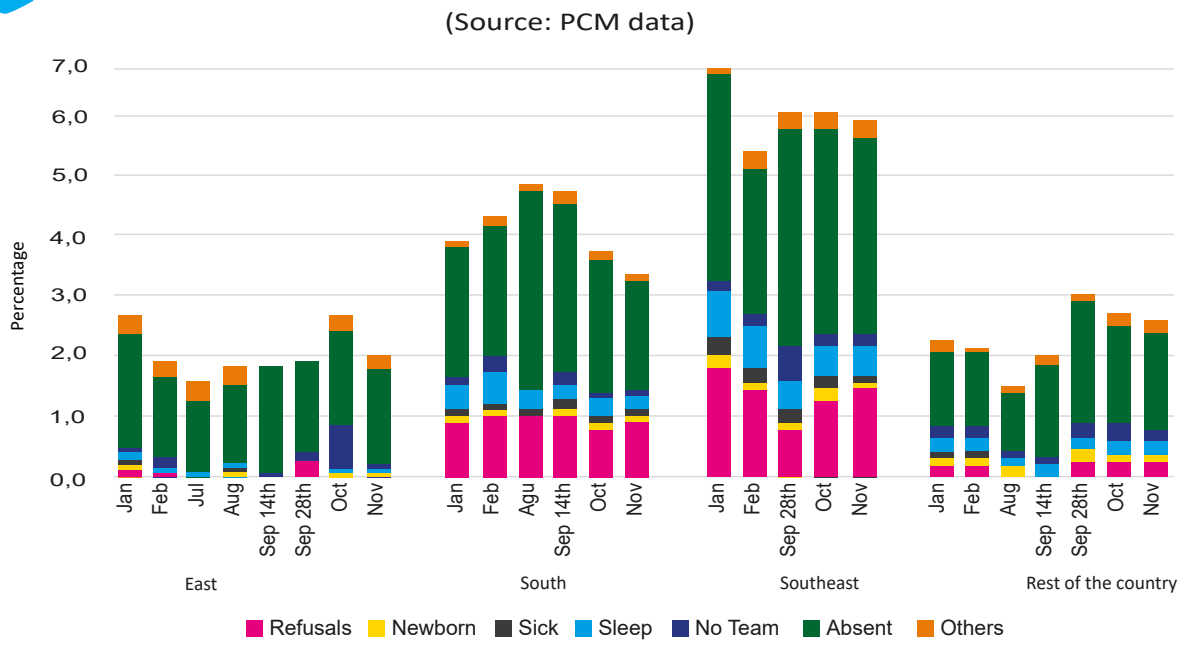
FIgure 3: Inaccessibility for House to House Campaign: 2019-2020



2. Sub-optimal campaign quality

The programme continues to face the challenge of compromised quality SIAs (both in accessible and AGE areas) due largely to management and accountability issues. Although the overall campaign quality in accessible areas is adequate, in-depth data analysis indicates that the quality of SIAs is not uniform at the sub-district level. This is particularly true for the critical areas of the South Region, including Kandahar city and Lashkargah provinces. Improving programme quality is one of the top priorities to eradicate polio which is prioritized and will be followed in the NEAP 2021. In accessible areas, the post-campaign independent monitoring indicates approximately 4% missed children in the South Region, 2% in the East, 5% – 7% in the South East and 2% - 3% in rest of the country; with 'child absence' and 'refusal' being the primary reasons (please see the graph below).

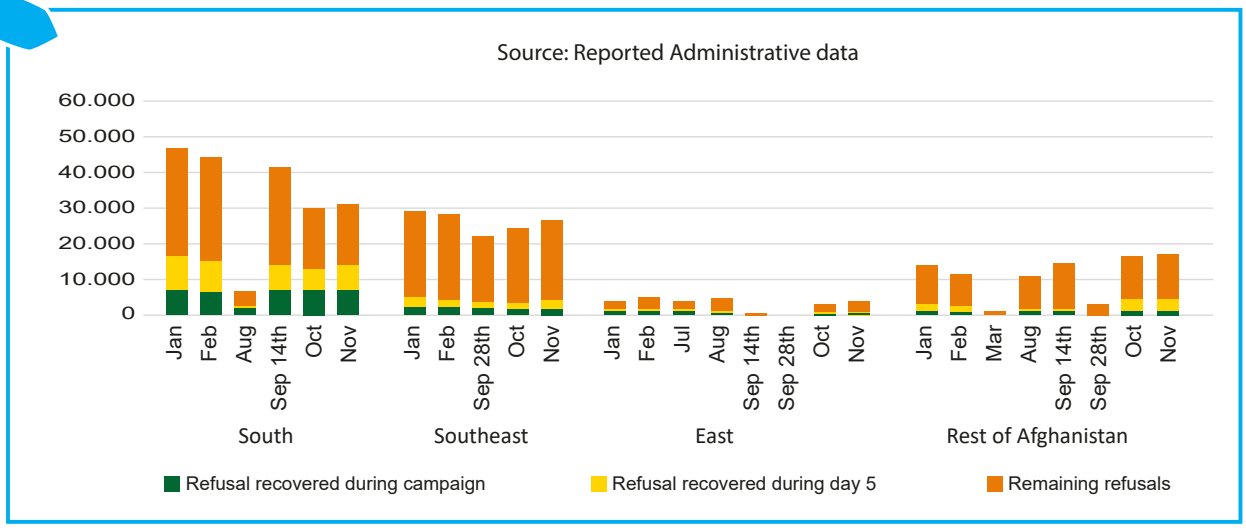
FIgure 4: Missed Children by Reasons & Regions – 2020



Reports from the field indicate problems in selection of frontline workers and other staff, lack of female vaccinators, training, supervision, capacity building, timely payment, monitoring, sub-optimal accountability, limited data use, gaps in follow-up actions in between SIAs, failed LQAS lots with lack of investigation and correction measures, sub-optimal implementation of revisit strategy and appropriate micro-plans implementation. In most of AGE areas, national monitors are not allowed to perform monitoring. The interference in selection of frontline workers / staff from many sources (in the accessible and AGE controlled areas) continues to be a challenge. Selection committees are either not sufficiently empowered or influenced, or lack commitment to follow the guidelines.

3. **Clusters of refusals**, particularly in and around Kandahar (South Region) as well as in the South East region. The refusal size in general is not very high; however, persisting high number of refusing families continue to be reported from the South and South East region, with the highest concentration in the Kandahar city and surrounding districts and Paktika province of South East region (please see 2020 trend in the graph below).
   The key reasons for refusals continue to be the religious objection, campaign fatigue, contents of the vaccine and lack of other health and development services, particularly in the marginalized and underserved communities in the South Region. Part of such refusals exist in the currently inaccessible areas of Helmand, Kandahar and Uruzgan provinces with active WPV-1 and cVDPV2 circulation.
   Reports also indicate that use of non-local staff, involvement of young male volunteers and lack of female vaccinators/social mobilizers add to the challenges around community acceptance for polio vaccine. These is exacerbated by community fatigue, multiple door knocking, staff capacity and low staff motivation pose additional challenges that will be under focus during 2021.

FIgure 5:Reported, Covered, Remaining Refusals by region, by campaign – 2020



4. High Risk Mobile Population, Moving between Afghanistan and Pakistan

Continued cross-border population movement between Pakistan and Afghanistan across due strong socio-cultural ties, trade and commercial reasons, continues to constitute a significant challenge for the programme – both in terms of difficulty to reach such populations (for SIAs and surveillance) as well as leading to ongoing shared WPV-1 and cVDPV2 transmission. This movement is not just limited to the border areas and demographically-linked areas close to the borders, but also to the areas far off the borders due to a variety of reasons. The four main groups identified by the programme and that will continue to be focused, include:

- Straddling population within the corridors
- Returnee refugees / displaced populations
- Nomads (seasonal and others)
- Long distance travelers

The UNHCR data show more than 10,000 refugees from Pakistan with ongoing influx of new Pakistani refugees from North-Waziristan Agency (Pakistan) to Khost and Paktika provinces in the South East Afghanistan, taking the total number to above 70,000.

Precise estimation of figures for nomadic population and long-distance travelers remains a challenge. The programme continues to focus on mapping of nomads, timely deployment of transit teams on the key routes of nomadic movement, further identification of any missed routes, and strengthening inter-sectoral collaboration with ARCS, UNHCR, Disaster Management Unit and Nomad's Independent directorate.

5. Low EPI coverage in high-risk polio areas

High routine immunization coverage always provides a strong base for population immunity to minimize the risk of polio. The RI coverage continues to be very low in polio high-risk provinces, particularly in the South region. The latest AHS survey (2018) indicates very low Penta-3 coverage in the polio high-risk provinces with the most intense polio transmission; that is Helmand less than 20%, Kandahar about 30% and Uruzgan less than 5%. Vaccination status data for non-polio AFP cases shows that 86% non-polio AFP cases aged 9 to 23 months were un-immunized or under-immunized in routine immunization in 2020. The proportion of unimmunized and under-immunized non-polio AFP cases in 2020 was 95%, 77% and 91% in Helmand, Kandahar and Uruzgan respectively. Considering these figures, there is need to upscale the efforts to improve EPI services in these provinces, including the birth OPV dose strategy.

The NGOs working at the provincial / district level are supposed to cover the entire population of the province. With only US$5 per capita and a contractual target population of 50% of the total actual population (comparing to NID population), even a high-performing NGO only has resources for around half of the eligible children.

The 'white areas' (geographical areas and population pockets missing due to inconsistent distribution of health facilities), insufficient budget, very few health facilities as well as governance issues, continue to be significant challenges.

With more than a million new births every year in Afghanistan, there is a growing immunity gap. Reaching newborns is an operational and communication challenge, with factors like cultural practice of keeping newborns inside the house for 40 days from birth. Reaching newborns requires emphasis and monitoring during training and implementation of the EPI service as well as during

house to house and transit points vaccination. Moreover, appropriate communication strategies need to be designed and utilized, accordingly. Timely OPV-0 through routine immunization will also have positive impact on stopping transmission. Moreover, timely EPI vaccination with IPV will help reduce paralytic disease from WPV-1 and cVDPV2.

6. Continued COVID-19 Pandemic

The COVID-19 pandemic is still continuing in Afghanistan with varying intensity, sub-nationally. The programme will continue to assist response as appropriate. The risk of varying COVID-19 impacts on the programme implementation will continue, until the pandemic comes under complete control. Afghanistan is planning for the roll out of COVID-19 vaccine, during the course of 2021. The polio programme will have to adjust its activities and strategies as per the evolving polio and COVID-19 epidemiology as well as interventions for the two initiatives. The programme will also continue to ensure appropriate application of infection prevention and control (IPC) for the safety of frontline workers and the communities.

Section 4:

Development and operationalization of NEAP 2021

The programme continued to face unique and critical challenges during the year 2020. The ongoing ban on house to house vaccinations is now completing almost three years. In view of the current epidemiology and challenges, including the cVDPV2 outbreak (following importation from Pakistan), the National Emergency Action Plan was updated for 2021 using a bottom-up consultative approach. The Regional EOCs consulted and brainstormed with the provincial and district teams on identifying the current challenges, interventions implemented, and key lessons learned in 2020. Based on the deliberations, adjustments to the current strategies and activities as well as new interventions will aim to address the remaining challenges.

The National EOC convened a workshop with regional teams to discuss and compile the plans proposed by the regional teams. All the propositions were compiled and reviewed by the National EOC's Strategy Working Group for technical and operational feasibility and response was shared with the regional teams. Moreover, the NEAP document incorporating feedback from regions and partners was shared with the TAG (and presented during a consultation meeting in March 2020) and guidance of the TAG was incorporated. The NEAP was also discussed and shared with NGOs of high-risk provinces as well as widely shared with partners, and relevant comments were considered and incorporated.

For the effective operation of NEAP 2021, the programme will take the below actions:

Improving the Implementation Mechanisms through Strengthened leadership and Management of PEI programme at the central and provincial levels

The network of EOCs in South, East, West and Southeast regions under the direct leadership of NEOC with the support of MoPH leadership play an important role in coordination of activities within and among the programme stakeholders, collaboration with other MoPH departments, sectoral ministries, CSOs and managing and oversight of the NEAP implementation countrywide.
The established EOCs at the regional and provincial levels of South, East, West and Southeast have shown great success but there is further need for support to improve the capacities and performance of the programme implementation in the rest of the country through PPHOs/REMTs/PEMTs, where there are no EOC.

Implementation of plan

Based on the new changes and clear instruction of HE the President and MoPH leadership, the NEAP should be jointly developed with precise, clear accountability roles and responsibilities of each involved partners.

Costing

The GPEI local partners under the leadership of NEOC will cost the NEAP interventions and share with MoPH leadership and GPEI global partners.

Accountability framework

A joint team under the umbrella of National EOC is assigned by MOPH leadership to develop a clear accountability framework capturing programme implementation, monitoring and oversight for the entire programme. The NEAP implementation will strictly be tracked by the EOC to monitor the progress towards the plan objectives and resources utilization.

The accountability framework will lay special emphasis on monitoring the programme quality at local level in the accessible areas of South and Southeast Regions, with region specific indicators and linked accountability related measures.

Coordination bodies

- National steering committee:
  - Chaired by H.E. the President of IRA
  - Attendees: Minister of Public Health, NEOC Coordinator with NEOC assigned staff, One-UN Team leader including GPEI implementing partners
  - Meets quarterly or biannually to review the progress and garner support from all parts of the Government including line ministries and Governor

- Polio executive committee/Polio partners dialogue:
  - Chaired by H.E. the Minister of Health, and participated by National NEOC Coordinator, NEOC senior staff, country representative of WHO & UNICEF, International partners including GAVI and World Bank, and program executives
  - Meets quarterly or scheduled based on the need, to review the progress and challenges in polio eradication and provide feedback to H.E. The President

- TAG meeting: every 6 months
- IMB meeting: Every 6 months
- POB meeting: Every 6 months
- Polio update to MoPH Executive Board meeting: every 3 months
- PEI and EPI coordination meeting including NGOs and MoPH Directors: every 3 months
- Polio program strategic and technical working groups meeting: On weekly or biweekly basis and the frequency of the meetings would be decided based on the need and priorities
- Field EOCs coordination meeting: On weekly or biweekly bases and the frequency of the meetings would be decided based on the need and priorities
- Exposure visits for the national and regional EOCs on quarterly basis

Section 5:
Goal

- To stop transmission of wild poliovirus in the South and East regions of the country and respond to / stop any WPV-1 outbreaks in the non-reservoir areas and prevent the spread to currently polio-free areas
- Stop the cVDPV2 outbreaks by third quarter of 2021

Section 6:
Objectives

The NEAP 2021 has the following objectives:

1. To stop ongoing WPV-1 transmission in the South and East regions, with special focus to stop transmission in the accessible areas in 2021
2. To stop cVDPV2 transmission in the accessible areas by end-2021
3. To review, streamline and optimize the functioning of polio EOCs, by quarter-3 of 2021
4. To rapidly and effectively respond to any of WPV1/VDPVs outbreaks in the polio free areas of Afghanistan, ensuring no secondary cases following any importation
5. To ensure safety of frontline workers and communities through maintaining effective infection prevention and control for COVID-19 transmission during the polio eradication activities
6. To maintain a scenario-based approach to rapidly adjust to any possible/anticipated access and programmatic situations
7. To improve community acceptance and demand for vaccination and address vaccine refusals through effective and locally appropriate communication strategies
8. To integrate gender equity considerations at the program planning and implementation level, appropriate to the Afghanistan context; and monitor adherence to these considerations from the EOCs level
9. To maintain effective access dialogue in coordination with all the national and international partners aiming to have access for house to house polio campaigns across the country
10. To achieve and maintain high population immunity among HRMPs
11. To enhance program quality with focus on high risk provinces/districts to uniformly reduce missed children to less than 3% at the sub-provincial level (especially in the accessible areas). Special emphasis will be laid on effectively reaching the new-born and infants.
12. To maintain sensitive and high-quality surveillance for polioviruses, across the country with consideration for possible expansion of environmental surveillance, as per feasibility

Section 7:
Key Residual risks

The programme considers the following as major risks to stopping endemic WPV-1 transmission and cVDPV2 outbreaks in Afghanistan; some of which are beyond the control of the programme making it significantly challenging.

- Continued / prolonging inaccessibility in the traditional polio reservoirs; significantly influenced by the broader geo-political situation
- WPV-1 and cVDPV2 co-infection (following cVDPV2 importation from Pakistan) over a large geographical region, including the inaccessible areas.
- Competition between response to WPV-1 and cVDPV2
- Risk of further seeding with mOPV2 / tOPV use
- The ongoing unprecedented COVID-19 pandemic (and introduction of COVID-19 vaccine during 2021)
- Impact related to the fact that Afghanistan and Pakistan are one epidemiological block; both countries need to finish the job together.

Section 8:
Strategies / Strategic Interventions

This section describes the programme's salient strategic course as well as the key interventions planned during the period of March 2021 to March 2022. It is pertinent to mention that the programme was significantly impacted by the COVID-19 pandemic in 2020, including a complete pause of SIAs from March to July 2020. The pandemic also delayed the SIAs response to the cVDPV2 importation from Pakistan, that led to an explosive cVDPV2 outbreak that is continuing. The approaches and interventions in the NEAP 2020 could not be implemented in letter and spirit due to unprecedented situation related to the COVID-19 pandemic.

The key strategies to expedite the interruption of WPV1 as well as stopping the cVDPV2 outbreaks in Afghanistan, during the course of the 2021 and early 2022, are as follows:

- Implement four NIDs and two SNIDs in 2021 with bOPV and targeted use of IPV as part of the multi-antigen / accelerated campaigns in selected high-risk areas (as per the evolving WPV-1), as and when feasible
- Case response to new WPV-1 cases / isolates in the non-reservoir areas of the country i.e. implementing three bOPV vaccination rounds in synch with planned bOPV rounds (preferably within 8 weeks after the onset of last WPV-1 case / collection of last WPV-1 environmental samples). The scope of case response campaigns will be decided as per the epidemiology
- Plan and implement case response vaccination rounds with type-2 containing vaccines, as per the evolving cVDPV2 epidemiology; the country will use tOPV or nOPV2, based on availability and findings during the initial nOPV2 use with considerations of the epidemiology of both cVDPV2 and WPV1
- Review the risk categorization for high-risk areas and continue focus on the high-risk districts identified in NEAP 2021
- Improve programme quality in accessible areas with focus on high-risk provinces/districts (special attention on reaching newborns and infants)
- Maximizing reach in inaccessible areas, using all possible strategies and contingency interventions, particularly in the context of expanding cVPDV2 outbreaks in inaccessible areas
- Assess / review (in view of the evolving challenges), optimize and further augment communication / social mobilization strategies to improve community vaccine acceptance and demand
- Identification, mapping and coverage of High-Risk Mobile Populations with focus on the Southern, Eastern and South-eastern regions

- Maintain sensitive surveillance for polioviruses; and continue desk and field monitoring / reviews; consider an independent / international review during 2021, as feasible (considering the security and programmatic situation)
- Maintain PEI's support to strengthen routine immunization with focus on polio high risk areas
- Review the accountability framework, identify ways to fine-tune and initiate it's use latest by mid-2021
- Review the implementation and impact of the integrated health services towards building population immunity in 2021, and further fine-tune / improve the planning and implementation (in the light of lessons learnt) of these services in high-risk areas of Kandahar, Helmand and Uruzgan provinces of the South region
- Maintain vigilance for the evolving situation of the COVID-19 pandemic and continue adjusting the polio eradication activities accordingly, to ensure the safety of health workers and communities
- Review all programme plans and ensure incorporating gender related analysis for all regions / areas, with special focus on high risk communities / localities. Gender disaggregation will be ensured in the information / data sets on SIAs and surveillance to generate evidence for planning and decision making at all levels. Moreover, clear parameters will be included in the program's human resources (HR) policy at all levels to ensure gender equity as well as ongoing supportive supervision of the female workers / staff.

Overarching focus

Southern region

Given that south region has been the driver of poliovirus circulation in Afghanistan, the programme will continue focus on interrupting transmission in this region in 2021.

- Intensive HR support along with establishing infrastructure for provincial EOC in Helmand
- **"No tolerance policy"** for campaign quality gaps in accessible areas
    - "Strengthen the basics" – improving frontline worker selection (minimizing interference, improving female participation at all levels), trainings, microplanning, monitoring and supervision – all focused to improve the reach to all the children inside the households
    - In-depth analysis of the reasons of missed children and devise appropriate interventions to reach them
    - Disaggregate and analyze the refusals by reasons and geographic clustering and address them with "reasons specific strategies / plans"
    - Further probe into the new-born (under a new-born strategy), sick and sleeping children and find out the real reasons of these missed children, to be addressed
    - Disaggregate the category of "others" among the recorded missed children, analyze to understand the reasons and strategize to address
    - Special focus on mobile populations and tailoring appropriate communication strategies suiting the local context
- **Ensuring maximum reach in inaccessible area**
    - Intensified access dialogue with engagement of all partners and utilizing any possible opportunities at all levels
    - Engage with local communities to enlist their support towards addressing operational challenges and build trust
    - Roll out integrated services plan to reach maximum number of children
    - Regular review and rationalization/ strengthening of alternate strategies such as PTT, IPV campaigns, utilizing alternate opportunities (measles campaigns, multi-antigen campaigns) based on changing access situation
    - Maintain preparedness and implement SIADS (3 passages) of H2H campaigns as soon as restrictions lifted

Eastern region

- Continue to focus on quality assurance measures in all the areas that can implement house to house campaigns, with "no tolerance policy" for any under-performance
- Recognizing the continued cross border WPV1 / cVDPV2 transmission with Pakistan, the following strategies will be at priority:
    - Maintain sensitive surveillance with regular review at all levels
    - Close coordination with Pakistan program to address HRMPs, and coordinated vaccination strategies (SIAs & case response)
    - Continue focus on reducing missed children in accessible areas
    - Enhanced emphasis on newborns and infants

Southeastern region

- **Systematically address refusals among refugees**
- **Maximize efforts to reduce missed children and tailored vaccination strategies for HRMPs as per their movement patterns**
- **Regular review of surveillance**

Rest of Afghanistan

While focusing efforts in core reservoirs / high risk areas, program will maintain high population immunity by improving quality of SIAs and improving EPI in rest of the country (including the birth dose).

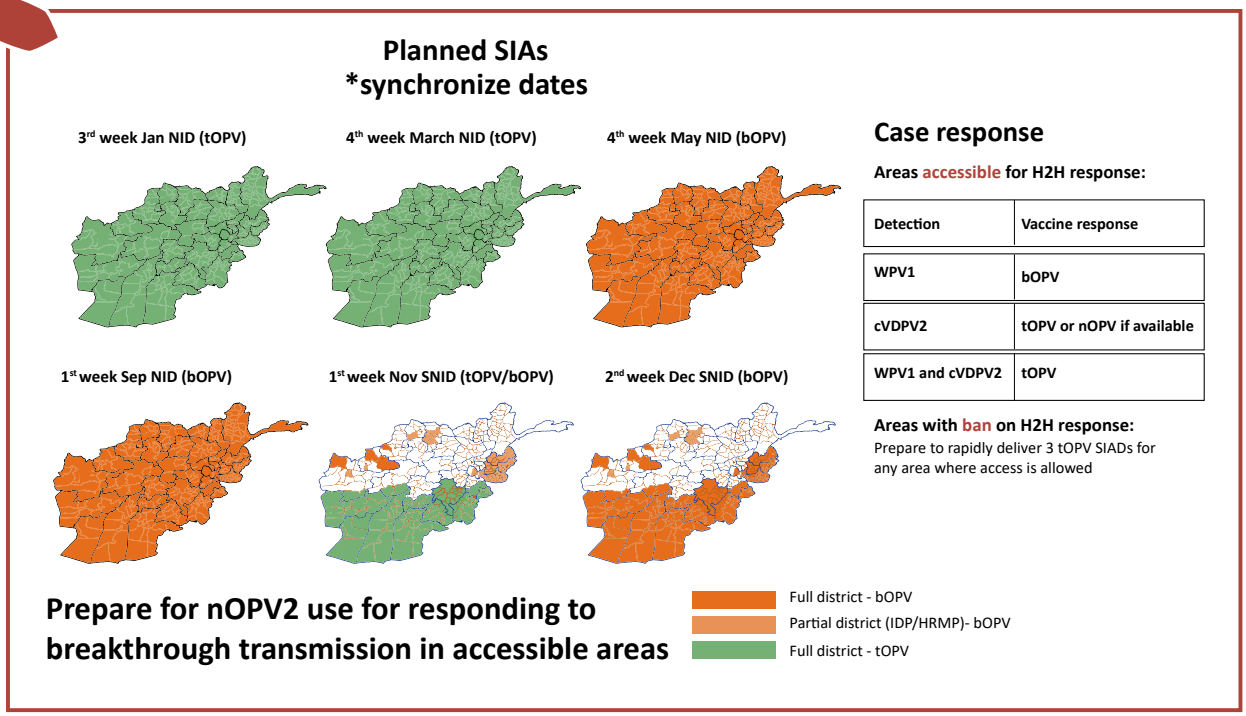
Below is a brief description of the key interventions planned as well as the measures to improve quality of the program activities.

8.1 Conduct supplementary immunization activities

The programme plans to implement 4 NIDs and 2 SNIDs in 2021. Of these, 3 NIDs and 2 SNIDs are planned during the low transmission season. The programme will continue to coordinate with Pakistan to synchronize the major SIAs, when feasible. The programme has consciously increased the number of NIDs and limited SNIDs considering the spread of WPV1 to earlier polio-free areas which are not a part of earlier scope of SNIDs and have reduced population immunity due to restriction on house to house campaigns that has resulted in poliovirus importation and established circulation.

Competing priorities of managing both WPV1 and cVDPV2 outbreaks are being considered in the 2021 SIA calendar. The planned calendar for 2021 includes two tOPV NIDs in Q1, one bOPV NID in Q2 and Q3 each, and two SNIDs in Q4 – one each with tOPV and bOPV. This will give a total of two type-2 containing OPV opportunities in the entire country and three in high risk areas; and, four type-1 containing OPV opportunities in entire country and six in high risk areas. Vaccine of choice for additional case responses will be bOPV for WPV1, tOPV or nOPV2 (if available and based on preparedness) for cVDPV2, and tOPV for co-infected areas with WPV1 and cVDPV2.

FIgure 6:Reported, Covered, Remaining Refusals by region, by campaign – 2020



The programme will continue to collaborate with the COVID-19 response, keep track of the pandemic and adjust the polio eradication operations including the SIAs as per the evolving situation. The programme will continue to prioritize the safety of polio health workers as well as the communities and will ensure infection prevention and control measures during the SIAs planning and implementation.

As part of the multi-antigen / accelerated campaigns led by the EPI Afghanistan, IPV will be used in identified high-risk areas in the light of the evolving WPV and cVDPV epidemiology. Inaccessible areas that become accessible, will be prioritized for IPV usage, after delivering two to three bOPV doses. IPV coverage / vaccination quality should be meticulously supervised and monitored and polio eradication assets / staffs will be engaged in the monitoring process, as feasible. Response to the cVDPV2 outbreak will be made using appropriate type-2 containing vaccine as per the evolving epidemiology and availability of vaccine, under the advice of the Technical Advisory Group.

8.2 Focus on high-risk provinces and districts

Access for vaccination has been continuously deteriorating since the first half of 2018, with some areas inaccessible for nearly three years (especially in the South Region). All the areas that have been inaccessible for house to house vaccination campaigns for prolonged period have very low population immunity against the WPV-1. Hence, the programme considers all districts with more than 50% target population inaccessible for vaccination for more than two years, as high-risk for programmatic purposes. Population immunity against type-2 poliovirus is very low across the country since it has been nearly five years since the tOPV-bOPV switch (except the areas that have recently implemented vaccination campaigns with type-2 containing polio vaccine).

Based on polio epidemiology, longstanding inaccessibility for SIAs implementation and other epidemiological factors (population immunity, presence of refugees/IDPs, in-country and cross border travel patterns etc.), 33 districts of the country have been flagged as high-risk, 109 as medium risk and 257 districts as low risk for sustaining poliovirus transmission (please see annex for risk categorization list and map). More than 85% of the polio cases since 2014 have been reported from the 33 high-risk districts. Seven provinces have been flagged as high-risk province, namely Kandahar, Helmand and Uruzgan in the South region, Nangarhar and Kunar in the East region, Paktika in the South East and Farah in the West region (these provinces account for more than 80% of the polio cases since 2014). It is important to note that inaccessibility in some critical parts of the country (notably South Region) has been persisting for almost three years, while access challenges have geographically expanded since mid-2019. The program will continue to periodically review and adjust the risk categorization, as per the evolving epidemiology.

The Programme will lay zoomed focus on the high risk districts as per the revised categorization, including adjustment of SIAs schedule and scope, enhanced technical and programmatic support for operations and social mobilization, targeted supportive supervision and monitoring from the provincial and national levels as well as support from the Ministerial and higher levels on administrative and accountability related aspects.
The program will further enhance focus on the districts having ongoing population movement with the core reservoirs i.e. northern and southern corridors, ranging from Afghanistan to across the border in Pakistan.

8.3 Improving programme quality in accessible areas

The programme aims to continue and innovate targeted interventions to reduce and bring the proportion of missed children to 3% or less at district and cluster level in high-risk areas and achieve proportion of passed LQAS @ 90% above 90%. Every LQAS lot below 90% will continue to be considered failed. These benchmarks will be particularly monitored for the accessible areas where house to house vaccination is possible.

The programme will regularly disaggregate and investigate the reasons of missed children for each vaccination round and address the root causes in between the rounds. The programme will revise guidelines for recording various types of refusals for targeted interventions. The programme will plan for better understanding and disaggregating the recoverable children (who return to their houses within the period of campaign) and non-recoverable absent children (children who do not return within campaign) to ensure every child available for vaccination is reached through appropriate approaches. Further in-depth analysis will be carried out for the missed children currently recorded as “newborn, sick, sleeping (NSS)” to identify the real reasons for missing these children.

The recording tools (used by FLWs / supervisors) and compilation / analyses at the regional / national levels will be reviewed and revised accordingly to guide the programme. Vaccinating newborns, identifying and vaccinating guests, and focusing on sick or sleeping children will be focused during the trainings and will be highlighted in training modules.

The use of ICN will continue to focus in the highest communication risk regions / areas of the country. The ICN will be optimized to ensure quality community engagement that goes beyond house to house visits while also appropriately complimenting the work of vaccination teams / volunteers.

Efforts will continue to increase female participation in ICN through special gender strategies and incentives. Continued emphasis will be placed on overall efforts to reduce missed children based on analysis of non-vaccine reasons and subsequent action plans and appropriate messages use. ICN in the high-risk areas of South Region will continue to report and track missing and absent children and report on emerging rumors in clusters, silent refusals and proposed actions for the program to consider.

A “No Tolerance Policy” for campaign quality gaps will be utilized for the areas fully accessible for house to house campaigns and monitoring, thoroughly utilizing the programme accountability framework at all levels. Any quality gap will be treated as priority for addressing the reasons. Appropriate steps will be initiated as per the accountability framework, aimed at improving the program implementation quality. The National EOC will continue to encourage frank and transparent data / information reporting, with zero tolerance for data / information misreporting / fudging. Persistence of any issues in resolving the quality gaps will be immediately taken up by the National EOC for intervention from national level including the Ministerial level. Fundamental elements of campaigns planning, and implementation will be focused, including the microplanning, selection of frontline workers, trainings, monitoring & supervision, and data quality & utilization. Interventions listed below are directed to address these fundamental components of the programme.

The national EOC in coordination with the regional / provincial EOCs will continue to focus on improving quality of end-day / evening meetings during the campaigns, to be maximally utilized for improving the implementation quality by providing necessary support and exercising necessary accountability. The national EOC will also hold regular post campaign review meetings (engaging the regional / provincial teams) to ensure that the feedback and lessons learned are documented and used for quality improvement.

Continued monitoring of process indicators such as team composition, team performance and supervision indicators will be done to address gaps affecting the quality of campaigns. Also, the monitoring and coverage data of revisits will be analyzed in a disaggregated manner to identify and address implementation issues.

8.3.1 Frontline workers

Unbiased selection of appropriate FLWs will be ensured for all the campaigns. Any favoritism or nepotism related to selection process will have no acceptance and appropriate actions will be initiated about any such finding. Close monitoring from national level will be done for FLW selection through the following interventions:

- Close monitoring and support to the FLWs selection committees by the NEOC and empowering them to function effectively and transparently, without any interference. Heads of all selection committees will have direct access to the National EOC to report any undue influence for selection of FLWs.
- Establish functional, impartial and well-balanced district selection committees in coordination the relevant health shuras, particularly in high risk provinces
- National monitors will review FLWs selection for each campaign, particularly in SNIDs' areas of their assigned provinces. Any deviation from guidelines or influence on selection will immediately be brought to the attention of the Coordinator National EOC and Strategy Working Group for appropriate action. When required, chronic interference and nepotism will be brought to the attention of the Ministerial level for support and rectification.
- Selection committees will make transparent and active efforts to engage more females as FLWs including vaccinator, supervisor, ICN and ICM. Percentage of females as FLWs, particularly in urban areas, will be tracked over the rounds to monitor the progress.
- Selection committees in the high-risk provinces will have at least one female member, to facilitate and promote the recruitment of female FLWs.
- The National EOC will track and regularly update database for the FLWs composition.
- The national EOC in coordination with regional / provincial EOCs will ensure appropriate and timely escalation of any interference in selection of FLWs, under an institutionalized mechanism. This would include timely reporting of such issues to the highest levels (Governors, Ministerial level etc.) and track the actions.
- The National EOC will continue to directly monitor and support the engagement of female FLWs and mid-level managers. The National EOC will also ensure an enabling environment at all levels for recruiting and sustaining female workers at all levels.
- The program will review and strengthen accountability of FLWs and will track the implementation including removals based on objective documented criteria.
- The program will recognize the best performing personnel and reward the best performing FLWs (using non-monetary incentives) to maintain their motivation.

Along with this, the below measures will be taken to sustain motivation:

- Timely payments of FLWs will be ensured, i.e. 90% of payments to be made before the next planned campaign in SNIDs areas and within 1 month in non-SNID areas. This will be tracked from the national level.
- A thorough joint review of the Direct Disbursement Mechanism (DDM) was carried out in 2020 by the global experts and the national program. The action plan devised by the review could not be comprehensively implemented due to COVID-19 led major pause in the campaigns during 2020. The program will follow up and implement the DDM action plan to improve the timeliness of payment to the frontline workers by June 2021. Expansion of DDM to additional areas of the country will be done as per operational feasibility and preparedness. The program will continue to periodically review the payment mechanisms to identify and fix the gaps and continue working towards improving the efficiency and timeliness.
- Ensure transparent disbursement of incentives to the FLWs as per the rate card revised in 2020.

8.3.2 Training

Appropriate Training of the front-line workers will be among the key focus areas of the programme to improve the overall quality of campaign implementation. The following interventions will be done under close supervision of the National EOC:

- As follow up to the revision of training manual in 2020, the National EOC will review the implementation of the revised training manual during the first quarter of 2021 and tease out the lessons learnt. Any further required revisions will be made in the training manual by end-April 2021. In this regard, the key focus will be to ensure simplicity in the training module with focus on identification and recording of all eligible children, ensuring vaccination of newborns and guest children, and recovering missed children by the end of the campaign. Any material not relevant to vaccination team's work will be taken out of the training module. Training module should continue to include components on IPC and reflect different communication strategies for H2H and site-based vaccination. The training module will also include building the basic skills on field problem solving at the household and community level.
- Trainings in high-risk districts by programme staff themselves (rather than team supervisors)
- Effective use of training monitoring data to take corrective measures
- Direct oversight on the functioning of training committees in high risk provinces and ensuring their effectiveness

8.3.3 Microplanning

Following the micro-plan validation exercises undertaken in recent years, revision and updating of micro-plans will be ensured before each campaign. Mechanisms to monitor the revision of microplans by each supervisor will be maintained, with special focus on the high-risk provinces / districts. In addition, key components of microplanning such as team/supervisor/coordinator workload and team composition will be tracked for each campaign.

The programme will continue to monitor the need for any major micro-plan revision based on the findings of campaign monitoring. If there is need (based on significant evidence), targeted micro-plan revision exercise will be carried out in between the campaigns under the supervision of the regional / provincial and National EOCs (more details in section on monitoring and evaluation). Need for special micro-plans revision will be assessed in the provincial capitals on annual basis.

8.3.4 Focus on newborns and infants

Special attention will be paid to newborns and infants during vaccination campaigns, including during revisit and catch up phases, through:

- Recording of newborns/infants by ICN in pre-campaign and in-between round phase and support to vaccination teams during the campaigns.
- Emphasizing importance of vaccinating newborns and infants during training and monitoring.
- Increasing female frontline workers for better interaction at household level to identify and vaccinate newborns and infants.
- Increasing the participation of female supervisors and monitors to support the frontline workers.
- Training the transit vaccination teams (including the cross-border teams) to appropriately approach families and vaccinate newborns / infants.
- Strengthening referral mechanism to enroll and follow up newborns for EPI vaccination and other convergence aspects to gain and maintain trust in the community.
- Engaging women and community at large on the importance of newborn vaccination through dedicated messages on the overall child vaccination, combined with complimentary giveaways at risk areas.
- Improving accessibility of health service and vaccines through harmonizing existing and polio plus activities and integrated health services.
- Identifying 'white (areas not covered by any health facility for routine immunization)' and underserved areas (villages level) and coordinating them for inclusion within the outreach schedules with or without additional resources.

8.3.5 Revisit / catch up vaccination of missed children

Given that the most remaining missed children are absent or refusals, the program will take the below mentioned interventions to strengthen revisits for their vaccination:

- The National EOCs will make necessary changes for timing and modality as well as aim to streamline the work division among the vaccination teams / volunteers and ICN (whereas ICN role continues to focus on vaccine promotion and community engagement rather recovery and vaccination of missed children). The daily revisit strategy will be strengthened by appropriating the supervision mechanisms / checklists. As well, the planning for revisit will also be fine-tuned / improved, appropriately utilizing the planning day.
- The revised revisit strategy piloted and successfully adopted in Kandahar city and Lashkargah will be expanded to other high-risk districts of the South Region and other regions (as feasible), by the end of mid-2021.
- Strengthen supervision and monitoring of the daily revisit during three days of the campaign to improve effectiveness of "recovery of missed children during campaign" followed by proper and focused planning and implementation of missed children catch-up on the revisit day(s).

8.4 Maximizing reach in inaccessible areas

Access for vaccination in Afghanistan has been very dynamic; of note is the rapidly deteriorating and fluctuating access situation since May 2018. There is generally an increase in inaccessibility since May 2018 with a period of complete ban from April to September 2019. Despite the lifting of ban in end-September 2019, house to house vaccination remains restricted for more than 40% target population of the country, particularly in the South, South East and Western regions as well as some pockets of North and North East regions. Apart from these on-off bans, the program also faces chronic inaccessibility in some parts of the Eastern and Southeastern regions accounting for around 30,000 children missing vaccination opportunities for several years.

For gaining and maximizing reach to children in inaccessible areas:

- The programme will maintain neutrality for polio eradication and will continue to strive toward reaching all Afghan children with polio and other vaccines
- Access dialogue will continue at all levels ranging from local to international, with engagement and support of all partners who can positively assist on gaining / maintaining access for house to house polio campaigns.
- Local coordination will be maintained with the AGEs aiming high quality polio program implementation and reaching all the children with polio vaccine during all the planned vaccination campaigns. In case of some specific local situation or objection by AGEs on some component of the program, the Regional EOC/regional teams will take decision in consultation with the National EOC.
- The programme will continue local level dialogue (at village, district and provincial level) to address any local bans / restrictions through local staff and if not resolved, national level will take it up to appropriate level for interventions.
- For areas with bans on house-to house-campaigns, the programme will:

    o Continue to utilize scenario-based approach / matrix to adapt to the evolving access situation

- Negotiate site to site vaccination in case there is utmost AGE resistance for house to house strategy
- Develop enhanced key messages and materials to explain why house to house vaccination approach is the gold standard for polio eradication.
- For any site to site campaigns, there will be enhanced planning, mobilization and monitoring to achieve the highest possible quality. Program will continue to review and improve SOPs for site to site campaigns based on the lessons learnt from previous implementations.
- As site to site vaccination is primarily a contingency plan and has shown to not reach coverage required for eradication, the program will continue to negotiate for house-to-house campaigns while conducting S2S campaigns. Preparedness will be maintained to start SIAs within 10 days of gaining access. In the event of possibility of only S2S campaigns, the program will maximally utilize the lessons learnt from the previous such campaigns aiming to reach maximum possible children
- The programme will continue to use additional vaccination opportunities e.g. IPV-OPV campaigns, addition of OPV to other vaccinations activities, intensifying EPI and mobile health teams. Also, necessary modifications will be considered for Permanent Transit Team strategy as per access situation

- For chronic inaccessibility, e.g. the Eastern and Southeastern regions, the program will conduct:

  - Regular rationalization and redistribution of PTTs as per inaccessibility at entry/ exit and health facilities
  - Preparedness to conduct 3 passages of catch up SIADS within 10 days of opening-up. The program will assess the situation and may consider expanding age group during SIADS, depending on duration of inaccessibility and other epidemiological factors. The program will also explore the possibility of delivering IPV with one of the rounds.
  - Polio Plus activities/ mobile health teams and IPV/OPV from health facilities near chronically inaccessible areas through BPHS NGOs as well as other actors having capacity to deliver
  - Additional vaccination opportunities, e.g. addition of OPV to other vaccinations activities and intensifying EPI

A comprehensive plan is being developed for the inaccessible areas of the three high risk provinces of South Region i.e. Helmand, Kandahar and Uruzgan. The plan will be supported by the GPEI partnership (as feasible), in support of the National EOC / Ministry of Public Health (Government of Afghanistan) with the aim to reach all the Afghan children with polio vaccine across the three provinces (and ultimately in the entire country). The main objective of developing this plan (as an extension of the NEAP) is to strengthen coordination among the several efforts and interventions being supported by the GPEI and international partners and to ensure complementarity for all such efforts.

Key components of the plan (as of Feb. 2021) include polio and routine vaccination through appropriate outreach approaches, strengthening existing complimentary intervention to reach additional children, strengthening the existing health facilities and support setting up new health facilities, supporting the existing efforts for routine immunization and further strengthening the access dialogue approaches. This comprehensive plan will follow a live planning approach with coordinated contribution from all the GPEI partners and will be adjusted according to the evolving situation.

For areas bordering Pakistan, inaccessibility information will be shared with Pakistan for possible interventions from their side, mainly for deploying PTTs at exit/entry points.

8.5 Enhancing EPI/PEI convergence through delivery of Integrated Services to build population immunity in high risk districts of South Region

As mentioned above, the districts of South region with ban on house to house vaccination have been driving the polio epidemiology in Afghanistan. Health facility-based vaccination campaigns in these districts could reached less than 10% target children since 2019, as the health facilities merely operated in a usual daily routine, offering routine immunization for 4 days with a few additional permanent transit teams. It is noted that:

- Many areas in the high-risk / inaccessible districts of Kandahar, Helmand and Uruzgan (south region) do not have any health facilities.
- Some of the existing health facilities are not fully functional and some could not be included in the plan and lack proper budget, staff and supervision/monitoring mechanisms.
- More than 300,000 target children live at a walking distance of more than one hour from the nearest health facility in the AGEs controlled areas.
- In a very fluid security situation in the AGE controlled areas, the families are not expected to walk for hours with several children unless there is a comprehensive package of health services and pluses at the HFs.

More than half (54%) of the population in Afghanistan lives below the poverty line. The 2019 Integrated Food Security Phase Classification (IPC) report shows that 37% of the population are in need of humanitarian assistance, and recent estimates indicate more than 41% children aged less than five years are stunted. These figures are even more significant for Kandahar, Helmand and Uruzgan provinces in the South Region. Moreover, very low literacy rates in these provinces (<15%) lead to very low community awareness for utilizing immunization services. Being very underserved, the communities in these provinces continue to demand other health services, increasingly refusing stand-alone polio vaccination. Embedding polio vaccination within broader routine immunization and health interventions is an option to be considered in the given scenario (no house-to-house vaccination since May 2018).

The National EOC in coordination with BPHS NGOs management, National EPI and in-country GPEI and development partner has developed a plan for the delivery of polio vaccination embedded within integrated health services. The key geographical focus of this plan is Kandahar, Helmand and Uruzgan provinces in the South Region. The goal of the plan is to fast-track the progress to interrupt poliovirus transmission in the south region of Afghanistan and to contribute to the strengthening of immunization services and health system to help achieve and sustain polio eradication. The plan aims to reach approximately 800,000 missed children, in coordination with all potential partners, and utilizing existing and new health facilities through expanding immunization services and opportunities in fixed, outreach, mobile and health week strategies. With no access for house to house and site to site vaccination, this kind of approach becomes the mainstay for the program to reach maximum possible number of children.

Considering the prevailing situation in the South region, a comprehensive national "integrated services plan" was developed in consultation with in-country and global partners as we all as national and provincial teams. The plan aims to build population immunity in the chronic reservoirs of south region including the inaccessible areas and sustain it in medium to long term, in the context of persisting challenges in the South region. The plan is in line with 2019-2023 polio end game strategy and TAG recommendations in the scenario of continued ban on house to house vaccination. In addition, the plan is a follow up to the endorsement made in November 2019 at the POB meeting in Abu Dhabi and IMB recommendations.

Key interventions for convergence, Integrated and Polio plus Service Delivery in South Polio-endemic Areas will focus on following areas and interventions:

In order to further boost polio eradication efforts, EOC and its partners will continue strengthening convergent interventions for addressing basic needs to facilitate the implementation of NEAP. The polio affected provinces of south region will be further used as entry points of convergence and integrated services; and the interventions will be made more accessible and be delivered closer to the community. Summary of planned intervention to enhance implementation of NEAP in South region includes the following major activities:

1. Health interventions: BPHS NGOs are providing integrated maternal and child health in PHC units through fixed and outreach services. In order to strengthen the provision of basic health services to the people of high-risk districts, special focus is placed on increasing penta-3 coverage to >90% by the end of June 2021.

The proposed intervention will include:

- Establishment of 62 new HFs, staffed with two to four vaccinators, one midwife and one nurse in three provinces of the south
- Establishment of additional 72 MHTs (Integrated Service Outreach teams) in high-risk provinces in the south,
- Improved utilization of health/immunization services through pluses at the health facilities to attract clients such as soaps and baby blankets
- Improved routine immunization coverage through deployment of additional human and material resources (technical staff and outreach vaccinators, solar fridges) in polio high-risk areas of South
- Strengthened capacity of existing HFs, through training, technical and financial support inclusive of training of new vaccinators for underserved and white areas
- Adjusted target age for OPV from under 1 to under 5 in high risk provinces in routine immunization in fixed, outreach and mobile strategies until WPV interruption is achieved.
- Private sector health facilities / clinics will be possibly included in the micro-plans and their role to be defined by their capacity to provide routine immunization

Strengthen community-based polio immunization services through deploying permanent local teams (community contract)

- This will be a two-member team and the first vaccinator will be female resident accompanied by her Mahram as the second vaccinator.
- These teams will cover the entire village (depending on the size of village from 200-600 families, geographic distance maximum 1-2 km).
- The vaccinators will deliver only OPV vaccines until their capacity is upgraded to eventually administer all vaccines.

2. Nutrition interventions:

a. Integrate nutrition services into mobile health teams
b. Provide deworming tablets to children 24-59 months
c. Provide therapeutic food (RUTF) for treatment of children 6-59 months with Severe Acute Malnutrition (SAM)
d. Distribute alternatively Vitamin-A and Albendazole to the children during national polio campaigns, as per the age policy in the national SIAs guidelines.

3. WASH interventions:

e. Construction of solar-powered water supply piped systems with house connection
f. Introducing a full package of WASH in selected schools
g. Introducing a full package of WASH in selected schools

4. Education Interventions: The education intervention will be implemented in response to the repeated request made by some community elders in inaccessible areas, where polio transmission has been intense. The intervention is unique as it reflects an innovative, coordinated approach between Education and Health through community-based initiatives with a solid complementary social behavior change approach. Interventions include:

h. Establishing Community based schools / Accelerated Learning Centers, teachers as polio influencers,
i. Providing scholarships to female students,
j. Training teachers on INSET and formative assessment packages and
k. Training teachers and children on immunization with the intention of making them education/ health ambassadors.

5. Polio Plus activities to increase vaccine acceptance, promote polio and other vaccines, decrease missed children and increase routine immunization coverage

l. Distribution of soaps for children vaccinated during routine immunization sessions.
m. Distribution of blankets to newborn in maternity clinics.
n. Distribution of crayons and exercise books for children.

6. Decentralized management

o. Establishment/strengthening of provincial EOCs in Helmand and Uruzgan
p. Consolidation of the newly established UNICEF provincial offices.

All the convergent interventions (listed above) will aim to improve vaccine acceptance and coverage in polio high-risk areas, by addressing the needs and demands put forward and valued by the communities.

The current support mechanisms of PEI support to EPI will be maintained. There will be further strengthened on:

- Supportive supervision and monitoring of EPI with focus on outreach and mobile sessions
- The PEI staff will also support on improving of EPI micro-plans.
- Collated findings with basic analysis of PEI staff monitoring, including "Zero Dose AFP cases data" will be regularly shared with the National EPI as well as with NGOs, GCMU and PMU departments for planning and intervention (please see annex for monitoring SOPs).
- BPHS NGOs are expected to share information on actions taken for issues identified by the polio program.
- Systematic engagement of ICN in demand creation
- Coordination between BPHS NGOs, polio eradication partners and PEMT/REMT will be enhanced using the floors of EOCs.

There will be provincial joint monitoring plan with focus of monitoring and oversight on districts at risk of virus transmission from reservoirs inside and outside the country due to high population movements. The highest risk districts have been identified through the recent two cross border surveys in late 2019.

Inter-sectoral approach in polio high-risk areas

To address additional needs felt by the communities for basic social services, the program will prioritize efforts in Kandahar and coordinate with other line ministries and UN agencies. Support from other line ministries will be garnered through the 'Polio high council' as well as the 'council of Ministers'. These efforts will focus on water supply and sanitation, community-based education, expansion of nutrition services and expansion of mobile health teams and sub-centers.

Under the umbrella of integrated services plan, the National EOC will also explore and utilize the opportunities to collaborate with other stakeholders involved in Humanitarian Response Activities in the high-risk / inaccessible areas of South region.
PEI support to EPI is an integral part of the plan on delivery of Integrated Services. This subject is explained in detail in the section on "Enhancing EPI/PEI convergence in high-risk districts", later in the document.

8.6 Communication

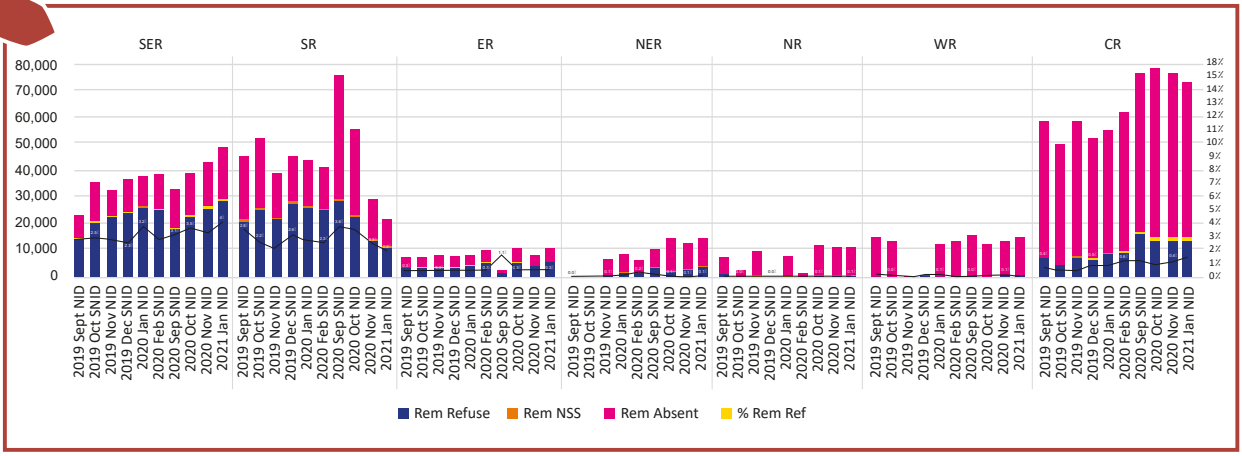
8.6.1. Strategic Communication

Strategic communication continues to play a critical role in polio eradication in Afghanistan. Despite multiple challenges faced by the polio programme in 2020, polio communication interventions have successfully promoted and maintained general vaccine acceptance across the country. The public health emergencies included the outbreak of wild polio virus type 1 (WPV1) and the circulating vaccine-derived polio virus type 2 (cVDPV2) in addition to emergence of COVID-19 pandemic which led to disruption of polio campaigns and increase of immunity gap. In addition, inaccessibility in the South and South East regions have complicated the overall epidemiological and social situation.

Moving into 2021, the programme will continue to work amidst COVID-19 as part of the "New Normal" and would prioritize reaching caregivers in the accessible areas especially of refusing families as well as those residing in inaccessible areas to increase the vaccine uptake. The programme will also adjust its communication strategies to address the communication narrative around cVDPV2 outbreak; prepare and introduce nOPV2 vaccine while continuing to support the implementation of quality response to stop the circulation of wild polio virus type 1.

Quality of campaigns remains suboptimal in some accessible areas leading to consistently missing the same children in those areas. 'Absent child' and 'refusals' are equally problematic in the South, while refusals continue to be the main issue with South East region. For all other regions, absenteeism is the main reason for missed children. The percentage of refusals has significantly decreased in Kandahar city and Dand in 2020 from 5.2% in January 2020 to 2.5% in January 2021, mainly to cluster level approach and a combination of community engagement interventions as well as improvement in female engagement in the vaccination teams (>65% in Kandahar city as of December 2021).

FIgure 7: Remaining missed children by region and reason Sep 19- Jan 21



Last June 2020, the Independent Monitoring Board (IMB) recommended that "the community engagement should deliver something that looks fundamentally different, otherwise it will not get over the finishing line of polio eradication." The same report emphasized the need to use "local knowledge and insights as well as communities' deeper interests to shape its work." and called for creative and innovative approaches to use data and solve problems. Equally, Technical Advisory Group (TAG) had similar conclusions from its last two reports. The last communication reviews also recommended the need to consider a package of interventions that would ensure effective synchronization and coordination of all communication activities to maximize the impact during this critical time. The 2021 NEAP presents an important opportunity to revisit some of the communication strategies and introduce required shifts to bring about the desired outcomes by end of 2021.

8.6.2. Outcomes of Communication Efforts in 2020

To address the priority communication needs, the national and regional communication plans for 2020 were revised to ensure ICN, female mobiliser/vaccinators networks were deployed as per the programme plans. In addition, engagement with health workers, influencers, local authorities, community leaders and religious leaders and women's associations were activated as part of the community mapping to maximize the results of community networks. Meanwhile, polio branded promotional materials were also provided to communities at risk to enhance their vaccine uptake and promote other relevant health practices such as hygiene promotion. Other targeted community dialogue sessions for mobilization of community members due to polio outbreaks in those areas, were also executed to timely address any vaccine acceptance issues.

The National Islamic Advisory Group (IAG) members have been actively engaging other government partnerships such as Ministry of Haj and Auqaf and Ministry of Education across Afghanistan. Training of NIAG provincial focal points and religious scholars/mullahs were conducted at national level focusing on vaccine, child health from Islamic perspective, interpersonal communication skills for polio and routine immunization promotion. This strategy will continue in 2021.

The effective use of mass media and social media engagement have been successful in reaching large audiences especially when influencers have been profiled. The Afghanistan digital engagement strategy that included the launch of the polio website and social media platforms such as the Facebook, Twitter, Instagram and YouTube had a wide reach that was most effective during COVID response time. Since the launch of the Facebook page in late 2019, an average of 5 million social media users are reached month. The digital engagement activities helped to target some of the inaccessible areas and ensure that those communities are consistently receiving polio messages. Other innovations such as use of WhatsApp was also introduced and used by community mobilizers to disseminate key message within various communities while also tracking of rumors and providing appropriate information on the spot.

The following sections summarize highlights for the main communication approaches planned for 2021 NEAP and the suggested strategic shifts. However, the national strategic communication framework and the regional plans will provide further details on the conceptual framework, tactics and activities to address the priority areas and communication challenges.

8.6.3. Communication Considerations for 2021

As part of the planning of communication strategies under the NEAP and the National Communication Strategy and Action Plan and other regional communication plans the following need to be considered:

1. The continuation of the COVID-19 pandemic and the impact on community engagement activities and possible public fear of infection require equipping frontline workers with all protective measures, listening and responding to community concerns and continue reassuring public through messages and different communication images in relation to COVID safety.
2. The strategic communication programme would need to solidify its base of social evidence through reliable quantitative assessments (e.g.: community knowledge, attitudes and trends for refusals) to inform medium- and longer-term strategic decisions. In the meantime, the program would need to deepen its understanding of community concerns and possible confounding factors that directly and indirectly influence decisions of caregivers.
3. A special communication strategy tailored for the South and South East to overcome existing challenges of access and refusal will be developed. The plan will detail how urban areas and cities such as Kandahar would be reached vs. other inaccessible areas.
4. A comprehensive strategic approach for engagement with religious leaders at all levels in and outside AFG will be important to initiate to build influencers support to the program at various levels especially in the South.
5. The introduction of the novel OPV2 (nOPV2) vaccine is going to be an important milestone in 2021 and it requires that special communication preparedness measures to be in place and hence it could influence the scope of other activities to be undertaken. Additionally, the potential use of nOPV2 vaccine (to address wide spread of cVDPV2) will require the development of a crisis communication plan, and an advocacy and a communication strategy to ensure political buy-in and community acceptance.
6. Finally, the interdependence and synchronization among different arms of the communication programme including crisis and risk communication, advocacy, partnerships and community engagement would be crucial to effectively reach desired results in an efficient way.

8.6.4 Core Communication Strategies and Interventions

Communication Plans and Tools

National communication plan will be decentralized to the regions. Regional communication plans are developed to address the communication needs at regional levels along with detailed action plans and include the following core interventions for 2021.

1. The program will continue to engage and advocate with the Governors, Ministry of Rural Affairs, directorates (Women's Affairs Department, Sports, Media and Culture department) on the ground, mayors to ensure their commitment, sustainability of community interventions, as well as to nurture a sense of ownership for the polio eradication among the local groups.
2. Interpersonal networks of doctors will be mobilized to combat refusals caused by disinformation related to medical concerns. The programme will partner with key medicine faculties & nursing, midwifery schools to organize seminars on vaccines for teachers and students.
3. MNCH, polio and hygiene key messages will be packaged appropriately and disseminated to vaccinators and mobilisers to facilitate dialogue with caregivers. Multimedia messages and materials will be updated to ensure that relevant vaccine concerns are addressed.
4. Polio branded promotional materials such as baby blankets, soaps will be designed and distributed to increase polio awareness and build community trust.
5. New cross border communication materials will be developed in coordination with Pakistan team to ensure synchronized communication materials are displayed at the border to target the movement of high-risk mobile populations between the two countries.
6. Regional communication plans will be reviewed through joint planning with the regions to ensure updates of the content are tailored and aligned with data driven communication issues at local level.

Mass Media

1. Revise and implement media engagement plan with efficient monitoring mechanism to ensure timely placement and broadcast of polio communication products across all media channels.
2. Media mapping will be done every quarter to ensure all trusted and reliable channels are included in the media plan to improve consistency in key polio messaging.
3. A suite of multimedia content will be developed and produced to address reasons for refusals and missed children. Production of advocacy materials will be evidence based to address communication gaps including missed children, refusals and high-risk mobile populations.
4. Edutainment media products such as mini radio drama or short videos will be developed for social media platforms to engage the community on a variety of issues including polio and routine immunization to influence refusals and instill vaccination as an important behavior and community practice (social norm).
5. Media will be used for Campaign monitoring and documenting the vaccine impact stories for general awareness

Digital Engagement and Other Innovations

1. Strengthen social media approaches to increase engagement across all platforms and disseminate polio messages to amplify vaccine acceptance. Use state-of-the-art software to analyze the social media trends, identify traffic, track rumors and their origin and design appropriate messages to counter them. Continue to utilize WhatsApp groups to disseminate messages.
2. Maintain a polio website that will act as a resource center for the polio program with polio information/updates, eradication strategies and success stories, achievements, and challenges. The portal will be run in three languages: English, Pashto, and Dari.

Crisis Communication

1. Train national and regional EOCs on crisis management to better understand crisis, mitigate and respond to potential crisis related to the programme.
2. Implement crisis communication plans as required (e.g. for cVDPV2, nOPV2 preparedness etc.)

Partnerships And Advocacy Interventions

1. Scale up advocacy with decision makers that influence policy and leadership.
2. Continue to build the capacity of Journalists to better understand polio and vaccines through media orientation sessions and enhance their reporting skills on polio and health-related issues.
3. The program will partner with key medicine faculties & nursing, midwifery schools to organize seminars on vaccines for teachers and students.
4. School teachers and other important community groups that have community influence will also be engaged, oriented to serve as additional advocates for polio vaccine uptake in their various communities.
5. As part of addressing cross border movement of population with Pakistan, communication initiatives with Pakistan polio program will be strengthened following the high frequency of high-risk mobile populations' movement between the two countries. The visibility on cross border points will be strengthened with messages for all age vaccination.

Community Engagement

1. The programme will continue to use ICN to engage with communities in polio communication priority areas of Southern region where active circulation of polio virus is combined with high number of refusals, high mobile population movement, and where ICN monitoring is possible.
2. District community engagement coordinators will be engaged in South East to ensure effective implementation of the planned interventions. Regular follow up of activities will be conducted to track the efficiency of this modality.
3. Cluster level approach will continue to be the pillar to effectively identify and address various communication challenges at local level. This approach has been exemplified in reducing refusals in Kandahar city.
4. Female Mobiliser & Vaccinators (FMVs) in polio high-risk provinces recruited at health facilities will disseminate polio, EPI messages, mobilize caregivers for vaccination services of their children, and participate in vaccination activities.
5. Local area representatives and influencers such as Wakili Guzar, Maliks, community elders, teachers will be engaged to endorse vaccines as well as mobilize the communities for vaccine uptake.
6. The program will continue to work with elderly women who have influence over families, engage the polio survivors in community events, conduct polio awareness interventions with Madrasas among others. Female staff will continue conducting questions and answers sessions for women's groups, including community engagement with elderly women ('grandmothers') to promote knowledge on polio and promote health education.
7. Focus Group Discussions and consultation sessions will be held to gather feedback and to track the changes in vaccine perception, as well as to evaluate the effectiveness of the community engagement interventions.

Religious Leaders Initiative

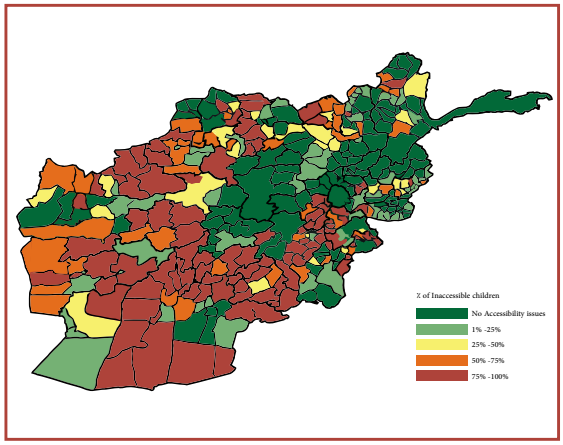
1. In partnership with the Ministry of Hajj and Awkaf, identify and map supportive religious scholars and Madrassa's and those which are resistant to polio vaccine.
2. For each group (supporters or opponent), ensure mapping their higher level of influencers who could work with them.
3. Improve the understanding of real reasons behind those opposing and thoroughly prepare feedback and answer to each point through a credible source.
4. Engage with local mullahs to increase awareness and influence vaccination in the communities.
5. Support implementation of IAG plan.

Communication Interventions In Inaccessible Areas

The communication activities in inaccessible areas will include:

- Use of local available media channels and tools, local influencers and community networks.
- Tailor communication approaches to address health facility, mosque to mosque and site-to-site vaccination.
- Develop communication materials tailored to the local audience in consultation with the local leadership.
- Engage influencers including religious leaders and local communities to support operational challenges and encourage the population to vaccinate their children against polio.
- Maintain communication preparedness to implement H2H campaigns as soon as restrictions lifted.

FIgure 8: Inaccessible Children by District NIDS OCT 2020



8.6.5 Polio Communication Coordination for Efficiency and Effectiveness

To increase efficiency and effectiveness of the efforts of polio communication, there is extremely needed to strengthen the coordination of polio CWG with EPI Communication team and health promotion department of the MoPH in order to use their resources for polio communication. In addition to that, the decentralization of the regional and provincial communication plans of the polio program should not be resulted to the disconnection between the National and regional communication teams. On the other hand, the outbreak of the WPV1, cVDPV2, COVID-19 pandemic, Inaccessibility in the south and South East regions and preparedness for introducing of nOPV2, and the problem of refusal and miss children during the polio campaign intensified to the need of coordination strengthening among the above mentioned health communication teams and departments. All these should work jointly as a one team and one voice for increasing the knowledge, awareness and behaver change of the community for vaccine acceptance by disseminating the integrated package of the messages and information through their channels and tools. For the strengthen coordination the following need to be considered:

- One focal point from National EPI communication team and one focal point from health promotion department should be added to the CWG of NEOC and attend regularly to its weekly meeting.
- One UNICEF national polio communication staff should be permanently present in the national EOC in order to strengthen coordination for efficiency and effectiveness of the polio communication efforts.
- Both communication teams of National EOC and EPI to integrate polio and routine immunization messages and disseminate through their channels.
- Awareness, orientation and training sessions for the Ulama, medical staff and community influencers should jointly be conducted by EPI and NEOC communication teams through the IAG involving.
- The operation annual plans of the communication teams of NEOC and EPI should be jointly developed and some activities which are required to be performed jointly should be specified and added.

- The communication teams of NEOC and EPI should jointly utilize the effective channels for increasing the knowledge and awareness of the specific target audiences about the all kind of the vaccines and its benefits.
- Both communication teams work jointly for increasing the trust, credibility and popularity of PEI and EPI by reflection the hard work of top, middle and low level of both programs staff.

National and Regional Communication Coordination

- NEOC Communication, as a national polio communication team should oversee activities of regional and provincial communication and provide feedback to them.
- The monitoring and reporting documents of regional and provincial communication should be shared with NEOC M&E WG and CWG.
- NEOC Communication should increase the field visit for overseeing the communication activities and support the local communication for further engagement of community and addressing the rumors and misperception of the community about the vaccine.
- As a "one team" approach to the communication work, monthly regular meeting between NEOC and REOC communication teams should be held via Video Conference to discuss the challenges, progress and provide suggestion for the SWG.

8.6.6 Other Enabling Strategies

Training and Capacity Building

1. Train and build capacities of various community mobilizers cadres will be important, including providing conducive environment for learning. This would be viewed as a continuous process with equal attention to improving the supervisory skills and providing continuous support.
2. As part of the continuous learning and building capacity, monthly communication planning meetings utilize vaccine uptake data and trends will be held at priority areas at the end of each month to inform communication actions.
3. Champion distinguished workers and promote female's participation. Support includes vouchers for learning activities for dedicated workers, giveaways will be provided at key occasions and the World Polio Day will honor FLWs' efforts and sacrifices.
4. Establish and institutionalize accountability for all teams will be an important enabler that will ultimately enhance productivity while guaranteeing mutual responsibility. These will improve program outcome in a manner that will be cost-effective while improving community trust.

Initiatives under the Islamic Advisory Group IAG

In 2021, IAG as member of the Communication Working Group of EOC will continue to work with religious influencers through communication capacity building and knowledge sharing with regards to immunization and child health in Islam. The following interventions will be pursued:

- Training of IAG provincial focal points and religious scholars on vaccine, child health from Islamic perspective.
- Religious scholars training on interpersonal communication skills for polio and routine immunization promotion and tackling refusals on religious reasons.
- Development and implementation of training curriculum on child health, vaccine and Islam for medicine and Sharia school students as well as key Madrasa leaders.
- Training of FLWs on the Fatwa book content for informed discussions during household visits and community meetings.
- Advocacy with religious scholars, community influencers and line departments,
- Engagement of at least one faith based non-governmental organization to support IAG activities in polio eradication and child health.

8.7 Identification, mapping and coverage of High-Risk Mobile Populations

The evidence of shared transmission between Afghanistan and Pakistan continues to highlight the significance of mobile populations travelling across the border and within the countries, in sustaining and spreading poliovirus transmission. To strengthen the mapping and vaccination activities for these populations, the appointed HRMP focal points in the national and regional EOCs will follow the implementation of agreed strategies related to HRMPs (with enhanced focus on newborns / infants). In addition:

- The programme will continue to collaborate with other UN agencies and line departments for elaborate information about IDPs and will immediately plan vaccination activities according to the dynamics of IDPs
- SNIDs will continue to include HRMP settlements in non-endemic areas
- Nomads: Continuous mapping and cross border information sharing about movements of nomads will be carried out with vaccination strategies (nomad campaigns in southeast and special transit teams along nomad movement routes in south and west)
- Cross border:
    - The programme will continue to vaccinate the travelers of all age group, crossing border with Pakistan at Torkham. The program will explore feasibility of all age vaccination on the southern border crossing point at Friendship Gate.
    - Regular assessment of informal crossing points will continue, and cross border vaccination teams rationalized accordingly
    - The program will continue vaccination at all cross-border points and international airports and explore new informal crossing points to deploy vaccination teams
    - Regular coordination with Pakistan polio eradication team for mutual advance information sharing on any major population movement and ensure preparation for vaccinate on any such instance
    - Vaccination of travelers as per IHR will continue for all age groups

- Returnees:

    - Through regular coordination with UNHCR, IOM and DoRR, the programme will monitor the flow of returnees to Afghanistan and adjust the vaccination teams in the repatriation centers as required
    - All major congregations will be identified, and special vaccination opportunities will be provided
    - The programme will exercise all possible flexibilities while endeavoring to reach on cross border resettling families during and outside the campaigns; with the core aim of "consistently reaching and vaccinating the children" in such families.

8.8 Maintaining sensitive surveillance

Afghanistan maintains a sensitive surveillance system, irrespective of access for SIAs. The number of routine / zero reporting sites was expanded from 2,744 in 2019 to 2,951 in 2020, active surveillance sites from 1,577 to 1,694 and reporting volunteers from 35,356 in 2019 to 41,676 in 2020 across the country. The indicators of Non-polio AFP rate and percent AFP cases with adequate stool specimens were maintained above the target benchmarks. Currently, Afghanistan is collecting environmental samples from 23 sites located in 14 major population centers of 11 provinces of the country. An internal surveillance review was conducted in 2020 in the East (in April) and South (in August) regions. It is important to note that internal surveillance reviews are done on annual basis targeting the high-risk regions and provinces. An extensive internal surveillance review was carried out in high-risk areas of all the provinces during the second half of 2020. A total of 682 stool samples from healthy children residing in chronically-inaccessible areas were tested in 2019-2020. In 2019, three WPV1 isolation in stool specimens from healthy children (collected in Sep 2019) from Chapadara District in Kunar province were reported, while in 2020, three WPV1were reported from Dare-e-Peach and 1 from Chapadara district in Kunar province. The laboratory also isolated 13- cVDPV2 from healthy children samples; 3 from Chapadara, 2 from Shigal Wa Shultan, 2 from Watapoor, 1 each from Chawkay, Marwara, Sarkani districts of Kunar province and 1 each from Dehbala and Khogiani districts of Nangarhar province and Zherey district of Kandahar province. There was an important development in the surveillance data management of Afghanistan, with the initiation of Web - Information for Action (Web - IFA), introduced in December 2019. The Web-IFA pilot was expanded during the first half of 2020 and the system was fully rolled out in all the regions of the country during the second half of 2020.

The AFP case specimen management reverse cold chain and samples storage capacity at all levels were re-assessed and enhanced amid the COVID-19 pandemic. The PEI programme did not minimize or limit any AFP or environmental surveillance activity/ies which were proposed in the interim guidance of polio surveillance in context to COVID-19. The programme continued sending AFP case specimens to RRL- Islamabad on a weekly basis.

The country AFP surveillance system closely coordinated National Disease Surveillance Response Directorate (NDSR) of Ministry of Public Health to provide possible assistance for the COVID-19 response. The areas of support included, case detection and reporting, capacity building / orientation and community engagement / awareness. The AFP surveillance personnel during their active surveillance visit (s) held from health facilities also looked for suspected COVID-19 cases during the records scanning and interviewing of the healthcare providers / doctors. All suspected COVID-19 cases are notified to MoPH / WHE teams. The PEI team developed a short weekly report and share with the NDSR/ MoPH/ WHE teams. The PEI staff during their periodic visits to the health facilities, provided training / orientation to the AFP surveillance focal points on identifying and reporting suspected COVID-19 cases and helped on distribution of printed material from the MoPH / WHE to the health facilities, during their periodic visits. The community-based AFP surveillance volunteers were engaged on dissemination of messages to the local communities on personal protection.

Afghanistan and Pakistan are considered to be one epidemiological block for polio eradication, since there is ongoing significant population movement among the two countries, especially in the bordering areas. Afghanistan program maintains close coordination with the Pakistan polio programme at the national and provincial levels focusing on synchronized program implementation in three common corridors i.e., northern corridor (East Region / Nangarhar – Great Peshawar / Khyber Pakhtunkhwa), Southern corridor (South Region – Quetta Block) and central corridor (South East Region – South KP/Tribal Districts). Joint corridor action plans are developed and being implemented for all three corridors. The key focus is to ensure that all types of high risk mobile populations (HRMP) are identified and specific strategies are in place to reach and vaccinate the target children among them. The key idenfied HRMP include the long-distance travelers within the corridors, the nomads, the straddling populations, and the returnees / refugees. Formal and informal border crossing points between Afghanistan and Pakistan have been mapped and vaccination teams are deployed. Currently, a total of 47 cross border vaccination teams are functioning on 17 border crossing points. Mandatory all age vaccination is being performed at the Torkham border in the northern corridor while target age of vaccination is optional at the Friendship gate in the Southern corridor. Reportedly, more than 1.6 million doses of OPV were delivered by the cross-border vaccination teams in 2020.

The program plans to take some key steps in 2021 to further improve surveillance sensitivity and quality.

- Further in-depth analysis will be carried out on regular basis to identify any gaps in the Southern Region, especially the areas that are inaccessible for SIAs and have some challenges for surveillance as well.
- The contact sampling strategy for AFP cases with inadequate stool samples will be revised, i.e. three contact samples will be collected (instead of 5) for every AFP case with inadequate specimens, to optimize efforts and resources.
- Review of the existing AFP surveillance Expert Review Committee (ERC) will be carried out with the help of national and international surveillance experts to inform further strengthening measures by end-2021
- The surveillance reporting volunteers workforce will be carefully reviewed to assess its ongoing contributions, document lessons and utilize these to enhance efficiency.
- Data disaggregation for gender will be further systematized, with generation of periodic reports to inform the planning and implementation processes
- The program will continue to work on further understanding the origin of isolated long-chain polioviruses and the areas they might be circulating in.
- The verification, documentation and supervision mechanisms in the inaccessible areas will be reviewed to identify any gaps to be addressed
- The programme will continue to explore ways to further expand environmental surveillance, based on the evolving epidemiology and programmatic risks

There is close coordination with Pakistan at the national and regional levels on operational and technical aspects, including information sharing on surveillance, communication, population movement, SIAs as well as coordinated response to poliovirus detection. Under the supervision of National and Regional EOCs, the teams of bordering provinces and district are maintaining coordination with the bordering areas' teams of Pakistan; focusing on joint microplanning and information sharing on population movement. A total of 13 AFP cases were cross-notified in 2020 among the two countries.

Section 9:

Enhancing EPI/PEI convergence in high-risk districts

Strategic work plans will be monitored quarterly

Below approaches will be utilized to further enhance and promote the EPI – PEI convergence, mainly focusing the polio reservoirs, high risk and difficult to reach areas and populations:

Periodic Intensification of Routine Immunization

In 2021, the National EPI plans to enhance routine and polio immunization coverage among children under 1 and under 5 years respectively through conducting the following strategies and interventions.

Conducting multiantigen campaign in 7 provinces (mainly polio endemic and high risk) including Kandahar, Uruzgan, Helmand, Paktika, Kabul, Nuristan and Zabul. The main objective is to enhance immunization coverage among children under one year and under two years with provision of all routine vaccines, MCV coverage among children aged 9-59 months, OPV coverage in children aged 0-59 months and TD vaccine among women of child-bearing age by using a combination of both routine and four rounds of campaign (PIRI) service delivery in the seven low performing provinces at high-risk for polio and other vaccine preventable diseases.

Key Objectives:

- Provide all vaccines to all unreached children aged less than 24 months and TD to all women of child-bearing age
- Give MCV to children aged 9-59 months and OPV to children aged 0-59 months
- Use a combination of approaches to reach everyone targeted for PIRI/campaign
- Expand vaccination beyond the traditional target groups, based on risk and considering operational feasibility
- Increase community demand for immunization
- Ensure that unreached populations are reached in every selected district at least 4 times in 2021
- Improve vaccine, immunization and injection safety
- Improve and strengthen vaccine-management systems
- Provide integrated service delivery with information, education, communication (IEC) and social mobilization.
- Evaluate PIRI/campaign and strengthen national immunization programs

Target, duration & strategy

The target groups are children aged less than two years and women of child-bearing age with below estimated breakdown:

- 114,551 children aged <1 year for all antigens
- 229,103 children aged <2 years for all antigens
- 486,843 children aged 9-59 months for MCV
- 572,757 children aged 0-59 months for OPV
- 572,757 women of child-bearing aged for TD vaccine

The proposed duration of PIRI:

- The four planned rounds will start from Feb 2021, the strategy to be applied as site to site, outreach and mobile.
- Among the total 10 provinces planned, seven will be covered in 2021

Continuation of the current support of EPI to PEI, and further interventions in order to strengthen the programme

Additional support to improve vaccination coverage in the polio high-risk provinces of Kandahar, Helmand, Uruzgan.

- Integration of polio and routine EPI is one of the priorities of MoPH to create synergy between the two programmes so that the coverage is boosted and strong immunity is achieved and maintained in under-performing communities. South region of the country has majority of polio and the region has been struggling to contain the poliovirus transmission. That is the reason this intervention at this stage will focus mainly on Kandahar, Helmand and Uruzgan provinces of the South Region.

Objectives

The overall objective is to increase routine and polio immunization coverage among children aged under one and under 5 years, respectively, through establishment of new vaccination service delivery points, and deployment of 240 additional vaccinators. This will help boost EPI coverage, sustaining immunity for polio and address the gap of shortfall in the number of vaccinators. Ultimately, this will contribute in improving the health status of target mothers and children. In addition, it will help provide timely, equitable and quality vaccination services to community dwellers both at health centers and through vaccine outreach/mobile programmes.

Expected Results

- Achieve at least 50% coverage of all antigens among children aged less than one year and sustain immunization of all antigens at district level by the end of 2021
- Achieve at least 90% OPV coverage among children aged less than 5 years, and polio virus transmission interrupted within the province specially in selected districts by the end of 2021
- Measles cases reduced to less than the expected rate in selected districts (or 1 case per 1 million populations) by 2021

National EPI Communication related intervention to strengthen PEI

Since, one of the important strategies for polio eradication is strengthening routine EPI programme and polio different serotypes are included in routine EPI schedule from zero OPV till OPV4 and two doses of IPV.

National EPI's Communication section has included demand generation intervention for EPI routine programme as has recently successfully implemented religious leaders training project for almost 24,000 religious figures (mullahs) across the country alongside visuals / IEC materials such as posters, leaflets, folders having influential messages, billboards and banners printed and distributed. Moreover, spots from National and local radios/TVs were aired had impact on both routine and polio vaccination activities, as most of EPI routine messages have polio eradication queries addressed.

One of the best examples is "bring children less than two years old to the nearest health facilities for routine EPI vaccine and vaccinate all children less than five years old in each round of Polio Campaign". The main intervention which is planned in 2021 is conducting IPCI training for 3,000 people in 34 provinces, which includes health professionals, EPI managers, supervisors, regional trainers, vaccinators, community health supervisors and community health workers, through this intervention we expect good routine EPI coverage along with reducing high dropout rates, missed opportunities and eventually strengthening routine EPI coverage which is a fundamental for Polio eradication, which in turn leads to control EPI targeted diseases and outbreaks.

Continuation of Supply and monitoring of OPV vaccine for under 5 children in 34 provinces

Based on the request of polio National EOC, the National EPI has started supplying OPV vaccine for children aged less than 5 to all health facilities of the 34 provinces and this will be continuing in 2021. This is expected to help boosting the population immunity against polio.

The current support mechanisms of PEI support to EPI will be maintained. There will be further strengthening on:

- Supportive supervision and monitoring of EPI with focus on outreach and mobile sessions
- The PEI staff will also support on improving of EPI micro-plans.
- Collated findings with basic analysis of PEI staff monitoring, including "Zero Dose AFP cases data" will be regularly shared with the National EPI as well as with NGOs, GCMU and PMU departments for planning and intervention (please see annex for monitoring SOPs).
- BPHS NGOs are expected to share information on actions taken for issues identified by the polio program.
- Systematic engagement of ICN in demand creation
- Coordination between BPHS NGOs, polio eradication partners and PEMT/REMT will be enhanced using the floors of EOCs.

There will be provincial joint monitoring plans with focus of monitoring and oversight on districts at risk of virus transmission from reservoirs inside and outside the country due to high population movements. The highest-risk districts have been identified through the cross border surveys in late 2019.

Section 10:
Monitoring

The NEAP 2021 will regularly assess implementation of strategies and take speedy corrective measures, identifying bottlenecks, facilitating resolution of the same so that the program leadership and the other oversight bodies are given an early indication of the progress or lack thereof in achievement of the program objectives. The National, Regional and Provincial EOCs will play an active role in ensuring that high standards of monitoring activities take place throughout the country.
The key areas and constituent activities that will be prioritized for the ongoing monitoring of NEAP 2021 are:

1. Ensuring every child under the age of 5 years is reached with an effective OPV every time with zero tolerance for poor performance in the accessible areas

    - Selection of appropriate frontline workers as per approved guidelines and training them as per the revised training module
    - Revising and updating microplans and conducting both desk and field validation prior to each campaign
    - Conducting intra-campaign monitoring with focus on expeditious resolution of issues identified
    - Investigating all LQAS failed lots and ensuring corrective actions and remedial measures
    - Engaging 3rd party monitoring in the inaccessible areas

2. Detecting every poliovirus transmission chain in a timely manner and investigating appropriately

    - Conduct internal and external AFP surveillance reviews
    - Weekly data review at national and sub-national levels
    - Maintain the high-quality standards of both AFP and ES surveillance
    - Expand the environmental surveillance sites where possible
    - Conduct annual refresher trainings for PPOs & DPOs as well as sensitization of the reporting volunteers
    - Transition from Information for Action (IFA) legacy surveillance system to the new web-based integrated IFA system
    - Ensure the program utilizes the most up to date surveillance guidelines and SOPs

3. Improving data process and systems

    - Fast track the setting up of the Afghanistan Polio SIA Information Management System
    - The deficiencies in credible and timely SIA data to assess risks and guide improvements are recognized as obstacles to progress. Increase accountability at all levels to ensure that all SIA data that is shared is valid, timely and complete (e.g. timely sharing of administrative data)
    - Conduct capacity building in data management for regional and provincial data personnel

- Simplifying data process by (where necessary), removing un-utilized data tools / variables
- Conduct rigorous and regular data audits (both internal and external) to ensure program data is reliable and decisions based on the program data is objective

4. Ensuring that communication & community engagement strategies are yielding impactful results

- Ensure shifts in communication strategies result in improvement of community mobilization and trust in the areas where house to house strategy is implemented
- Assess the impact of the revamped communication and community engagement strategies on the refusal situation in the South
- Document the effectiveness and utilization of mass media and social media – in addressing emerging issues from messages circulating in mass/social media
- Ensure the program is developing context specific and evidence-based communication approaches and IEC materials
- Develop and implement field reviews and conduct capacity building by the core National and Regional EOC communication teams

5. Ensuring effective management of vaccine logistics and cold chain

- Review and update vaccine forecasts for 2021 in accordance with the proposed SIA calendar
- Conduct trainings on vaccine management for all regional, provincial, and district workers on a regular basis
- Due to the continued use of Sabin type-2 containing vaccines – ensure the accountability and vaccine management SOPs are disseminated and implemented at the lowest level

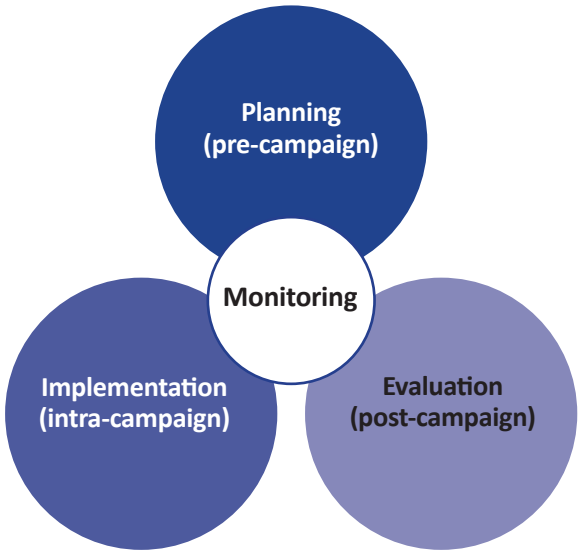
6. Providing support to and improving the coordination with EPI program

- Joint planning and implementation of routine immunization outreach sessions
- Joint monitoring and supervision by EPI and PEI staff of implementation of fixed, outreach sessions and community monitoring surveys
- Sharing with EPI team the line list of all RI zero-dose children identified through AFP surveillance on weekly basis
- Using PEI monitoring and evaluation tools to support continuous assessment of RI coverage
- Sharing of monitoring report and feedback with PEMTs, relevant NGO and NEPI on timely manner

Details of how each of the above activities are going to be monitored throughout the NEAP 2021 period is provided through different annexures. Similarly, there will be explicit key performance indicators to track on quarterly basis by the monitoring unit at the NEOC – providing quarterly monitoring reports to the SWG. On the other hand, considering the importance of ensuring high quality polio immunization campaigns in interrupting the co-circulating WPV1 & cVDPV2, the NEOC has decided to provide more precise details on specific interventions in the monitoring of the SIAs in 2021.

The National EOC through its Strategy Working Group (SWG) and M&E / SIAs working group will ensure systematic use of key performance indicators for to inform strategic and operational interventions respectively. Special focus will be maintained to improve pre-campaign management (e.g. FLWs recruitment, micro-plans validation etc.) and intra-campaign course correction through local problem solving mechanisms with necessary support from higher levels.

10.1. SIAs monitoring



Monitoring of SIA is one of the important components of the polio program as it informs the program on the quality of campaign and hence can be used to guide the interventions for reducing missed children and in planning for the next rounds. The program will aim to monitor every aspect of the SIAs during each campaign with the objective of improving the implementation quality with focus on accessible areas and making sure every child under the age of 5 years is reached with OPV in every SIA. Special focus will be to understand the recoverable absent children and reasons of missing recoverable absent children during revisits, and reasons for underperformance of vaccination teams.

An important approach among the several mechanisms of campaign monitoring is to continue deployment of National monitors to support the SIA activities in FDs/ VHRDs / HRDs during every campaign in all the three phases of the campaign (pre, intra and post). National Monitors complement the regional / provincial level monitoring activities, in addition provide capacity building, and gain national level oversight on all phases of campaign implementation.

Monitoring of SIA activities helps in generating quality data which is used by supervisors and higher authorities for checking whether these activities are going as recommended and initiating rapid corrective action.

Pre-campaign phase:

- FLWs Selection:
    - All efforts to ensure that team composition is as per SIA minimum standards and both vaccination team members are local (living in the same team area), at least one team member is literate, female and both are trained. In addition any newly hired FLWs will also be reported
    - The program will review and strengthen accountability of FLWs and will track the implementation including removals based on objective documented criteria
    - The program will endeavor to increase the proportion of female FLWs (supervisors, vaccinators, social mobilizer, ICM and support the engagement of female FLWs and mid-level managers. The National EOC will also ensure an enabling environment at all levels for recruiting and sustaining female workers at all levels. This activity will be closely monitored, and progress tracked

- FLWs Training
    - NEOC will provide direct oversight on the functioning of training committees in high-risk provinces and ensuring their effectiveness
    - Provincial and regional team members (program staff) to facilitate the FLW trainings in all Focus and Very High-Risk districts
    - All (100%) cluster supervisors and volunteers' training sessions should be monitored in FDs/ VHRDs, and the volunteer's trainings in HRDs (60%) and non HRDs (25%) (SIA minimum standards) should be monitored by district, provincial, regional, and national PEI team members
    - Effective use of training monitoring data to take corrective measures

- Successful implementation of SIAs requires meticulous microplanning at district, cluster, and team levels.
  Revision and updating of micro plans will be ensured before each campaign through field validation exercise by all district coordinators and cluster supervisors. National, regional, and provincial program staff will validate the microplans through desk review and field validation particularly in the accessible areas of high-risk districts based on SoPs for microplan validation. In addition, key components of microplanning such as team /supervisor /coordinator workload will be tracked for each campaign. Key components to scrutinized include the following:

  - List of all villages and settlements including target population
  - High risk population such as nomads, IDPs, returnee refugees, and straddling population
  - Team and supervisor maps / itineraries (with clear description of day wise area to be covered and route maps)
  - List of high-risk areas (e.g., where WPV1, cVDPV2 cases have been reported, areas with positive environmental samples)
  - List of special sites (e.g. brick kilns, hotels, kindergartens, madrassah) and plans to cover them
  - Cold Chain, Vaccine, logistics distribution plan
  - Social Mobilization and communication plan

- Field validations will be prioritized in the accessible districts. During this exercise the monitors will check and verify that whatever description made in the operation microplans and maps are matching with the ground realities. For instance; verifying the start and end points of a team's daily work plan, schools, madrasa, mosques, important landmarks, boundaries, fixed vaccination site and transit point etc. Field validations of microplans will be conducted by district and provincial teams regularly, and regional & national level monitors will also conduct field validation of microplans from time to time.

Intra-campaign phase:

- Good quality monitoring should be able to locate unvaccinated children for follow-up and identify management and operational issues that need immediate correction
- The intra campaign monitoring (ICM) will aim to provide real-time information and opportunities for local corrections
- ICM will assess whether areas are properly covered, identify missed children (if any) and the reasons for the same, supervisor and team performance, FLW workload, quality of daily and 5th day revisits, cold chain, and vaccine management; take immediate corrective actions.
- ICM will ensure that their findings are shared during evening meetings and poorly covered and missed areas identified are recovered the next day.

Post campaign phase:

- The outcome monitoring following SIA campaign include post campaign monitoring (PCM) to be conducted in 100% of clusters in VHRDs and 50% clusters in non-VHRDs, Lots Quality Assurance Survey (LQAS) and out-of-house finger mark survey conducted to assess the coverage and quality of the vaccination activity, to identify missed or poorly covered areas, identify reasons for missed children, and take immediate corrective actions.
- Remote monitoring by NEOC call center will continue in all high-risk, hard to reach areas and possible blind spots. Data from remote monitoring will be analyzed over the rounds to see any rising trends.
- To improve the reliability of PCM and LQAS the program will continue to validate the PCM and LQAS for data quality assurance and to identify poor performing clusters for corrective interventions.
- Program will continue to conduct joint investigation of the failed lots by a team comprising representatives from WHO, MoPH, UNICEF and other partner organizations at the provincial level. The objective of the investigation is to identify the root causes of missed children, take action by recovering the area and plan for remedial action. National team will investigate lots that fail more than 2 times in successive campaigns.
- NEOC in coordination with the regional and provincial EOCs to monitor the flow and utilization of financial resources up to the implementation level, with the aim to ensuring transparency.
- Financial accountability will be exercised with zero tolerance for any misappropriation.

Third party monitoring

Due to inaccessibility that exists in several parts of the country, mainly in the South, the traditional strategies of implementing and monitoring the polio vaccination campaigns cannot practically be accomplished. The alternative modalities of site-to-site/health facility to health facility in the inaccessible areas need to be monitored. To achieve this objective, NEOC is proposing a third-party monitoring of the vaccination activities. The identified third party is expected to have better access and will do the following:

- Validate the site-to-site micro plans before each campaign and ensure that all villages are included; ensure that the micro plans include accurate route maps that include all vaccination sites and how the teams will move from one site to the other
- Ensure that the vaccinators, supervisors, and social mobilizers are local and speak the language of the community and have been properly trained
- Develop a comprehensive site to site monitoring plans
- Develop innovative strategies that allow for intra campaign monitoring and out-of-house finger mark survey

10.2. Improving data systems

The program will continue addressing SIA data related challenges including plans to improve the timeliness of administrative data sharing. Also, the program will simplify and standardize data collection and collation processes at various levels. Afghanistan Polio Information Management System (APIMS), which will include online database and dashboard will be developed for timely data compilation and analysis. It will further support the program to have access to quality data and use of information for decision making. Once APIMS is fully functional we anticipate several data related issues will be resolved including timeliness and utilization of data.

NEAP 2021 will also monitor the data flow process and will assign task at different levels. To ensure the realization of the NEAP data related objectives, the program will conduct capacity building exercise for the regional and provincial data staff. On the other hand, the program will continue to implement validation mechanisms to ensure data quality and completeness. Any negligence or falsification of data will be considered a serious offence calling for disciplinary actions against the concerned staff.

10.3. NEAP monitoring

Implementation of NEAP will be monitored on quarterly basis by technical working groups under leadership of the 'Strategy Working Group (SWG)' of the National EOC by tracking the process against NEAP work-plan (developed jointly by the WGs under the leadership of SWG) and progress on identified key programmatic parameters against the objectives set in NEAP 2021. Country specific indicators are listed below:

- Polio epidemiology: number and spread of poliovirus detected in human and environment
- Proportion of under immunized children among non-polio AFP cases
- Timeliness and effectiveness of response to any detected transmission of WPV or VDPV

- Proportion of missed children in SIAs
- Number of missed children due to inaccessibility
- Number of children missed due to refusals
- Key surveillance indicators
- Number of districts identified with high number of villages remained uncovered by RI outreach

There are several interventions in NEAP 2021 that are region specific (for high-risk regions / provinces / populations) for which the respective Regional / Provincial EOCs will closely monitor the progress of the activities every month and address the bottlenecks in implementation. The National EOC will ensure provision of the necessary enabling support as well as full functionality of the Regional / provincial EOCs.

National EOC's monitoring and evaluation results framework will be developed as soon as the NEAP and the national communication plans are finalized, to guide the monitoring and tracking of different indicators and to streamline any duplication.

Given the high risk and ongoing transmission of polioviruses in the South Region, the National and Regional / Provincial EOCs will jointly monitor the progress in the region, preferably each month. The regional EOC will regularly share the status of progress and their findings with the WGs of National EOC. In addition to monitoring progress of the specific activities in the NEAP work plan, the regional team will assess program improvements based on certain identified parameters and the SIA minimum standards.

- Proportion of missed children in SIAs by district and province
- Number of missed children due to inaccessibility by district and province
- Number of children missed due to refusals (categorized by reason) by cluster and district
- Number of functional selection committee by province and district
- Proportion of female FLWs by district and province
- Number of districts identified with high number of villages that remained uncovered by RI outreach by province
- Proportion of under immunized children among non-polio AFP cases by district disaggregated by reason (as per investigation report)

A mid-term review of the NEAP implementation status and effectiveness of strategies will be carried out in mid-2021 and necessary mid-course correction and adjustments will be made, as needed.

10.4. Monitoring and Evaluation of communication and integrated health services

NEOC M&E section with the support of all relevant partners will conduct process, outcome and impact monitoring and evaluation of the communication and integrated health services interventions to support informed decision making.

I. Regarding the monitoring of communication activities, the National EOC M&E WG with the support of CWG will work to define key performance indicators and develop monitoring plan for the SIAs' demand generation activities.
II. Evaluation of communication activities

- Program will undertake surveys including KAP surveys conducted by the third party.
- The KAP will be designed to ensure comparability over years. Context specific surveys will be undertaken to assess the effectiveness of community engagement strategies. The assessment will utilize both quantitative and qualitative methodologies in triangulating findings.
- Program will undertake annual communication reviews to provide an external assessment of the progress and required corrective measures.
- Evaluation of ICN performance in accessible areas like Kandahar City against core SIA

outcomes (coverage, missed children, refusals, change in acceptance) to be included in the M&E annual plan. It will also develop operational measures to assess community trust in the programme and to assess impact of media/social media messages on household perceptions.

III. Monitoring of integrated services activities

- Following the assessment of white areas in Kandahar and Helmand provinces, a complete assessment of white areas in Urozgan province will be carried out for the establishment of at least 40 new HFs.
- Findings on EPI sessions monitored by PEI staff will be regularly shared with concerned entities.

IV. Evaluation of integrated services activities

- Semi-annual and annual evaluation of the integrated health services (BPHS+) will be conducted

Section 11:

Effective vaccine and cold chain management and accountability

In year 2020, the emphasis was targeted on ensuring timely and adequate delivery of all vaccines, expansion of cold chain storage at lower levels, enhanced training of teams on vaccine management and accountability and strengthening vaccine and cold chain management structure both at national and regional levels. With emergence of twin outbreaks of WPV1 and cVDPV2 in the country in 2020, the programme relied on use of different vaccines such as mOPV2, tOPV, bOPV and mOPV1, all of which have different characteristic and requirements for storage, handling, use and reporting. The Vaccine Management Working Group (VMWG) was re-activated in 2020, to support the programme by ensuring better management, coordination, accountability and reporting of all vaccine-related issues (including operational research).

The VMWG organized a national training of trainers (ToT) for mOPV2 and tOPV campaigns and facilitated the development and use of accountability tools up to the vaccination team level, supported reactivation/formation of vaccine vial disposal committees and developed standard operating procedures (SOPs) in line with the global technical guideline on use, management, disposal and reporting of tOPV and mOPV2 vaccines. The Afghanistan polio programme also initiated and implemented the firstpolio SIA vaccine temperature monitoring study, the outcome of which led to the decision by the NEOC to implement the nationwide tOPV (without VVM label) campaigns in October and subsequently in November 2020.
Although noticeable improvements in terms of ownership and responsibilities for vaccine management and accountability has been recorded at all levels from one campaign to another, the priority for 2021 will be that of continuous quality improvement practices.

Programme Priorities

To achieve and maintain this in 2021, the programme will thus prioritize on three main areas in strong coordination with EPI at national, regional/provincial levels, regional and provincial EOCs and with BPHS NGOs

i. Procurement:

Vaccines: Vaccine forecast of requirements and shipment by type of vaccines (based on planned SIA and for any case responses) will be done over the year, in a manner to ensure adequacy while avoiding over-stocking and/or under-stocking of supplies, taking into account the in-country storage capacities.

ii. Vaccine Management

Vaccine management practice at all levels in line with the global technical guideline will be promoted and improved upon through:

a. Continuous capacity building at all levels on mOPV2, tOPV and nOPV vaccine management targeting vaccinators, national monitors, regional and provincial EOC teams, cold chain technicians and PEMT.
b. Support to Cold Chain Technician (CTT) trainings in coordination with EPI.
c. Support to Quarterly Cold Chain inventory (CCI) activities.

iii. Accountability

Vaccine being a major campaign cost driver, vaccines need to be used rationally and effectively for better results. Accountability for all SIA vaccines will be prioritized and systematically enforced through:

a. Continuous use of accountability forms at team, cluster and district level for any form of campaign (planned SIA or Case responses).
b. Continuous monitoring and tracking of vaccine wastage rates and use of data to inform better decisions.
c. Ensuring all provinces have vaccine vial disposal committees and use the appropriate forms to report vial destruction on time as per the recommended technical guideline.

Section 12:

Ongoing Monitoring of the Impact of the COVID-19 Pandemic and Mitigation Measures

The programme will continue to monitor the evolving COVID-19 situation in the country and make necessary adjustments and take required mitigating measures to optimally implement the NEAP 2021 strategies and approaches. The National EOC remains committed to support the pandemic response using all possible capacities under the umbrella of the Ministry of Public Health; while ensuring that NEAP 2021 activities are not compromised towards addressing polio other vaccine-preventable diseases.

The programme will continue to prioritize the safety of frontline health workers and the communities they serve through several approaches in the NEAP 2021. In this regard, the programme will ensure continued appropriate trainings of all the concerned workers / staff on infection prevention and control as well as provision of necessary items (mask, sanitizers, soaps etc.) during the implementation of polio eradication activities.

Section 13:
Annexures

Annexure I: NEAP 2021 work-plan (to be finalized after the TAG) – WHO

Annexure II: List & map of High, medium and low risk districts (Risk Categorization) – WHO

Annexure III: Accountability framework (EOC)

Annexure IV: Minimum standards for SIAs – WHO

Annexure V: SOPs – Support of PEI staff on RI monitoring (WHO)

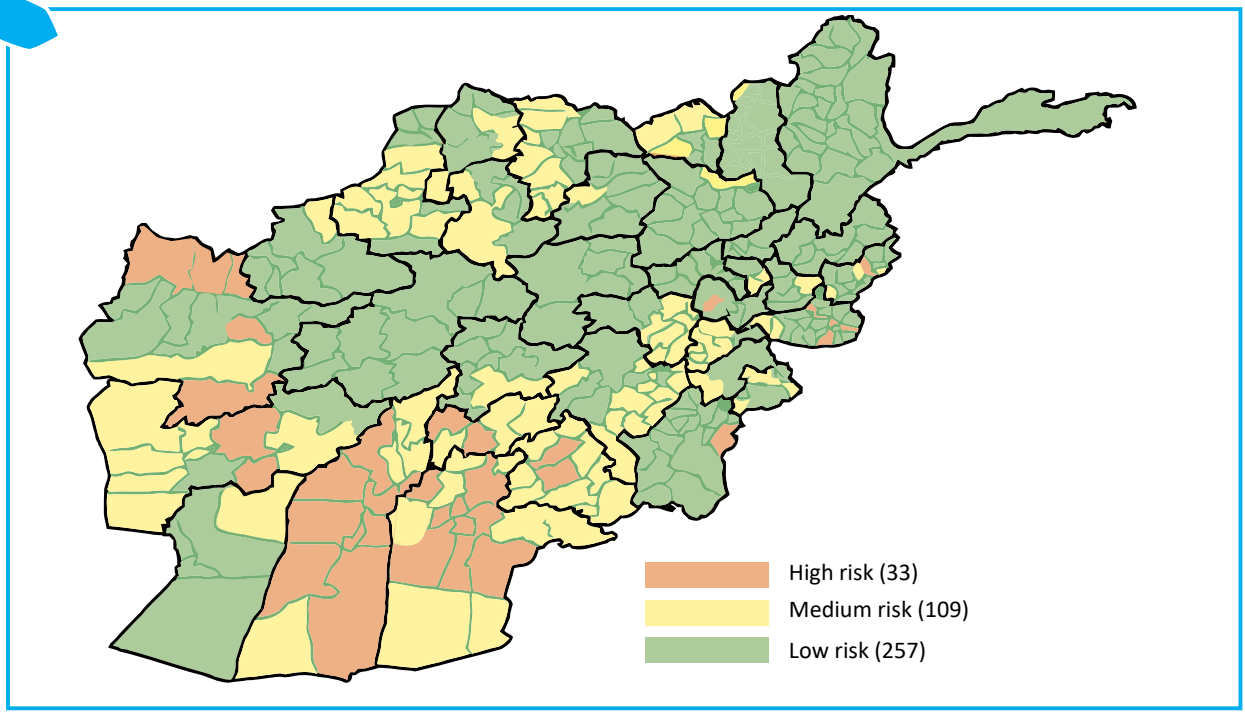
Annexure VI: Data flow chart (WHO)

Annexure VII: Implementation status / progress report of Integrated Services Plan (EOC)

Annexure II:

List & map of High, medium and low risk districts (Risk Categorization) – WHO

FIgure 9:Risk categorization



Categorization matrix

	High risk Epi Infected with WPV1 in > 3 years Continues to report cVDPV2 case in 2021 despite responses Large population centers with extensive population movement	**Medium risk Epi** Infected with WPV1 in 2 out of 7 years	**Low Risk Epi** Infected with WPV1 only in one out of 7 years
Fully Accessible Fully accessible in all campaigns Atleast 3 campaigns with > 80% access since Jan 2020	7	1	169
Partially accessible Upto 50 percent inaccessible consistently (did not manage to receive 3 doses since Jan 2020	3	4	87
Inaccessible More than half district inaccessible consistently	8	11	109

High risk districts			Medium risk districts			Low risk districts		
Region	**Province**	**District**	**Region**	**Province**	**District**	**Region**	**Province**	**District**
Central	Kabul	Kabul	Central	Kapisa	Tagab	South	Kandahar	Ghorak
East	Nangar-har	Jalalabad	Central	Kapisa	Alasay	Central	Kabul	Dehsabz
East	Nangar-har	Behsud	Central	Wardak	Maydanshahr	Central	Kabul	Shakardara
East	Nangar-har	Batikot	Central	Wardak	Jalrez	Central	Kabul	Paghman
East	Nangar-har	Achin	Central	Wardak	Nerkh	Central	Kabul	Chaharasyab
East	Nangar-har	Muhmand Dara	Central	Wardak	Daymirdad	Central	Kabul	Musayi
East	Kunar	Shigal Wa sheltan	Central	Wardak	Chak	Central	Kabul	Bagrami
South	Uruzgan	Tirinkot	Central	Wardak	Saydabad	Central	Kabul	Qarabagh
South	Uruzgan	Sha-hid-e-Has-sas	Central	Wardak	Jaghatu	Central	Kabul	Kalakan
South	Zabul	Qalat	Central	Logar	Pul-e- Alam	Central	Kabul	Mirbachakot
South	Zabul	Arghandab	Central	Logar	Khoshi	Central	Kabul	Guldara
South-east	Paktika	Bermel	Central	Logar	Mohammad-agha	Central	Kabul	Khak-e- Jabbar
West	Hirat	Pashtun-zarghun	Central	Logar	Barakibarak	Central	Kabul	Surobi
West	Hirat	Shindand	Central	Logar	Charkh	Central	Kabul	Estalef
West	Farah	Bakwa	Central	Logar	Kharwar	Central	Kabul	Farza
West	Farah	Balabuluk	East	Nangarhar	Hesarak	Central	Kapisa	Mahmud-e-Raqi
South	Hilmand	Lashkargah	East	Nangarhar	Sherzad	Central	Kapisa	Nejrab
South	Hilmand	Nahr-e-Sa-raj	East	Laghman	Alingar	Central	Kapisa	Kohband
South	Hilmand	Nad-e-Ali	Northeast	Baghlan	Burka	Central	Kapisa	Hisa-e- Du-wum-e- Kohes-tan
South	Hilmand	Nawa-e-Barakzaiy	Southeast	Ghazni	Walimuham-mad-e- Shahid	Central	Kapisa	Hisa-e- Awal-e-Kohestan
South	Hilmand	Sangin	Southeast	Ghazni	Waghaz	Central	Parwan	Charikar
South	Hilmand	Nawzad	Southeast	Ghazni	Andar	Central	Parwan	Jabalussaraj
South	Hilmand	Washer	Southeast	Ghazni	Dehyak	Central	Parwan	Shinwari
South	Hilmand	Garmser	Southeast	Ghazni	Zanakhan	Central	Parwan	Bagram
South	Hilmand	Reg	Southeast	Ghazni	Rashidan	Central	Parwan	Saydkhel
South	Kandahar	Kandahar	Southeast	Ghazni	Qarabagh	Central	Parwan	Salang
South	Kandahar	Arghandab	Southeast	Ghazni	Giro	Central	Parwan	Ghorband
South	Kandahar	Zheray	Southeast	Ghazni	Muqur	Central	Parwan	Koh-e- Safi
South	Kandahar	Panjwayi	Southeast	Ghazni	Abband	Central	Parwan	Shekhali
South	Kandahar	Daman	Southeast	Ghazni	Ajrestan	Central	Parwan	Surkh-e- Parsa
South	Kandahar	Shahwa-likot	Southeast	Ghazni	Gelan	Central	Wardak	Hesa-e- Aw-al-e- Behsud

South	Kandahar	Spinboldak	Southeast	Ghazni	Nawa	Central	Wardak	Markaz-e-Beh-sud
South	Kandahar	Ghorak	Southeast	Paktya	Zurmat	Central	Logar	Azra
			East	Kunar	Watapur	East	Nangar-har	Surkhrod
			East	Kunar	Dangam	East	Nangar-har	Khogyani
			East	Kunar	Nurgal	East	Nangar-har	Chaparhar
			Northeast	Takhar	Darqad	East	Nangar-har	Rodat
			Northeast	Kunduz	Emamsaheb	East	Nangar-har	Kama
			Northeast	Kunduz	Qala-e-Zal	East	Nangar-har	Kuzkunar
			Northeast	Kunduz	Chardarah	East	Nangar-har	Dara-e-Nur
			Northeast	Kunduz	Dasht-e-Archi	East	Nangar-har	Pachieragam
			North	Balkh	Shortepa	East	Nangar-har	Dehbala
			North	Balkh	Dawlatabad	East	Nangar-har	Kot
			North	Balkh	Charbulak	East	Nangar-har	Goshta
			North	Balkh	Chemtal	East	Nangar-har	Shinwar
			North	Balkh	Sholgareh	East	Nangar-har	Lalpur
			North	Balkh	Keshendeh	East	Nangar-har	Nazyan
			North	Balkh	Zari	East	Nangar-har	Durbaba
			North	Samangan	Dara-e- Suf-e-Payin	East	Laghman	Mehtarlam
			North	Sar-e-Pul	Sayad	East	Laghman	Alishang
			North	Sar-e-Pul	Kohestanat	East	Laghman	Qarghayi
			North	Sar-e-Pul	Sozmaqala	East	Laghman	Dawlatshah
			South	Daykundi	Gizab	Central	Panjsher	Bazarak
			South	Uruzgan	Chora	Central	Panjsher	Shutul
			South	Uruzgan	Dehrawud	Central	Panjsher	Rukha
			South	Uruzgan	Khasuruzgan	Central	Panjsher	Dara
			South	Zabul	Mizan	Central	Panjsher	Khenj (Hes-e- Awal)
			South	Zabul	Tarnak Wa Jaldak	Central	Panjsher	Onaba(Anawa)
			South	Zabul	Shinkay	Central	Panjsher	Paryan
			South	Zabul	Shahjoy	Northeast	Baghlan	Pul-e- khumri
			South	Zabul	Kakar	Northeast	Baghlan	Baghlan-e-Jad-id
			South	Zabul	Daychopan	Northeast	Baghlan	Daha-na-e-Ghori
			South	Zabul	Atghar	Northeast	Baghlan	Doshi
			South	Zabul	Shomulzay	Northeast	Baghlan	Nahrin

South	Zabul	Nawbahar	Northeast	Baghlan	Tala Wa barfak
Southeast	Khost	Sabari	Northeast	Baghlan	Khenjan
Southeast	Khost	Musakhel	Northeast	Baghlan	Andarab
Southeast	Khost	Terezayi	Northeast	Baghlan	Khwajahejran
Southeast	Khost	Qalandar	Northeast	Baghlan	Pul-e-Hesar
Southeast	Khost	Spera	Northeast	Baghlan	Dehsalah
North	Jawzjan	Mingajik	Northeast	Baghlan	Khost Wa Fereng
North	Jawzjan	Qushtepa	Northeast	Baghlan	Guzargah-e-Nur
North	Jawzjan	Fayzabad	Northeast	Baghlan	Fereng Wa Gharu
North	Jawzjan	Khanaqa	Central	Bamyan	Bamyan
North	Jawzjan	Aqcha	Central	Bamyan	Sayghan
North	Jawzjan	Mardyan	Central	Bamyan	Yakawlang
North	Jawzjan	Darzab	Central	Bamyan	Panjab
North	Faryab	Khwajasabzposh	Central	Bamyan	Shibar
North	Faryab	Pashtunkot	Central	Bamyan	Kahmard
North	Faryab	Shirintagab	Central	Bamyan	Waras
North	Faryab	Almar	Southeast	Ghazni	Ghazni
North	Faryab	Qaysar	Southeast	Ghazni	Khwajaumari
North	Faryab	Garziwan	Southeast	Ghazni	Jaghatu
North	Faryab	Dawlatabad	Southeast	Ghazni	Nawur
North	Faryab	Ghormach	Southeast	Ghazni	Jaghuri
West	Hirat	Kushk	Southeast	Ghazni	Malestan
West	Hirat	Gulran	Southeast	Paktya	Gardez
West	Hirat	Adraskan	Southeast	Paktya	Sayedkaram
West	Hirat	Kushk-e-Kohna	Southeast	Paktya	Ahmadaba
West	Farah	Khak-e-Safed	Southeast	Paktya	Shawak
West	Farah	Pushtrod	Southeast	Paktya	Zadran
West	Farah	Qala-e-Kah	Southeast	Paktya	Lija Ahmad Khel
West	Farah	Shibkoh	Southeast	Paktya	Alikhel (Jaji)
West	Farah	Lash-e-Juwayn	Southeast	Paktya	Janikhel
West	Farah	Gulestan	Southeast	Paktya	Chamkani
West	Farah	Anardara	Southeast	Paktya	Dand wa Patan
South	Hilmand	Musaqalah	East	Kunar	Asadabad
South	Hilmand	Kajaki	East	Kunar	Narang
South	Hilmand	Baghran	East	Kunar	Sarkani
South	Hilmand	Deh-e-shu	East	Kunar	Marawara
South	Kandahar	Khakrez	East	Kunar	Dara-e-Pech
South	Kandahar	Maywand	East	Kunar	Chawkay
South	Kandahar	Reg	East	Kunar	Khaskunar
South	Kandahar	Shorabak	East	Kunar	Barkunar
South	Kandahar	Arghestan	East	Kunar	Ghaziabad
South	Kandahar	Miyanshin	East	Kunar	Chapadara
South	Kandahar	Nesh	East	Kunar	Nari
South	Kandahar	Maruf	East	Nuristan	Poruns
South	Nimroz	Khashrod	East	Nuristan	Mandol
			East	Nuristan	Duab

East	Nuristan	Nurgeram
East	Nuristan	Wama
East	Nuristan	Waygal
East	Nuristan	Kamdesh
East	Nuristan	Barg-e- Matal
Northeast	Bada-khshan	Fayzabad
Northeast	Bada-khshan	Yaftal-e-Sufla
Northeast	Bada-khshan	Argo
Northeast	Bada-khshan	Arghanjkhwa
Northeast	Bada-khshan	Kohestan
Northeast	Bada-khshan	Raghestan
Northeast	Bada-khshan	Yawan
Northeast	Bada-khshan	Shahr-e-Buzorg
Northeast	Bada-khshan	Teshkan
Northeast	Bada-khshan	Darayem
Northeast	Bada-khshan	Khash
Northeast	Bada-khshan	Baharak
Northeast	Bada-khshan	Shuhada
Northeast	Bada-khshan	Shighnan
Northeast	Bada-khshan	Darwaz-e-Balla
Northeast	Bada-khshan	Kofab
Northeast	Bada-khshan	Khwahan
Northeast	Bada-khshan	Keshem
Northeast	Bada-khshan	Tagab
Northeast	Bada-khshan	Yamgan
Northeast	Bada-khshan	Jorm
Northeast	Bada-khshan	Warduj
Northeast	Bada-khshan	Eshkmesh
Northeast	Bada-khshan	Darwaz
Northeast	Bada-khshan	Shaki
Northeast	Bada-khshan	Koran wa Monjan

Northeast	Bada-khshan	Zebak
Northeast	Bada-khshan	Wakhan
Northeast	Takhar	Taloqan
Northeast	Takhar	Hazarsumuch
Northeast	Takhar	Baharak
Northeast	Takhar	Bangi
Northeast	Takhar	Chal
Northeast	Takhar	Namakab
Northeast	Takhar	Farkhar
Northeast	Takhar	Kalafgan
Northeast	Takhar	Rostaq
Northeast	Takhar	Chahab
Northeast	Takhar	Yangi Qala
Northeast	Takhar	Khwajabaha-wuddin
Northeast	Takhar	Dasht-e- Qala
Northeast	Takhar	Khwajaghar
Northeast	Takhar	Eshkashem
Northeast	Takhar	Warsaj
Northeast	Kunduz	Kunduz
Northeast	Kunduz	Aliabad
Northeast	Kunduz	Khanabad
North	Balkh	Mazar-e-Sharif
North	Balkh	Nahr-e- Shahi
North	Balkh	Balkh
North	Balkh	Dehdadi
North	Balkh	Charkent
North	Balkh	Marmul
North	Balkh	Khulm
North	Balkh	Kaldar
North	Balkh	Sharak-e-Hayratan
North	Samangan	Aybak
North	Samangan	Hazrat-e- Sul-tan
North	Samangan	Feroznakhchir
North	Samangan	Dara-e Suf-e-Bala
North	Samangan	Khuram Wa Sarbagh
North	Samangan	Ruy-e-Duab
North	Sar-e-Pul	Sar-e-Pul
North	Sar-e-Pul	Gosfandi
North	Sar-e-Pul	Balkhab
North	Sar-e-Pul	San-charak(sangc-hark)

West	Ghor	Chaghcharan
West	Ghor	Charsadra
West	Ghor	DoLayna
West	Ghor	Dawlatyar
West	Ghor	Shahrak
West	Ghor	Taywarah
West	Ghor	Pasaband
Central	Ghor	Lal Wa Sarjangal
West	Ghor	Tolak
West	Ghor	Saghar
Central	Daykundi	Nili
Central	Daykundi	Ashtarlay
Central	Daykundi	Khadir
Central	Daykundi	kiti
Central	Daykundi	Shahrestan
Central	Daykundi	Sang-e-Takht
Central	Daykundi	Kajran
Central	Daykundi	Miramor
Southeast	Paktika	Sharan
Southeast	Paktika	Matakhan
Southeast	Paktika	Yosufkhel
Southeast	Paktika	Sarrawzah(Sar-hawzah)
Southeast	Paktika	Zarghunshahr
Southeast	Paktika	Yahyakhel
Southeast	Paktika	Omna
Southeast	Paktika	Gomal
Southeast	Paktika	Sarobi
Southeast	Paktika	Urgun
Southeast	Paktika	Naka
Southeast	Paktika	Janikhel
Southeast	Paktika	Wazakhah
Southeast	Paktika	Wormamay
Southeast	Paktika	Gyan
Southeast	Paktika	Ziruk
Southeast	Paktika	Dila
Southeast	Paktika	Turwo (Tarwe)
Southeast	Khost	Khost(Matun)
Southeast	Khost	Nadirshahkot
Southeast	Khost	Mandozayi
Southeast	Khost	Tani
Southeast	Khost	Gurbuz
Southeast	Khost	Shamal
Southeast	Khost	Bak
Southeast	Khost	Jajimaydan

North	Jawzjan	Shiberghan
North	Jawzjan	Khwajadukoh
North	Jawzjan	Qarqin
North	Jawzjan	Khamyab
North	Faryab	Maymana
North	Faryab	Kohestan
North	Faryab	Bilcheragh
North	Faryab	Andkhoy
North	Faryab	Qaramqol
North	Faryab	Khan-e-Char Bagh
North	Faryab	Qorghan
West	Badghis	Qala-e-Naw
West	Badghis	Muqur
West	Badghis	Abkamari
West	Badghis	Qadis
West	Badghis	Jawand
West	Badghis	Balamurghab
West	Hirat	Herat
West	Hirat	Injil
West	Hirat	Zindajan
West	Hirat	Guzara
West	Hirat	Karukh
West	Hirat	Ghoryan
West	Hirat	Farsi
West	Hirat	Obe
West	Hirat	Kohsan
West	Hirat	Chisht-e-Sharif
West	Farah	Farah
West	Farah	Purchaman
South	Nimroz	Zaranj
South	Nimroz	Kang
South	Nimroz	Charburjak
South	Nimroz	Chakhansur

Annexure IV:

Minimum standards for SIAs – WHO

SIAs Minimum Standards

Component	Indicator
Vaccinator selection	Both vaccinators in each team are local and resident of the area in the team microplan
	The coordinator is literate to at least 7th standard or equivalent (enough to write and read)
	Increment in number of female vaccinators selected
Supervisor selection	At least 80% members of selection committee are in agreement with the selection
	100% supervisors are local for the district, preferably from the same cluster
	100% supervisors are literate - at least 12th standard (enough to understand/use all SIA forms and to compile reports)
	Increment in number of female supervisors selected
District coordinator selection	All members of selection committee are in agreement with the selection
	100% coordinators are local for the district
	100% coordinators are literate - at least 12th standard (enough to understand/use all SIA forms and to compile reports)
Trainings	ToT organized for trainers before each campaign
	At least 95% training attendance in vaccinator trainings
	100% attendance in supervisor and district coordinator trainings
	100% sessions monitored in VHRDs, 60% in HRDs and 25% in non HRDs
	Training material and logistics available in at least 95% monitored sessions
	Presence of provincial PEI staff from all stakeholders in every supervisor training
	Presence of regional PEI staff from all stakeholders in every district coordinator training
Implementation & Monitoring	ICM conducted in 100% clusters in VHRDs
	>95% missed children found by ICM recorded on the back of tally sheet in all clusters
	PCM conducted in 100% clusters in VHRDs, 50% in non VHRDs
	PCM coverage >95% in all monitored clusters
	Out of house survey >95% in all monitored clusters
	LQAS passed at 90% in the district
Data validation and use	5% ICM, 5% PCM and 10% lots validated
	ICM, PCM, LQAS, reported coverage compiled and submitted in time
	All data streams - ICM, PCM, LQAS and reported coverage analysis used in post campaign review

Annexure V:

SOPs – Support of PEI staff on RI monitoring (WHO)

Standard Operating Procedures for Polio Staff to Support Routine Immunization

One of the key activities of National emergency action plan (NEAP) for 2020 relates to PEI support to EPI. The program is trying to ensure that polio field staff spends at least 20% of their time on supporting the Routine Immunization (RI) by monitoring the RI activities at fixed sites / health facilities and outreach sessions as well as by participating in the training of health workers and mobilization.
PEI to EPI support working group under Emergency Operation Center (EOC) umbrella developed three checklists / formats for monitoring of the routine immunization activities, i.e. one checklist each for fixed centers, outreach/mobile sessions and for assessing community coverage.
The objective of these SOPs is to outline the procedures for monitoring of routine immunization services by polio staff that will be engaged as follows:

1. Each Polio Provincial Officer (PPO) and District Polio Officers (DPO) should prepare monthly plan for monitoring the routine immunization sessions. One working day a week is an approximate equivalent of 20% of time; therefore, the monthly plan should include 4 visits to the immunization sessions (twice a month to the fixed centers and one each to the outreach/mobile activities combining these where possible with active AFP surveillance visits). Copy of plan should be shared with Provincial Health Coordination Committee (PHCC)/PEMT and BPHS partners.

2. During each monitoring visit of fixed, outreach or mobile session, PPO/DPO should conduct community coverage survey by visiting 10 households in the area selected at random and filling in the relevant checklist.

3. The observations and findings will be recorded in the supervisory checklists; feed-back should be provided to the vaccinators at the time of visit and completed check-lists should be shared with the WHO Offices, EOCs (where exist), PEMT, PHCC as well as relevant BPHS partner.

4. At each RI session (fixed, outreach or mobile), PPO should spend at least one hour to observe the vaccination practices, complete the checklist and possibly address the identified gaps in knowledge of vaccinators.

5. Subsequent visit to the same center should occur in the next 2 or 3 months depending on the number of RI facilities in the PPOs area of assignment; PPO/DPO should follow up on his/her findings in the subsequent visits to the facility.

6. EOC and WHO Country Office will be tracking completeness and timeliness of the report's submission at the dedicated dashboard and providing feed-back on these indicators.

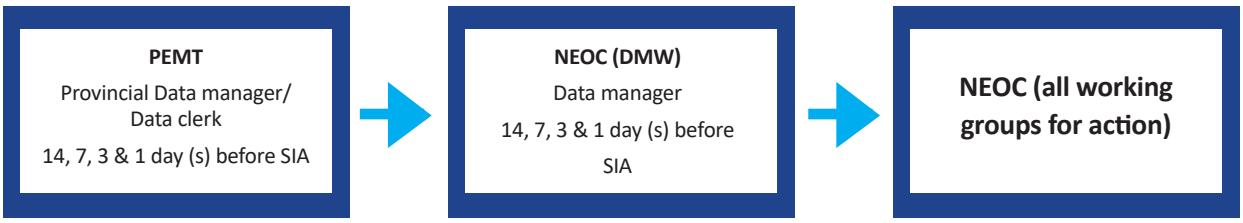
7. Copies of the supervisory checklists should be sent to WHO Country Office for compilation and analysis, while another copy should be kept in office for records. The WHO country office will share the compiled reports with the Polio National EOC and the National EPI.

Annexure VI:

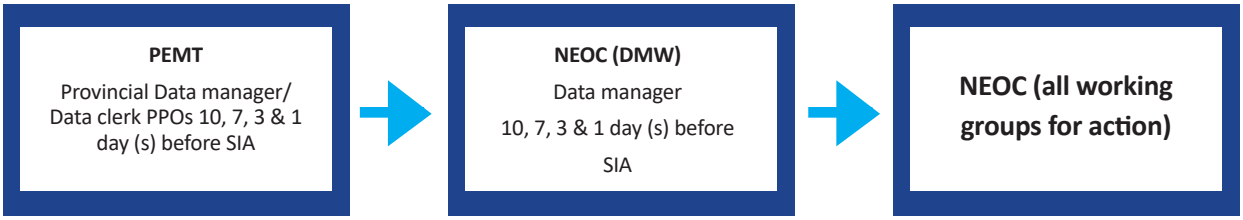
Data flow chart (WHO)

Pre-campaign data flow chart

Pre-campaign readiness data for dashboard

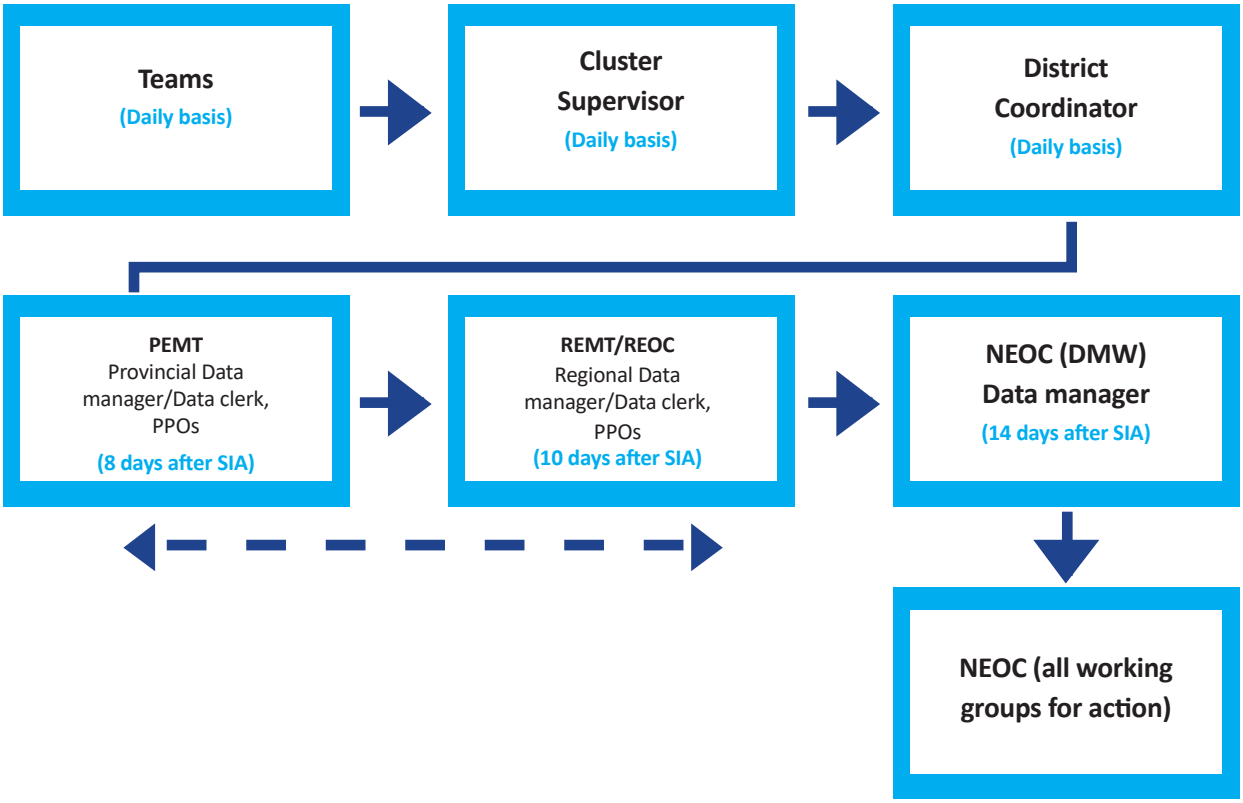


Assessment of Inaccessibility



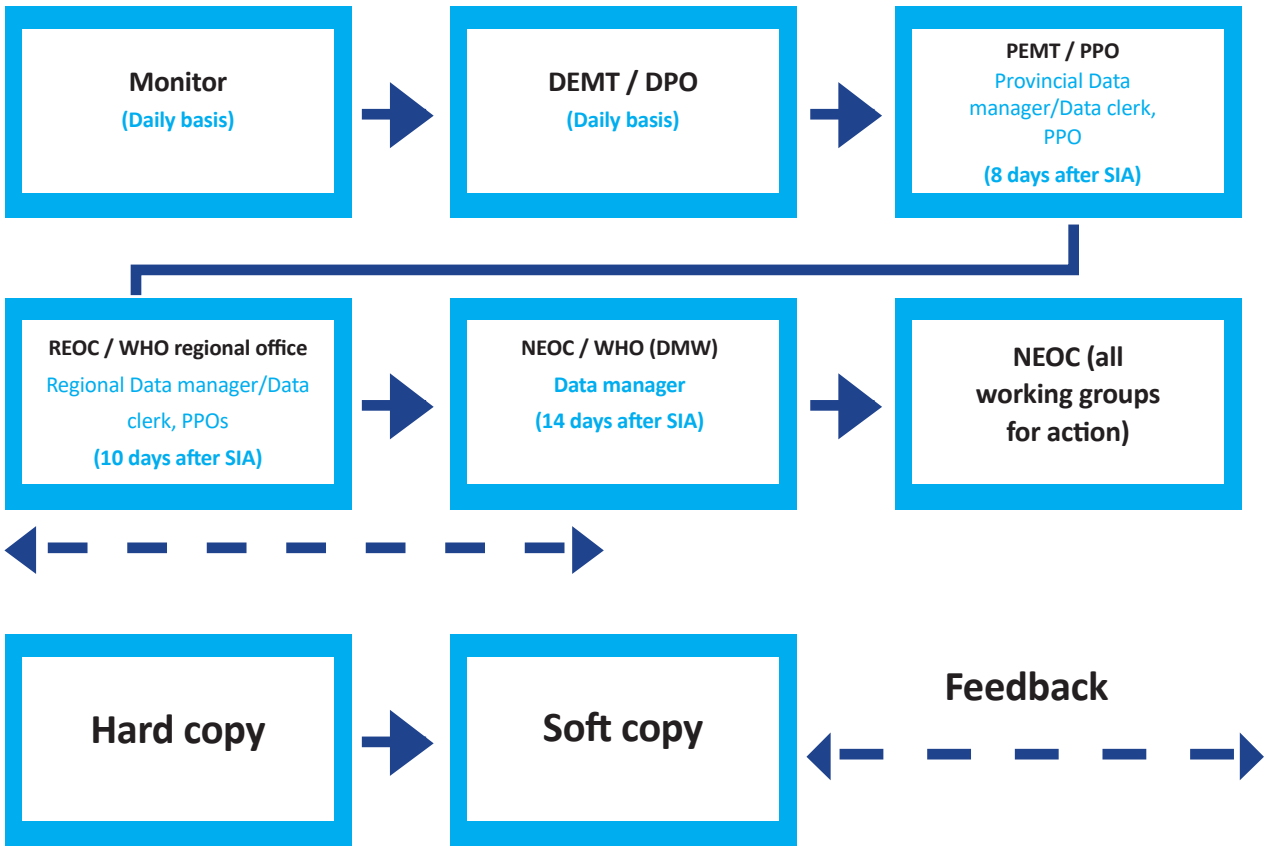
Intra-campaign data flow chart

Admin



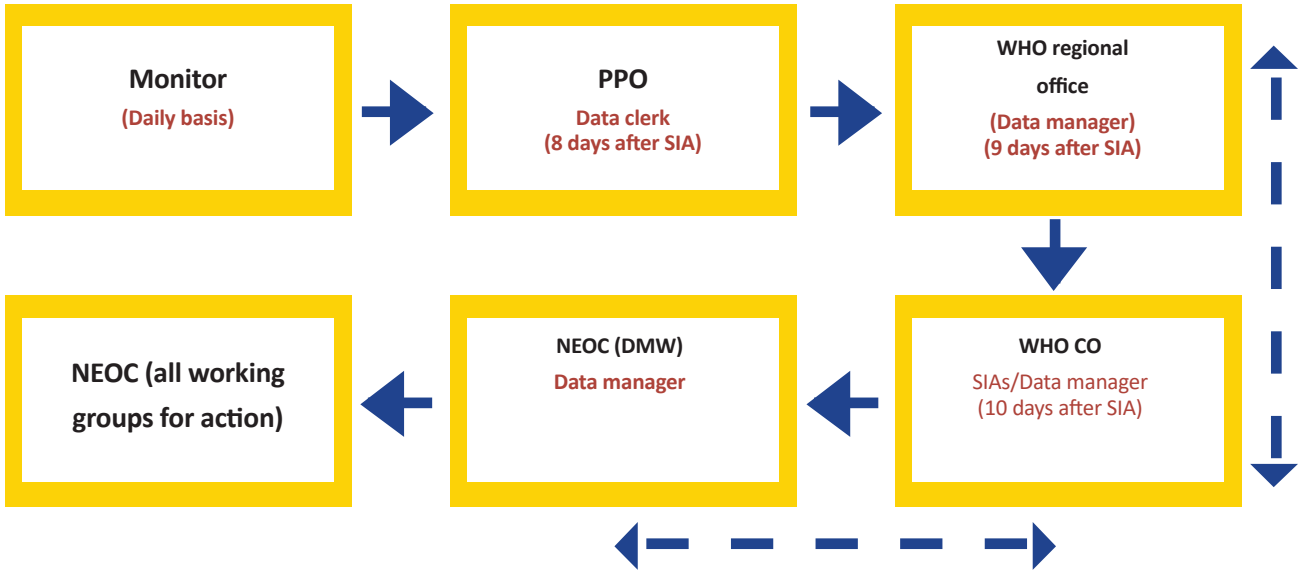
Intra-campaign data flow chart

Intra-campaign monitoring (ICM)



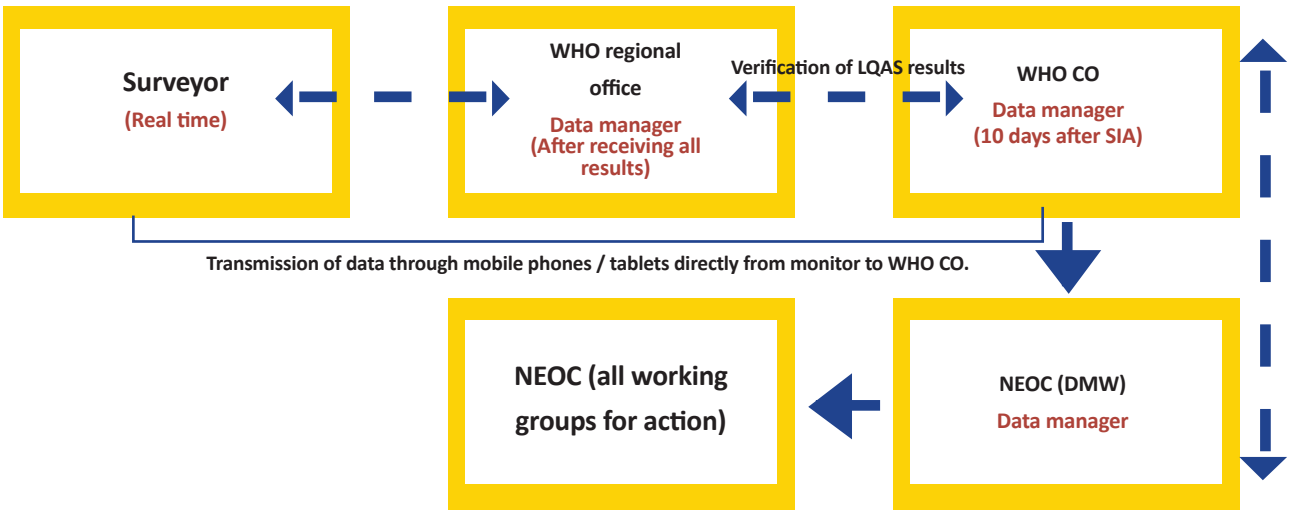
Post Campaign data flow chart

Post Campaign Monitoring (PCM)

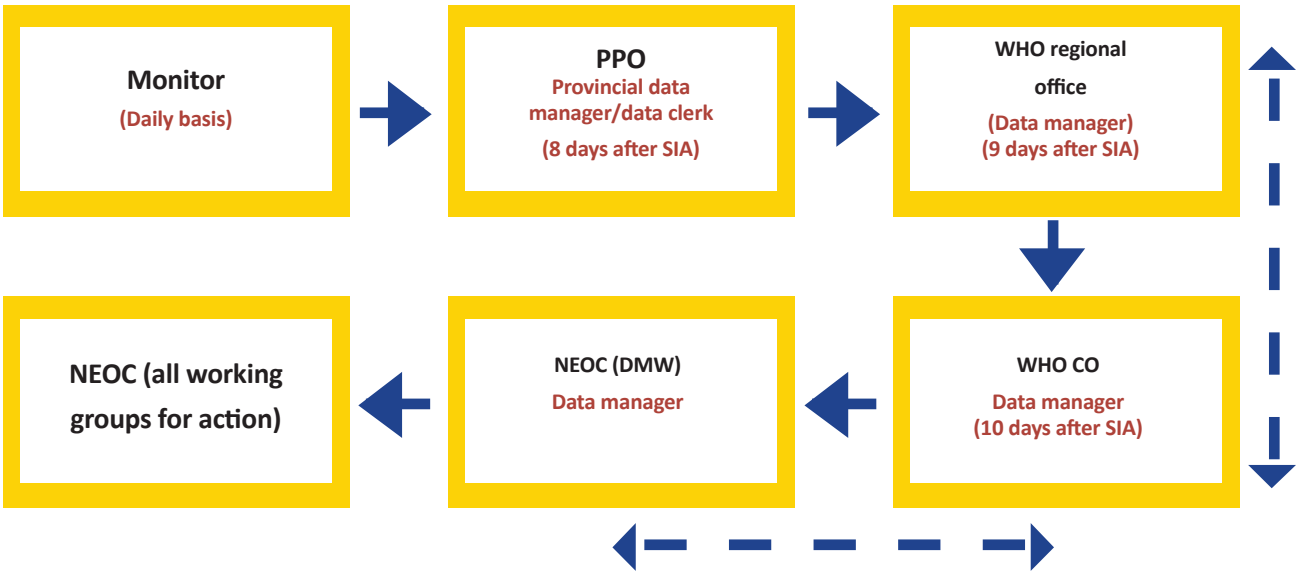


Post Campaign data flow chart

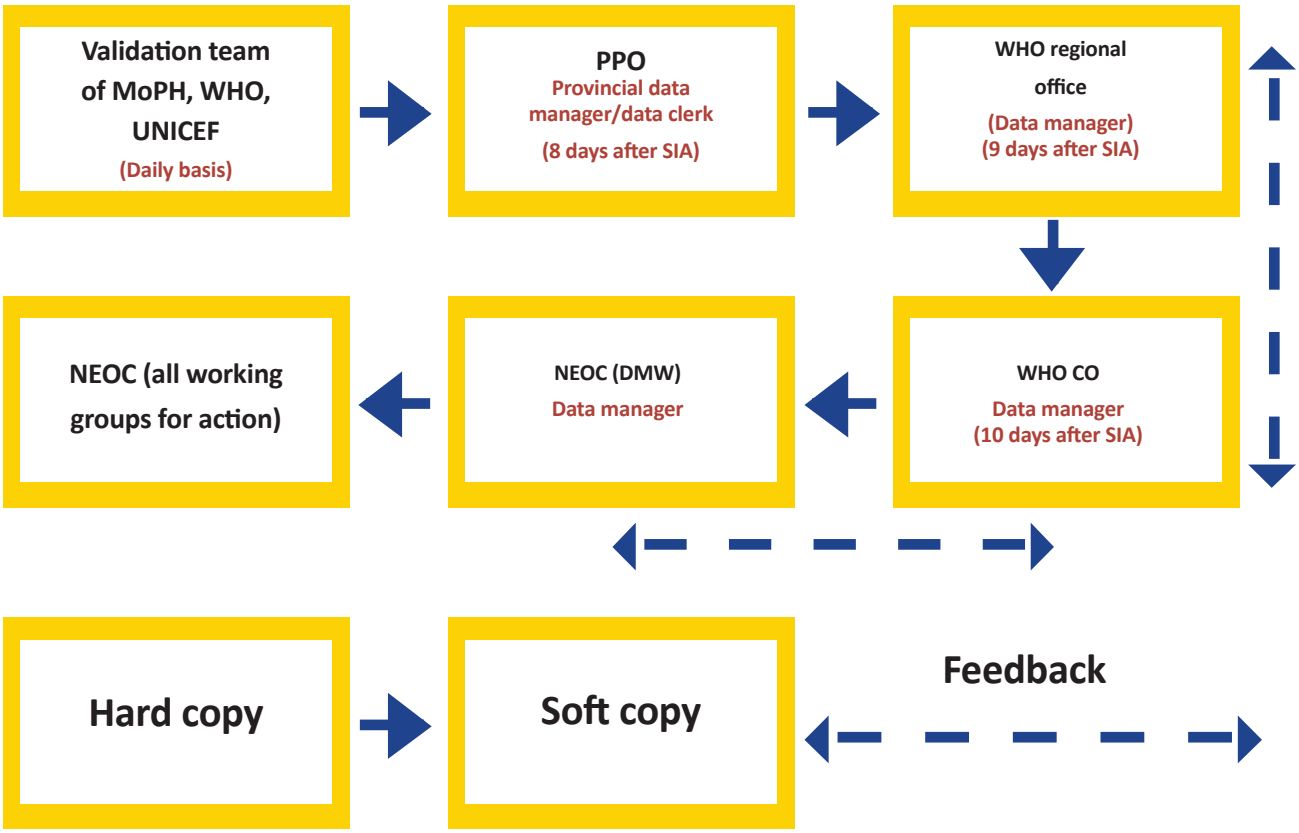
Lots Quality Assurance Sampling (LQAS)



Out of House Finger Mark Survey (FM Survey)

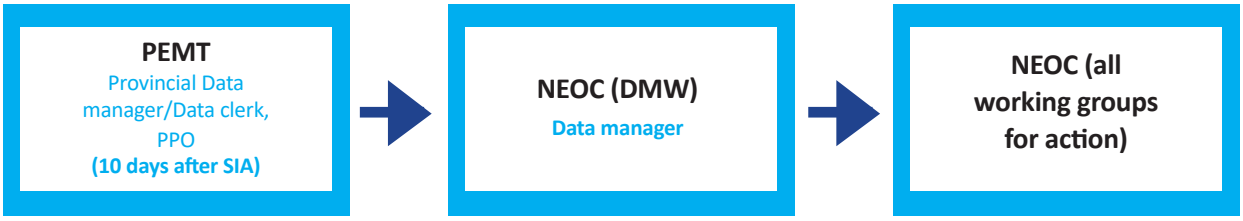


PCM and LQAS validation

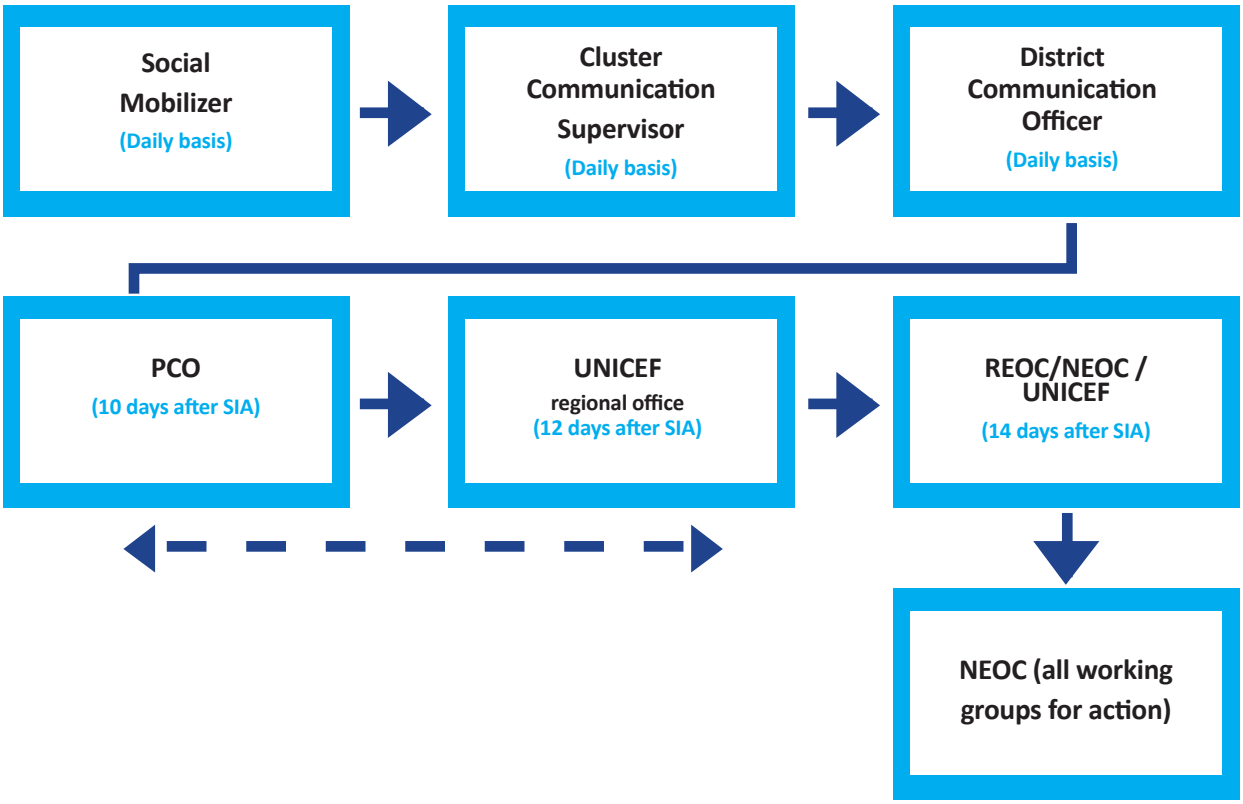


Post Campaign data flow chart

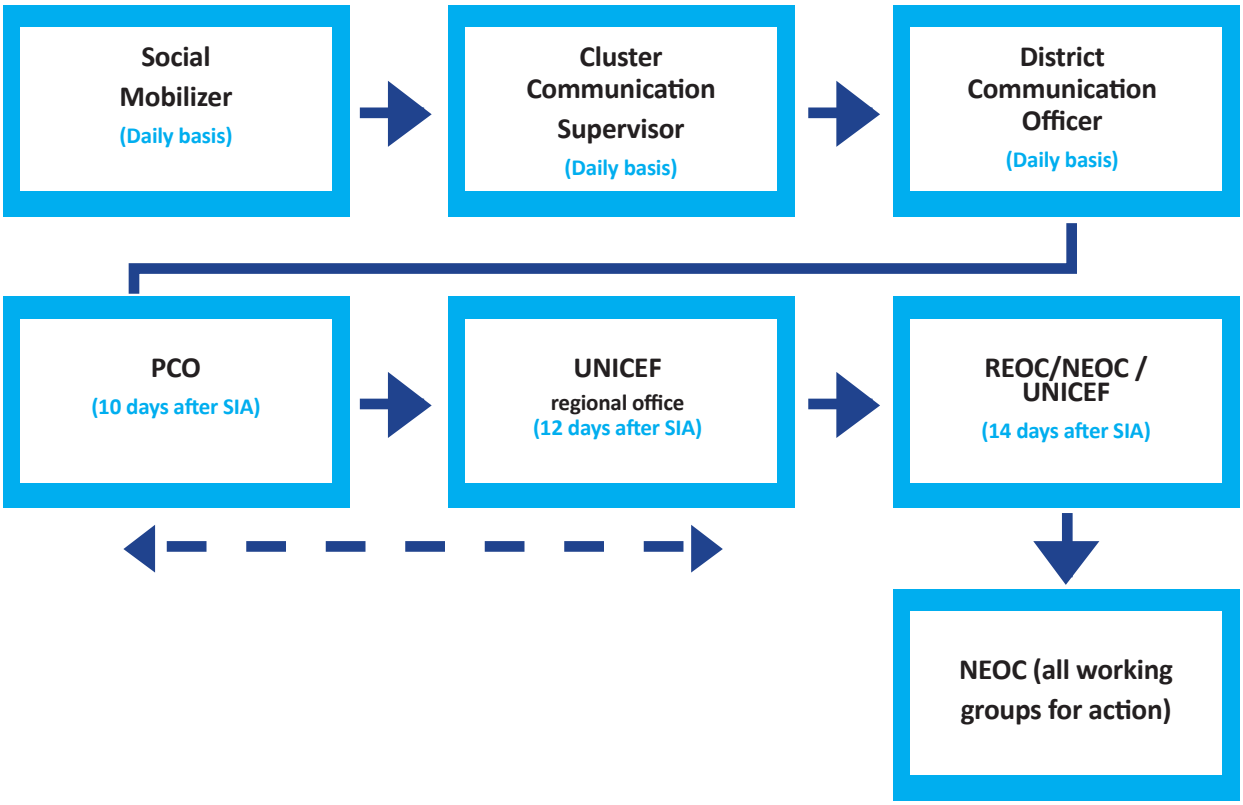
Inaccessibility Data



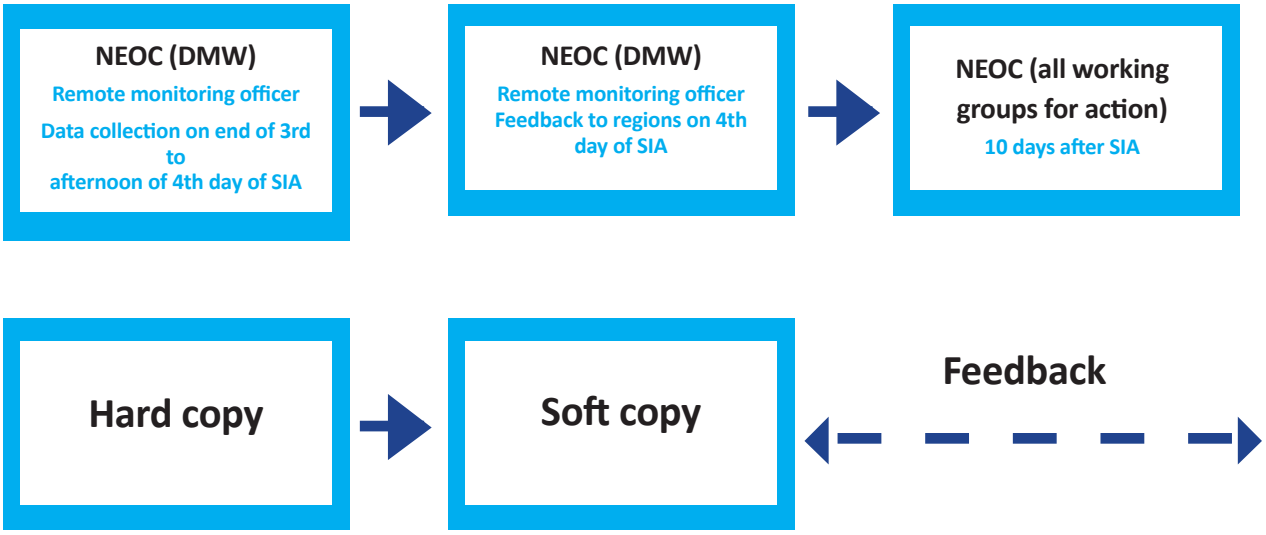
Immunization Communication Network (ICN) Catchup data



Immunization Communication Network (ICN) Chronic Refusal data



Remote Monitoring Data



We know a future where every child can grow up without fear of polio is possible.

We are determined to make it happen.