

# ANNUAL REPORT 2012

## Polio Eradication Initiative, Afghanistan



Expanded Program on Immunization  
Ministry of Public Health, Afghanistan



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## 1. Executive Summary:

Afghanistan is administratively divided into 7 regions and 34 provinces which are subdivided into 399 districts, the lowest administrative units. Although South and West are the largest regions area-wise but Central, Eastern and parts of Western & Northern regions are among the most densely populated areas of the country. Population estimate used for vaccination campaigns for children below 5 years is almost 8.3 million while the population below 15 years of age used for AFP surveillance is almost 17 million.

*Epidemiological situation:* Afghanistan reported total of 37 confirmed polio cases in 2012 compared to 80 cases reported in 2011 in the country. Epidemiological data shows that 65% of the cases (24/37) are reported from the known three provinces of Southern region; Kandahar (11 cases), Helmand (11 cases), Uruzgan (2 Cases). One case also reported from the adjacent province of Farah in South-West. In 2012, a new epidemiological situation emerged with the occurrence of sporadic cases followed by secondary cases in East and South Eastern region. There are 6 cases reported from the Eastern Region (Kunar, and Nangarhar) while 5 cases reported from South-East (Paktia and Khost provinces). One case is reported from the Ghor province. Another new epidemiological challenge in Afghanistan during 2012 was the outbreak of cVDPV2 reported from the Southern region. In 2012 eleven cases of cVDPV2 were reported from Helmand and Kandahar provinces

In comparison to the last year, the number of confirmed polio cases shows a significant decrease of more than 50% and also the number of infected districts reduced from 34 in 2011 to 21 districts in 2012. Vaccination status of non-polio AFP cases (age 6-23 months), immunization coverage in the last 4 SIAs and proportion and distribution of all Zero Dose AFP cases are used as the proxy for the population immunity in the various regions of the country. The analysis indicates that most of the country, except Southern region, has maintained high quality of campaign, reduced proportion of Zero Dose cases and higher routine coverage. This coverage level may prevent the establishment of circulation in most of the country. However, although number of Zero dose case in Southern region has declined but the campaign quality and routine EPI coverage continued to be less than expected and below the level required to stop the circulation.

Main reason for the outbreak and the continued transmission during 2012 is the prevailing immunity gap in the localized area of Southern region due to consistent compromised quality of campaigns compounded with very low routine EPI coverage, mainly due to precarious security situation, gaps in management and accountability and low community demand.

*Supplementary Immunization Activities (SIAs).* Four rounds of NIDs were implemented (March, May, September, and October) using alternatively bOPV and tOPV; Vitamin A and de-worming tablets were also administered twice during campaigns this year. Four additional rounds of Sub-NIDs using bivalent bOPV in South, South-East, Eastern region and Farah province of Western region. SNIDs were implemented in January, June, July and December 2012. Afghanistan pioneered, yet another intervention, where OPV was administered with Measles vaccine, in all over the country to all children of age up to 10 years. Immediate and large scale case response vaccination rounds are implemented in all the newly infected provinces, their adjoining areas as well as the districts bordering outbreak zone of Pakistan.

Analysis of Post campaign household coverage survey, out of house market surveys and vaccination of AFP cases shows that except Southern region rest of the country has maintained the campaign quality and is persistently achieving coverage of above 90%.

*Interventions in 2012* include declaration of Polio as emergency by Government of Islamic Republic of Afghanistan. Close coordination maintained with ICRC and local level negotiations were done to increase the access and safety of vaccination teams. Special training sessions were conducted to raise the capacity of service providers. In districts of regular conflict in South and East, transit vaccination teams were posted to vaccinate children of displaced population. Enough buffer stock of bOPV was kept as preparedness plan, and was used this year as response of poliovirus infection and mop ups were implemented within 10 days of receiving the laboratory results of a confirmed case in Eastern region and South-eastern region. Communication strategy is revised through

an integrated communication network aiming at increasing the demand. New tactics like short interval additional dose strategy (SIADs), Permanent Polio Teams (PPTs) are implemented in low performing districts.

AFP surveillance reporting and distribution of AFP cases by district and reporting category indicates regular reporting from all over the country. Analysis of AFP surveillance indicators and regular detection of wild virus from some of the difficult security affected areas reflects the presence of an overall satisfactory performing system in the country. The genetic sequencing data of confirmed cases in 2012 revealed that overall Afghanistan surveillance system remains sensitive.

Cross-Border coordination: Both the countries i.e. Afghanistan and Pakistan are working very closely for Polio eradication. The coordination between the two countries is exemplary and several key steps have been instituted to further strengthen the coordination. These include synchronizing campaign dates, data sharing, regular meetings, establishment of permanent vaccination posts at crossing points on the border and immediate cross notification of AFP cases. Approximately, more than 1 million children below the age of 5 years are vaccinated by Afghan teams at 11 cross border vaccination posts in East, South east and Southern region in 2012.

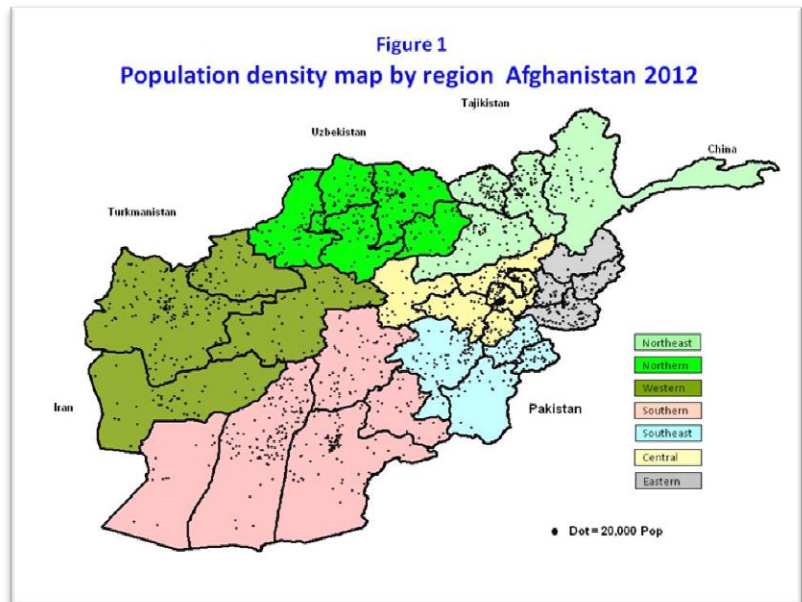
PEI Communication: In 2012, all NIDs, SNIDs, SIADs, Mop Ups and special polio vaccination interventions were adequately supported by communication interventions through the communication network at various levels. The key strategic focus of the interventions was to maintain high levels of community support and awareness and reduction in the number of missed children, particularly due to refusals or lack of knowledge. The Strategic Communication and Advocacy plan recommended strategies for 13 high risk districts. The Polio Communication Network (PCN) was restructured to Immunization Communication Network (ICN) with very clearly defined and structured integration with the operations. The ICN was expanded to cover the west region in addition to the high risk areas of Southern and Eastern Regions. Mass media (radio, television, posters and banners) remained the most effective source of information about the polio campaign at the national level during 2012, informing 77.9% (Oct'12 NID) of the informed people. Radio is the most effective medium in the South region informing 59.8% (Oct'12 NID) of the people who knew about the campaign. Overall level of awareness in south region at the end of the year (December campaign) was reported as 67.44%, higher than the preceding campaigns held in October and September and more than 26% higher than at the beginning of the year.

Important priorities; National Emergency Action Plan 2012-13: In light of the worsening polio situation and the implications nationally and globally, and to urgently address programme risks, the Government of Afghanistan developed an emergency plan.

*Main goals of the plan are to stop Wild Polio Virus (WPV) transmission in the Southern region and Farah province, prevent establishment of WPV circulation in the rest of the country and maintain a sensitive surveillance system.* The plan is based on the identification of major barrier and strategies to overcome these challenges. The plan focuses on improving the Management and Accountability, increase access to children for vaccination, enhance communications for awareness and demand creation and to strengthen routine EPI. The plan has new tactics and innovative measures to improve the population immunity.

## 2. Introduction:

Afghanistan is administratively divided into 7 regions and 34 provinces which are subdivided into 399 districts, the lowest administrative units. There are 5 provinces (Kandahar, Helmand, Uruzgan, Zabul and Nimroz) in Southern region, 4 provinces in South East (Ghazni, Paktika, Paktia and Khost), 4 provinces in East (Nangarhar, Kunar, Nooristan and Laghman), 4 provinces in West (Hirat, Badghis, Farah and Ghor), 5 provinces in North (Jawzjan, Faryab, Balkh, Saripul and Samangan), 4 provinces in North East (Baghlan, Kunduz, Takhar and Badakhshan) and 8 provinces in Central Region (Kabul, Kapisa, Parwan, Wardak, Logar, Panjsher, Bamyán and Dikundi).



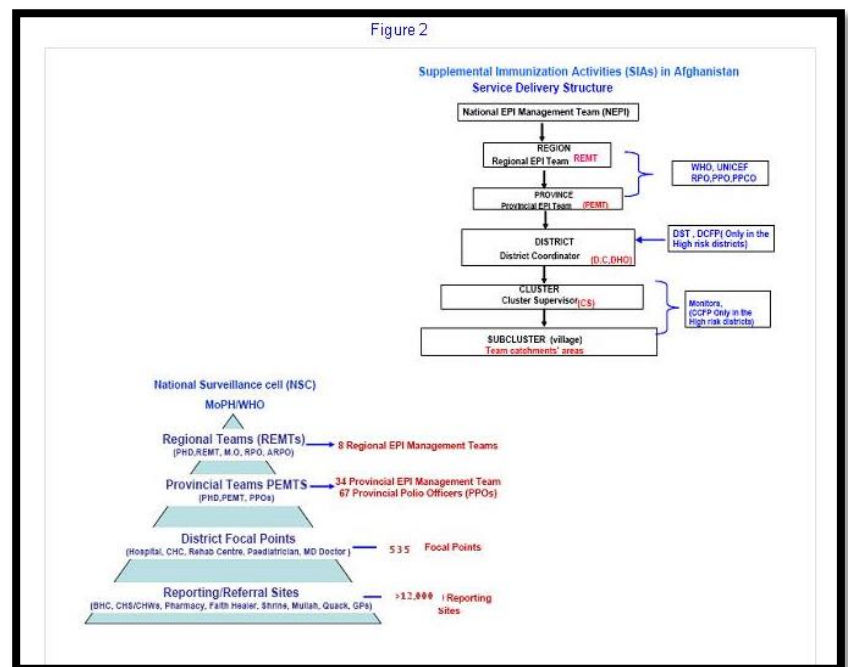
Although South and West are the largest regions area-wise but Central, Eastern and parts of Western & Northern regions are among the most densely populated areas of the country (Fig 1). Population estimate used for vaccination campaigns for children below 5 years is almost 8.3 million while the population below 15 years of age used for AFP surveillance is almost 17 million.

### 2.1 Polio Eradication Initiative (PEI) Service Delivery Structure Afghanistan

National, Provincial, District and Sub-district level PEI service delivery structure is designed with well defined roles and responsibilities. National and provincial EPI management teams are present at country and provincial levels having representation from EPI, WHO, UNICEF and NGOs. These teams lead the program at country and provincial level. Country team is mainly responsible for policy, planning, vaccine procurement and supply while provincial teams responsible for implementation, supervision and monitoring all EPI activities including Polio Eradication Initiative.

Routine EPI services are accessible to almost 80% of Afghanistan population through a wide net of 1,600 vaccination sites established at district and sub-district levels and are served by almost 3,200 vaccinators.

For Supplemental immunization activities (SIAs) which include National Immunization Days (NIDs), Sub-NIDs and mop-ups; micro-plans are developed by dividing districts into Clusters which are small geographic areas with well demarcated and mapped areas. Each Cluster is managed by a Cluster Supervisor, supervising 5-6 vaccination teams; each team consists of two members, termed as volunteers. There are 4,275 clusters and almost 47,209 volunteers to approach



house to house to administer Oral Polio Vaccine (OPV) to children below 5 years of age, in each vaccination



campaign (Table 1). At district level, there are district coordinators (on average there are 1 coordinator per 5-7 supervisors) and campaign monitors. There are 771 district coordinators and 1,522 monitors to monitor the activities during campaign and assess the coverage after the campaign. Additional human resource is engaged for polio communication activities in Southern, South-Eastern and Eastern region of the country. There are 41 district communication focal persons and 190 cluster communication focal persons and almost 1,850, community mobilizer in these high risk areas. In summary, almost 57,246 workers are involved to deliver vaccination services during NIDs (Fig 2).

(Table 1) General Information: Polio SIAs Service Providers, 2012\*

S/N	Region	Service providers					
		District Coordinator	Supervisor	Volunteer	Intra Campaign Monitors/Post Campaign Monitors	Social Mobilizer	Total
1	Eastern	86	447	4890	204	871	6498
2	Southern	97	731	8550	308	995	10681
3	Southeastern	83	367	4830	145	0	5425
4	Northern	97	517	6602	155	0	7371
5	Northeastern	97	411	4600	102	411	5621
6	Western	116	554	4876	189	464	6199
7	Central	141	1058	11326	351	728	13604
8	Badakshan	54	190	1535	68	0	1847
	<b>Afghanistan</b>	<b>771</b>	<b>4,275</b>	<b>47,209</b>	<b>1,522</b>	<b>3,469</b>	<b>57,246</b>

\* Data for March NIDs 2012

WHO is responsible for technical assistance, trainings, micro-planning, post campaign assessment surveys, data analysis and report writing, UNICEF supports the communication component of campaign, procurement of vaccines and other logistics and operational costs. MoPH and NGOs are the main implementing partners.

For AFP Surveillance, there is a country wide network of AFP Focal Points (FP) linked with community-based reporting volunteers. Each district has at least one Focal Point who is usually a Doctor (preferably a paediatrician) in the District Headquarter Hospital and is responsible for AFP case notification, investigation, sample collection and its shipment to provincial office. Each focal point is linked with a network of community-based reporting volunteers (RV) including pharmacists, traditional healers, Shrine keepers, General Practitioners and Mullahs. The RVs are responsible for case notification and their referral to the concerned FP. There are 548 focal points and over 16,000 community-based reporting volunteers all over the country.

## 2.2 PEI Staff Network:

In each region WHO supports MoPH by team of International and National Staff. Each regional team consists of International Medical



Officer, Regional Polio Officer (RPO), Assistant Regional Polio Officers (ARPO) and Provincial Polio Officers (PPO). RPOs and ARPOs are mainly responsible for supervisory support while PPOs carry out the field activities related to AFP Surveillance and SIAs in their assigned provinces/ districts. WHO PPOs are placed at the provincial level and have their assigned districts to facilitate vaccination and AFP Surveillance activities. There are 6 Medical Officers, 9 RPOs, 9 ARPOs, 81 PPOs and 23 DPOs distributed in various parts of the country to carry out polio eradication activities (Fig 3).

At the national level UNICEF has a team of four International and four national staff. Four national C4D Officers (Regional Polio Communication Officer – RPCOs) are deployed in the highest risk South, East, West and South East regions of Afghanistan, supporting communication/social mobilization activities at the regional level adapting plans to the local context. As part of the Immunization Communication Network (ICN), 7 Provincial Communication Officers (PCOs) and 39 District Communication Officers (DCOs) are also placed in high risk provinces including Kandahar, Helmand, Uruzgan, Farah, Nangarhar, Laghman and Kunar provinces

MoPH has Provincial EPI Manager in each of the 34 provinces whereas NGOs has their provincial project manager in each province.

### 3. Polio Epidemiology Afghanistan:

#### 3.1 Geographical Distribution of Confirmed Polio cases:

Afghanistan reported total of 37 confirmed polio cases in 2012 compared to 80 cases reported in 2011 in the country. Epidemiological data shows that 65% of the cases (24/37) are reported from the known three provinces of Southern region; Kandahar (11 cases), Helmand (11 cases), Uruzgan (2 Cases). One case also reported from the adjacent province of Farah in South-West.

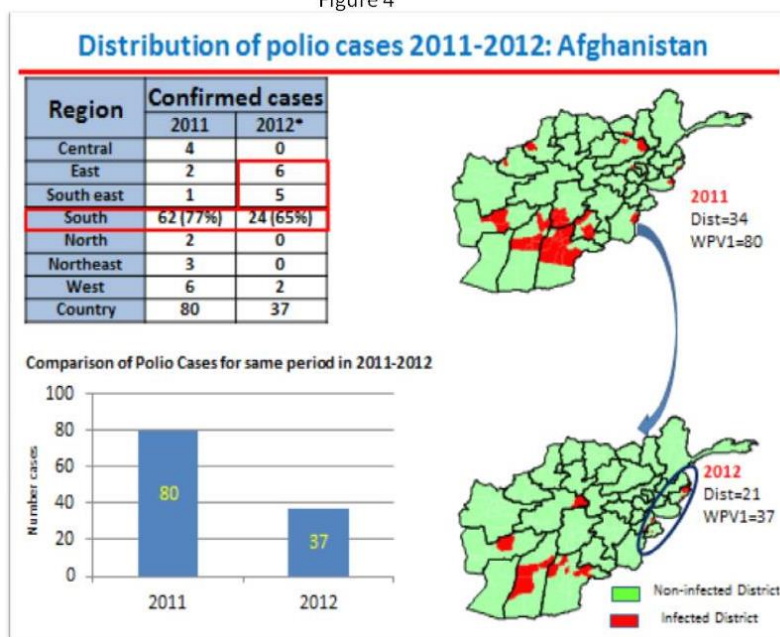
In 2012, a new epidemiological situation emerged with the occurrence of sporadic followed by secondary cases in East and South Eastern region. There are 6 cases reported from the Eastern Region (Kunar, and Nangarhar) while 5 cases reported from South-East (Paktia and Khost provinces). One case is reported from the Ghor province.

In comparison to the last year, the number of confirmed polio cases shows a significant decrease of more 50% and also the number of infected districts reduced from 34 in 2011 to 21 districts in 2012 (Figure 4)

#### 3.2 Age and Vaccination Status of confirmed cases

Thirty out of 37 confirmed polio cases (81%) were young children of age up to 2 years only. Median age of the cases was 18 months with range of 2-60 months. Proportion of male cases was higher than the females (M: F = 25:12). Thirteen cases (35%) did not receive any dose of OPV “zero dose”; neither through SIAs nor through routine. Thirty cases (81%) did not receive any OPV dose in routine. Median number of OPV doses received by the cases is 2.

Figure 4



### 3.3 Distribution of Polio cases by month and type

The pattern of occurrence of polio cases by month and over period of last 3 years (Figure 5) indicates isolation of type 1 poliovirus (NSL1) at regular interval and almost every month. This also shows that the number of vaccination campaigns and interventions done during this period of time were probably not effective enough to change the natural course of the type 1 virus. However, it is important to mention that poliovirus of type 3 (NSL3) is not in the last more than two and half year. Last NSL3 was isolated in April 2010.

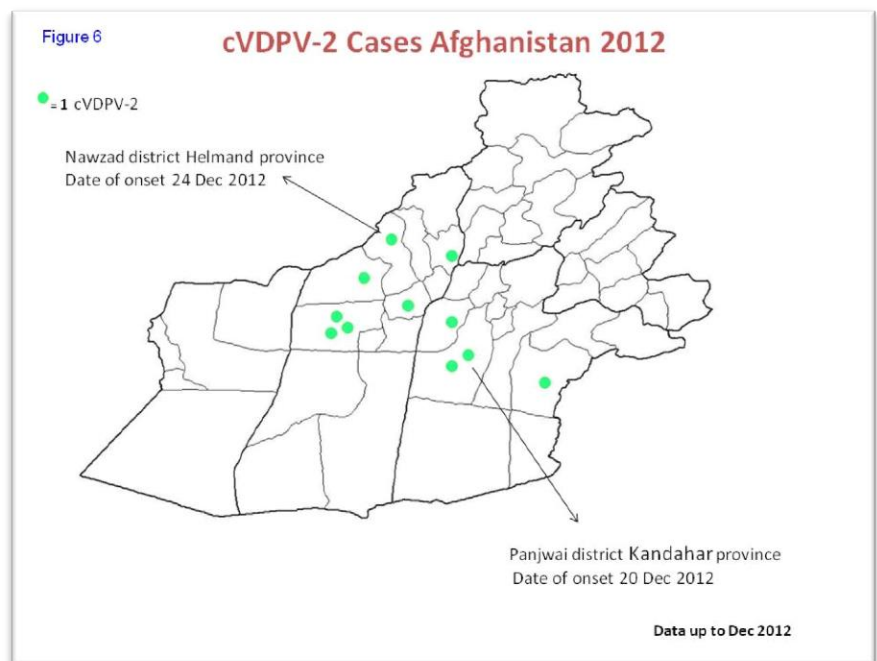
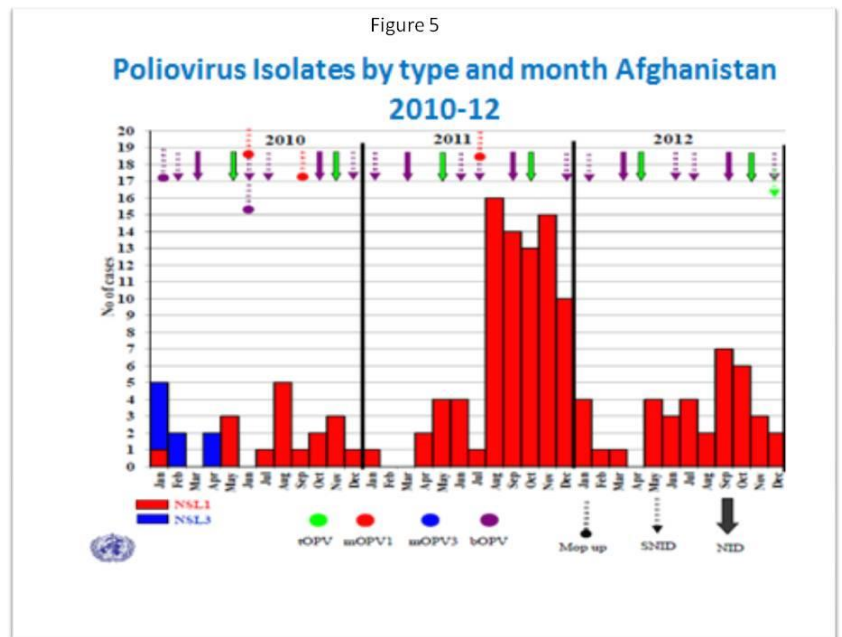
### 3.4 Circulating Vaccine Derived Poliovirus type 2 (cVDPV2):

Another new epidemiological challenge in Afghanistan during 2012 was the outbreak of cVDPV2 reported from the Southern region. In 2012 eleven cases of cVDPV2 were reported from Helmand and Kandahar provinces (Figure 6). Helmand reported 7 cases (3 from Nad Ali and 1 each from Nahrissiraj, Washer, Kajaki and Nawzad districts) and Kandahar 4 cases (2 from Panjwai and 1 each from Maiwand and Spinboldak). Median age of these cases is 18 months and Median OPV dose 2. Ten out of eleven cases are zero routine (90%) and one case has received only 1 dose. Four out of eleven cases are zero SIAs (36 %). Most of the cases are genetically linked with 2010-11 circulation while the last two cases of Maiwand are linked across the border with Baluchistan and Killa Abdullah cVDPV2 cases.

VDPV2 occurs in populations with very low vaccination coverage persistent over a long period of time, particularly the low routine EPI coverage as also persistent low coverage in NIDs/SNIDs and less frequency of use of tOPV in campaigns and lastly is the presence inaccessible pockets of sub-group of populations. Considering the population immunity in that area, the possibility of having few more VDPVs cannot be ruled out, particularly in inaccessible pockets of Kandahar and Helmand.

### 3.5 Polio Compatible Cases

In addition to the confirmed polio cases, there were 7 AFP cases in 2012 which were labelled as Polio Compatible (5 Kandahar and 2 Uruzgan) by National Expert Review Committee (ERC). All these compatibles were from Southern region. ERC is an independent and voluntary group of Paediatricians', Neurologist, epidemiologist and





microbiologist. ERC meets every month to review and classify all AFP cases that had inadequate specimens and have residual weakness in 60 days follow up.

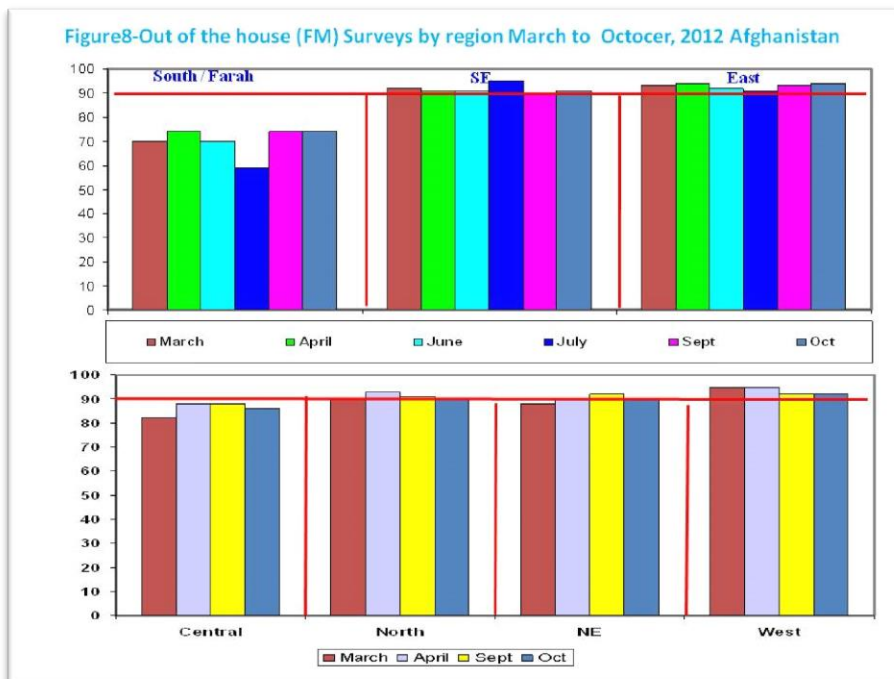
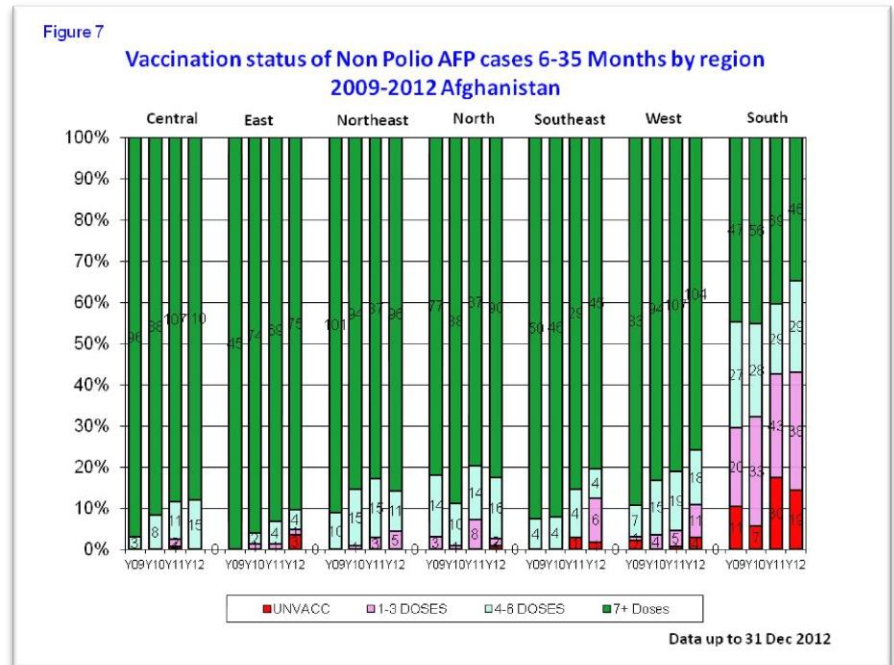
### 3.6 Genetic Analysis of Poliovirus isolates 2012:

Genetic sequencing of Poliovirus isolates in 2012 shows that two of the lineages labeled as Q3 and R2 continue to circulate in Southern region and are considered as the indigenous circulation. The third type of lineage is R4 mostly reported from Eastern and South-Eastern regions and also parts of Southern Region. This R4 closely matches with the circulation across the border in Pakistan, indicating that both countries constitute one epidemiological block due to huge population movement.

### 3.7 Population Immunity:

Vaccination status of non-polio AFP cases (age 6-23 months), immunization coverage in the last 4 SIAs and proportion and distribution of all Zero Dose AFP cases are used as the proxy for the population immunity in the various regions of the country.

- *OPV history of AFP cases:* the proportion of non-polio AFP cases of age 6-23 months who received 3 or more OPV doses through routine EPI was 60% in 2011 and 62% in 2012 nationally, but for **Southern region** this proportion of fully vaccinated children remains very low and reduced from 12% in 2011 to 8% in 2012.
- The *proportion of 'zero dose' non-polio AFP cases* (who did not receive any OPV dose, neither routine nor SIAs) among age 2-23 months was 5% nationally in 2011 and reduced to 4% in 2012. Stratifying this age group by region shows that in Southern region, the proportion of zero dose non polio cases was highest and was 19% in 2011 and reduced to 14% in 2012. This indicates a little decrease in population sub-groups that are not vaccinated through routine or SIAs held during 2011-12. The proportion of Zero dose cases in rest of the country remain very low indicating better quality of campaigns and higher routine EPI Coverage (Figure 7)
- *Post-campaign coverage assessment (PCA):* over the most recent SIA rounds, in 2012, based on the out of house (Market) finger mark survey, the coverage for the Southern region



and Farah province remained sub-optimal, and was less than 80% in most of the SIAs. However, most of the other regions of the country shows consistent performance and has maintained the quality of campaign (Figure 8)

The analysis of these proxy indicators for population immunity indicates that most of the country, except Southern region, has maintained high quality of campaign, negligible proportion of Zero Dose cases and higher routine coverage. This coverage level may prevent the establishment of circulation in most of the country. Although number of Zero dose case in Southern region has declined but the campaign quality and routine EPI coverage continue to be less than expected and below the level required to stop the circulation.

### **3.8 Southern, Eastern and South-Eastern Regions:**

**Kandahar and Helmand provinces** continue to be the only reservoir of poliovirus in the country. Within these provinces block of low performing districts continue to serve as the main reservoir and 17 of the 24 cases in South are reported from the 4 main districts; Maiwand (7 cases), Nahriraj (6 cases) and two cases each from Nadali and Kandahar city. Distribution of rest of the cases by districts is; one case each from Khakrez and Arghistan districts of Kandahar; on case in each Sangin, Lashkergah and Reg districts of Helmand and 2 cases from Gizab district of Uruzgan.

Although program has been able to contain and restrict the circulation of wild poliovirus (WPV) within a block of low performing districts which are serious conflict affected and have prevailing insecurity that affects the campaign quality adversely but persistent isolation of NSL1 strains of poliovirus during 2012 and presence of polio compatible cases, shows continued uninterrupted circulation of Wild Polio virus in the localized areas of the region where the quality of campaigns, despite number of efforts, remain far below the desired level.

Vaccination status of reported non polio AFP cases from different provinces of Southern region and Farah Province and post campaign household survey, finger mark coverage surveys for out of house children shows that despite continued innovative efforts to address challenge of insecurity, management and introduction of new interventions, the quality of campaign remain compromised in most of the vaccination rounds held, mainly in Kandahar, Helmand and Uruzgan provinces of South. Also routine vaccination status of AFP cases from these provinces shows coverage of less than 20%. All these factors lead to enough pool of susceptible children that allows on-going transmission

**Eastern Region: Kunar and Nangarhar provinces reported six cases.** Four cases are reported from Kunar province (2 in Barkunar and 1 each in Marawara and Nari districts); and two cases reported from Nangarhar province (1 each from Lalpoora and Achin districts). Date onset of the last case reported from Kunar was on September 21, 2012 while case from Nangarhar is reported on December 20, 2012. There are three districts/areas in Kunar which remain inaccessible with 15,000 children which constitute almost 10% of the total target of almost 114,000 children. The districts in Kunar are seriously affected by the insecurity and adjusted coverage on these districts remains below 90% in most of the rounds. The overall indicators of population immunity in Nangarhar province indicate persistent quality of campaigns. Most of the virus isolates in Eastern region are linked closely with the outbreak in neighboring KP province of Pakistan.

**South-Eastern Region: Khost and Paktia reported five cases.** Three cases are reported from Khost (2 in Mandozai and 1 in Musa Khel districts); and two are reported from Paktia province (1 each from Chamkani and 1 Zadran districts). Date onset of the last case was on November 25, 2012 and was secondary case (linked with the earlier case in Khost).

### 3.9 Key epidemiological Successes and Risks:

One of the key successes of the program is that program has prevented establishment of circulation in most of the country after large outbreak in 2011 with occurrence of cases in North, North-East, West and Central regions. No case of Poliomyelitis is reported in 2012 from these parts of the country which constitute almost 75-80% of the total population of the country. Also the virus circulation is becoming more localized geographically within Southern region.

Finger mark surveys for out of house children (Markets, Hospitals, Bus Stations and other public places) and vaccination status of AFP cases are indicating presence of, most probably, adequate immunity levels that prevails in most part of the country and may prevent the establishment of poliovirus circulation. This also shows that in areas of lesser security threats, the program has made significant progress and quality of campaign is consistently of satisfactory levels.

There are four major epidemiological risks for PEI program Afghanistan. These include

1. There is risk of continuation of circulation of Poliovirus in reservoir areas of Southern region, particularly in Kandahar and Helmand provinces. This also underscore the need to prompt and effective measures else there is risk of occurrence to more case and geographical expansion
2. The outbreak in Eastern Region South-Eastern region where prevailing insecurity is getting worse, number of inaccessible children for vaccination is increasing, particularly in Kunar can affect the vaccination adversely and may lead to establishment of circulation in these areas.
3. The outbreak of cVDPV2 reported from Kandahar and Helmand provinces may complicate achieving the target of stopping P1 type (NSL1) circulation due to trade off in the choice of vaccine type (tOPV and bOPV).
4. Last but not the least is the risk of occurrence of sporadic cases in “non-transmission” areas of the country as was seen in 2011 and this may lead to secondary cases if routine EPI coverage in these areas is not increased.

### 3.10 Summary (Epidemiology)

In Summary, main reason for the continued transmission in Southern region during 2012, is the prevailing immunity gap in the localized area of Southern region due to the compromised quality of campaigns compounded with very low routine EPI coverage, mainly due to gaps in management and accountability, precarious security situation leading to pockets of inaccessible children and low community demand. This points towards the possibility of occurrence of more cases with risk of geographic extension towards neighbouring areas and underscore the need of immediate adequate measures but more importantly work to overcome management challenges to improve quality of campaign. At the same time and more importantly, distribution of confirmed cases by district for the last three years shows that even within the Southern Region the circulation is confined to only a block of few high population density districts which shows that if continued extra efforts are made, Afghanistan has an opportunity and outstanding chance of stopping polio virus transmission. It is estimated that program has been successful in protecting almost 84% of the country's population from this dreadful disease.

## 4. Security Situation: Impact on Program

The security affected areas in the country expanded from the Southern region to the Western and South-eastern regions in 2012. The announcement to withdraw international troops from the country has also resulted in increased incidents and deterioration of situation particularly in Kunduz, Nangarhar, Khost, Helmand, Farah, Kandahar and Uruzgan provinces where situation changes on almost day to day basis with frequent eruption of active fighting. Different fighting groups trying to show their power and existence. The insecurity adversely affects the monitoring and supervision of activities, particularly in districts of Kandahar, Helmand and Kunar. Also in these areas there are persistent pockets of children who are not accessed for vaccination due to various insecurity related reasons.

## 5. Priorities, Challenges and Interventions in 2012

Following the large and an unprecedented outbreak of 2011, a joint in-depth review of the situation was carried out, in the beginning of 2012, by a team of national and global experts. The aim was to identify the root causes of outbreak, major barriers, measures taken and their degree of success and failures were considered to outline the priorities, set targets and plan future activities to interrupt the poliovirus circulation. Also World Health Assembly (WHA) held in May 2012 passed resolution declaring completion of Polio Eradication as programmatic emergency for global public health and urged the remaining three countries with poliovirus transmission (Afghanistan, Pakistan and Nigeria) to take it as *national public health emergency*.

In response to joint review and the WHA resolution, the MoPH, in collaboration with WHO and UNICEF, launched National Emergency Action Plan (NEAP) with an aggressive, well focused and measurable approach.

There were two important priorities for the program in 2012. First and foremost was to take immediate measures to control the outbreak in Southern region and secondly to prevent the establishment of poliovirus circulation in other parts of the country. Within the Southern region the priority was to improve campaign quality in 13 “high-risk” districts of Southern region. These districts are labelled as “high-risk” because epidemiological data for the last so many years shows that most of the confirmed cases were from these districts. Five of these districts are from Kandahar province (Kandahar, Spin Boldak, Panjwai, Maiwand/Ziarai and Shahwalikot), five are from Helmand province (Lashkerghah or Bust, Nadali/Marja, Sangeen, Nawzad and Musa Qala) and three districts of Uruzgan province (Tirinkot, Dihrawud, and Shaheed Hasas).

### 5.1 Important Challenges in 2012

Analysis of post campaign assessment data shows that on average 6% of the children (almost 500,000) were missed in each SIA all over the country and most of these missed children are in Southern region. Segregation of reasons for these unvaccinated children shows that 20% of them were missed in areas which were not accessed by vaccination teams due to insecurity but 80% of them are missed in areas where teams had accessed. Further analysis of children not vaccinated in the accessible areas shows that these children were missed because the child was not present at home, or a newborn or team did not visit their house or the area was not in the plan and weak supervision and monitoring. All these factors points toward the major barrier of Management and Accountability followed by inaccessibility to areas due to insecurity. Children not vaccinated because they were absent or newborn/sleeping indicates towards another challenge of low community demand.

In order to address these challenges and barriers Afghanistan National Emergency Action Plan (NEAP) following major challenges is identified and constitute important component of NEAP.

- Enhance oversight and advocacy: Political Commitment in Afghanistan remains very high. However, in order to translate the same level of commitment at implementation level, NEAP endorsed to have a Focal Person at the Office of H.E President of Afghanistan to provide oversight to the implementation of the actions devised by the Inter-Ministerial Task Force (IMTF), monitoring progress, and engagement of Provincial Governors of high-risk provinces.
- Improve Management and Accountability
- Increase access to children in security affected areas
- Enhance community awareness and demand
- Strengthen Routine immunization

### 5.2 Key Program areas and Interventions during 2012:

- Four rounds of NIDs were implemented (March, May, September, October) using alternatively bOPV and tOPV; Four additional rounds of Sub-NIDs using bivalent bOPV in South, South-East, Eastern region and Farah province of Western region. SNIDs were implemented in January, June, July and December 2012.



- Afghanistan pioneered, yet another intervention, where OPV was administered with Measles vaccine, in all over the country to all children of age up to 10 years. This was done in two phase; first phase was for 17 provinces in July while second phase was in December for remaining 17 provinces.
- Immediate and large scale case response vaccination rounds are implemented in all the newly infected provinces, their adjoining areas as well as the districts bordering outbreak zone of Pakistan. Monitoring was intensified in these case responses. Bivalent OPV was used in the case response rounds in Eastern, South-Eastern region while tOPV was used in selected districts of South to respond to cVDPV2. These additional rounds were held during in September, November and December, 2012 using Short Interval Additional Dose strategy (SIAD).
- **Political Commitment, enhance Oversight and advocacy:** Political commitment in Afghanistan remains very strong, with a high level of interest from the Office of the President and Minister of Public Health. Office of the President has nominated a focal person on PEI with main aims to provide oversight to the implementation of action plan, monitor the progress to report to the office of H.E President, establish close liaison to effectively engage the provincial governors of high-risk provinces. An inter-ministerial task force is constituted to engage all the line departments and its first meeting was held in December 2012. First meeting with the District Governors of high risk districts in Kandahar was also held and was co-chaired by Governor of Kandahar, Minister of Public Health and President's Focal Person on Polio Eradication.

Meetings of Polio Policy and Strategic Group chaired by Minister of Public Health are held regularly.

- **Strengthen Management and Accountability:**
  - District EPI Management Teams: In each of the high risk district in Southern region, District EPI Management Teams (DEMTs) are constituted as part of structural and functional reforms to improve and strengthen SIAs delivery services at district and sub-district levels. This is a four member team composed of District EPI Manager (MoPH), District Polio Officer (WHO), District Communication Officer (UNCIEF) and NGOs representative in the district.
  - Enhance capacity: In order to enhance the capacity of provincial and district mid-level SIAs manager formal trainings were conducted in Kandahar, Helmand and Farah provinces. These trainings were designed and implemented by an experienced private firm with focus on management and accountability. This was a 5-day training package and was done twice during 2012 training 140 persons in the first training and 70 personnel in the second training.
  - Establishment of Dashboard system: Program also has established a dashboard system to regularly monitor the progress at national, provincial and district level. The aim of this dashboard is to use for advocacy with provincial and district governors
  - Accountability Framework: An accountability framework is developed to regularly monitor the performance of district and provincial staff and take appropriate measures.
- **Increase Access to all children in conflict affected areas:**
  - a. Local level access negotiation used as basic strategy and local access negotiators from within the communities who are acceptable to various parties are recruited.

- b. Engaging ICRC in access negotiation at national and provincial levels through regular meetings. There are 16 meetings held at ICRC Kandahar between the program and AGEs to allow and facilitate the vaccination teams.
- c. Also program has been able to maintain its neutrality in Afghanistan due to local level interventions and ICRC.
- d. Systematic listing & mapping areas by 7 categories and sub categories (Perception of fear , AGE not allowed, Local community not, Supportive , On-going security Operation , Management problems , Economic Issues (Poppy Cultivation) , Environmental Issues (Floods ,Snow etc) )
- e. Acquiring community confidence after permission by the AGEs
- f. Mobilizing communities with polio out breaks, through awareness regarding the risks

*As a result of all these efforts the number of inaccessible children which were almost 77,000 reported for all Southern regions in June was reduced to 15,000 in December 2012. However, this has not worked out in Kunar and Nuristan provinces of Eastern regions where more than 20,000 children continue to remain inaccessible in each campaign.*

In order to cope with internally displaced population due to security situation and those districts of Kunar and Nuristan where access to vaccination teams are not allowed, permanent vaccination posts were established at the entry and exit points of conflict affect districts in Kandahar, Helmand and Kunar provinces. Over 20,000 children were vaccinated by these posts every month.

- **Increase Community Demand**

- g. Polio/ Immunization Communication Network restructuring is completed. Social mobilization network covered 80% of the high risk clusters for communication in south region
- h. Rolled out the new polio communication campaign, ‘Ending Polio is MY RESPONSIBILITY‘ ; Extensive media (TV/Radio) involvement ; media monitoring firm hired to assess coverage
- i. Communication strategy is revised aiming at increasing the demand and new indicators are included to monitor the progress on effectiveness of communication activities

- **Strengthening Routine EPI**

- a) Routine EPI reported coverage for DPT3 for the national level is 68% while recent MICs survey gives coverage of 18%. According to estimation, the coverage of routine is almost 30%. This coverage varies widely with lowest in the Southern region. In fact, 23 out of 27 confirmed polio cases did not receive any dose of routine EPI showing very low routine EPI coverage.
- b) Periodic intensification of routine immunization (PIRI): like child health week were implemented in the selected districts
- c) Supporting EPI through PEI network through providing feedback using AFP surveillance data on areas of low routine EPI, regular supervision and monitoring of fixed centres by PPOs during the Active Surveillance visits
- d) The formal evaluation has started from August 25 and teams of MoPH, WHO, UNICEF and GCMU carried field review with the objective to improve routine immunization services on the country

- Independent Program Reviews: Joint Partners review mission, Independent Program Review in light of recommendations of IMB and also meetings of Technical Advisory Group were held to review program performance regularly and advise on corrective actions.

- New tactics like introduction of Short Interval Additional Dose Strategy (SIADs), Permanent Polio Teams (PPTs) strategy, District Focus Campaign, high risk cluster approach, integration of communication at

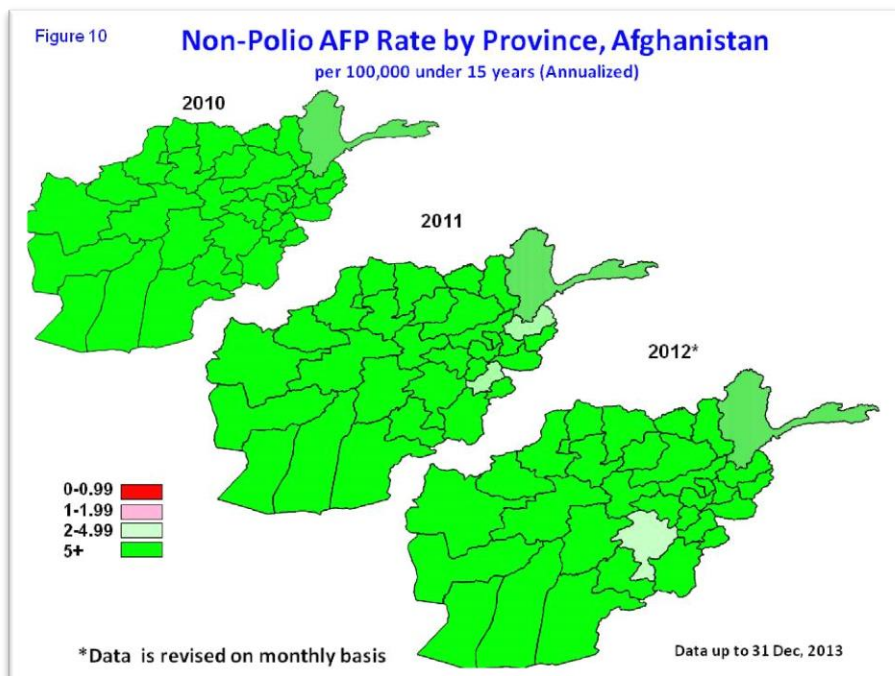
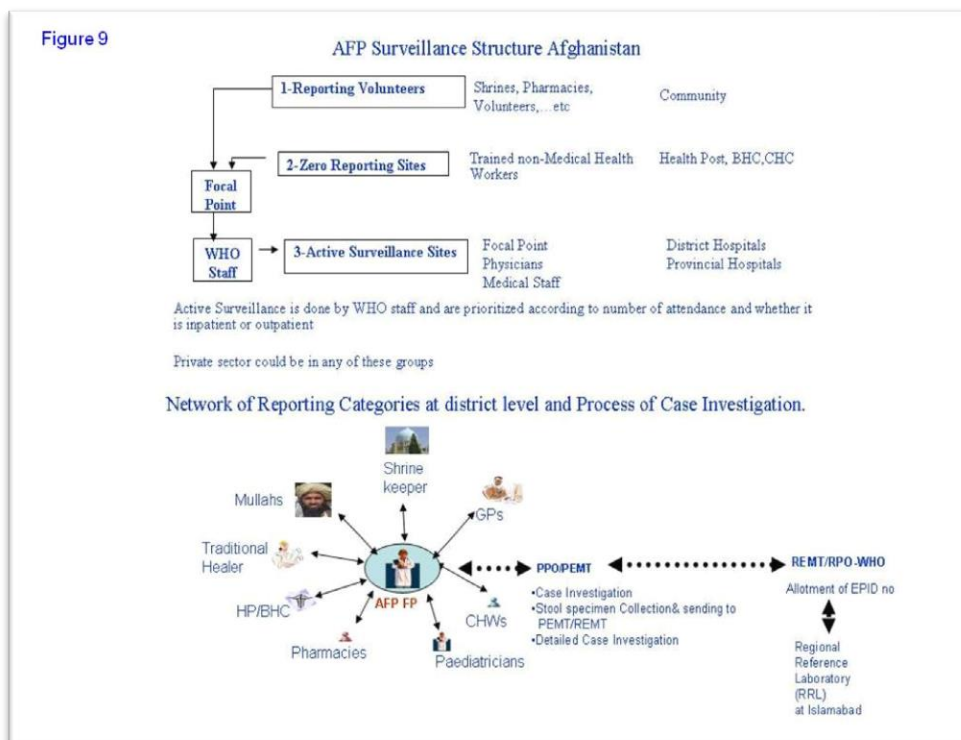
cluster level operations; indirect monitoring mechanisms and using “window of opportunity” in conflict affected areas are adapted during 2012.

- Permanent polio teams in 8 of the high-risk districts. These serve as permanent vaccination teams that supplement vaccine delivery outside normal campaign schedules. Almost 195,000 children vaccinated by these teams from April to September and 6% of them received OPV for the first time
- In order to ensure that sensitivity of AFP surveillance system in the country, particularly in regions, provinces and districts, AFP focal Points training and Mid level staff orientation session conducted all over the country

## 6. AFP Surveillance:

Health care services in Afghanistan are delivered through public and private sectors. Most of the health care services in public sector are provided by NGOs, in accordance to Basic Package of Health Services (BPHS), through Provincial hospitals, Comprehensive Health Centres (CHC) and Basic Health Centres (BHC). Private medical practitioners, Quacks, Faith healers and Shrine keepers are the main service provider in private sector.

AFP surveillance network includes most of the main health care providers and is spread all over the country. Besides this, network also includes community based Reporting Volunteers including pharmacies, teachers, Mullahs and community notables (Fig 9). Each district have at least one AFP surveillance Focal Point (FP), who is usually the in-charge of Health facility or a paediatrician and is responsible for case notification, investigation, facilitating specimen collection and shipment process and submission of zero reports. AFP cases detected by health facilities, private practitioners or community based reporting volunteers (pharmacies, faith healers etc) are referred to concerned focal point in their district. Tertiary care hospitals and Provincial Hospitals usually have more than one focal point. Focal points are also responsible for timely notification of AFP cases to Provincial EPI Team including WHO PPO, who



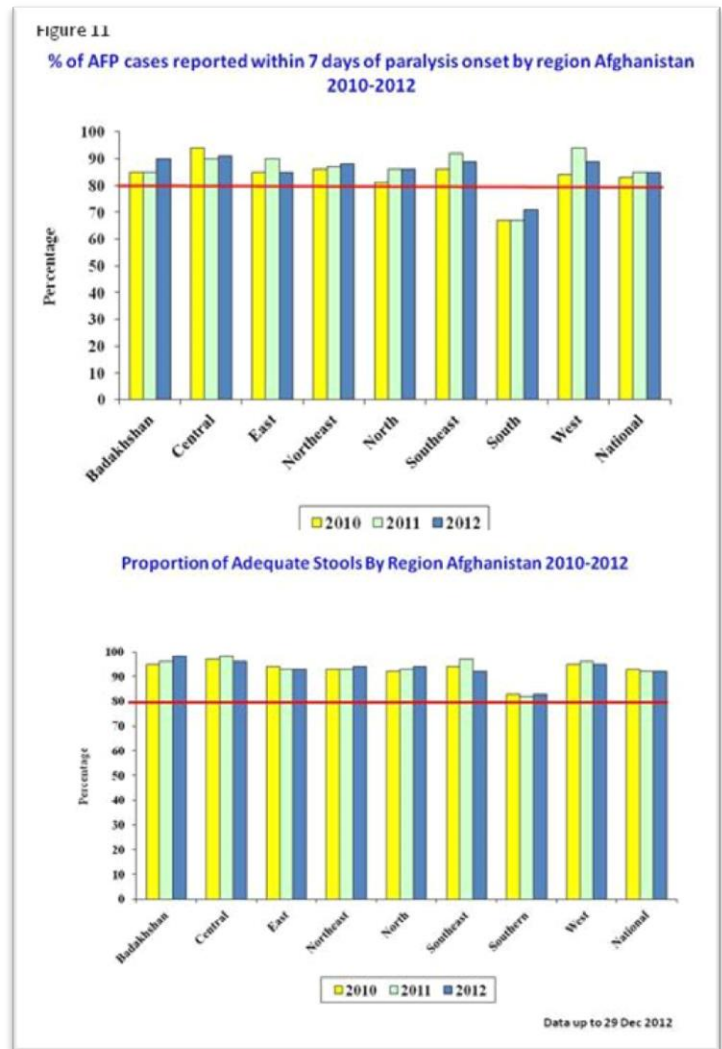
carries out the field visit in the area of residence of reported case for detailed investigation and to ensure that all steps of investigation are carried out by the focal points.

### 6.1 Characteristics of AFP cases 2012

Expected annual number of AFP cases for Afghanistan was at least 368 @ of 2/100000 children below 15 years of age (Fig 10). Total of 1,829 AFP cases are reported during 2012, compared to 1,830 AFP cases reported in 2011. Early case detection and stool adequacy above the required level at the national level (Fig 11).

Out of total 1,829 cases, there were 37 confirmed, 7 compatibles and 1,785 are discarded as non polio. The characteristics of AFP cases show that all age groups were reported with range of 0-179 months. Comparison of median age for confirmed/compatible cases with non polio AFP cases shows that the confirm cases were significantly younger with median age of 18 months than the non polio with 36 months and received considerably lower number of doses (*Median Doses 2*) compared to non polio AFP cases (*Median Dose 12*)

Analysis by gender reflects that male and female AFP cases were reported with predominance of male cases (56%) among the non Polio AFP cases and in confirmed cases the proportion of male is 66% than female (34%).



### 6.2 AFP Surveillance Indicators:

Analysis of AFP surveillance indicators at national and regional levels shows the system is achieving the desired level of targets for Non Polio AFP rate, 9.9 per 100,000 children below 15 years of age and percent of adequate specimens 92% during the year 2012 (Fig 12).

Percent of specimens with Enterovirus is well above the required level, 20% at country level with above 10% in all regions. Lowest EV was 11% in

Figure 12

Regions	Exp @2	NP AFP Rate	Stool ADEQ %		Detection within 7 days of paralysis		No of MF		Median OPV <60 Month		NPAFP age range		EV %		SL %	
			2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
			BADAKHSHAN	10	10.6	96	96	87	89	25\22	32\21	15	12	57 (1-168)	42 (8-168)	13
CENTRAL	80	7.9	98	98	90	91	152\148	171\147	12	11	42 (6-168)	42 (1-172)	19	20	2	4
EASTERN	37	9.4	93	94	92	85	9\177	105\67	16	17	36 (1-179)	28 (1-179)	23	27	4	4
NORTHEASTERN	41	11.6	93	93	87	87	131\102	138\99	11	11	38 (1-180)	36 (1-174)	24	17	1	5
NORTHERN	47	11.5	93	93	86	85	178\126	142\129	12	12	48 (2-179)	36 (1-179)	20	19	4	4
SOUTHEASTERN	37	7.2	97	97	92	89	58\48	72\60	15	13	42 (2-156)	36 (3-168)	17	19	6	3
SOUTHERN	67	10.3	81	80	65	70	219\162	188\154	4	4	24 (1-168)	29 (1-171)	20	19	6	11
WESTERN	49	12.4	96	96	94	89	155\134	185\119	11	11	36 (1-168)	36 (1-169)	17	23	3	2
NATIONAL	368	9.9	92	92	85	85	1009\819	1033\796	11	11	36 (1-180)	36 (1-179)	20	20	3	5

Data up to Dec 2012



Badakshan province and highest was 27% from Eastern region. However, Sabin like (SL) was isolated from at least 5% of specimens in the country with lowest 2% from Badakshan and Western region and highest 11% from Southern region. Both these indicators show that the technique and process of stool specimen collection and shipment is over all satisfactory.

Overall early case detection rate (Cases detected within 7 days of onset of paralysis) has improved to 85% in 2012. All regions maintained above 80% cases reported within 7 days of onset except south region with 70% where it was 65% in 2011. This indicates the integrity of community based referral system in most part of the country.

### 6.3 Maintaining AFP surveillance in difficult to access areas

It is also important to mention that most of the confirmed cases are detected and reported from some of the worst security affected districts indicating that surveillance network is functional even in those difficult districts. There were 206 AFP cases reported from high-risk districts among which 13 were confirmed. Among these districts 7 cases reported from Maywand, 2 each from Nadali and Kandahar and 1 each from Lashkergah and Sangin districts. Eight districts namely Nawzad, Shahwalikot, Musa Qala, Shahid Hasas, Panjwai, Dihrawud, Spin boldak and Tirinkot did not report a case in 2012. Six out of 5 districts reported cases have maintained adequacy of specimen over 80% (Figure 13).

Figure 13

District	Expected NP AFP @ 2	2011			2012		
		NP AFP	Conf	% Adeq	NP AFP	Conf	% Adeq
Bust	3	26	1	89	23	1	96
Musa Qala	3	3	3	83	3	-	100
Nawzad	2	3	-	100	2	-	50
Nadali	4	16	8	81	34	2	92
Sangin	2	3	-	100	2	1	100
Kandahar	3	61	13	76	46	2	72
Shahwalikot	2	10	3	69	2	-	100
Maywand	1	17	8	77	18	7	68
Panjwai	2	9	-	79	7	-	100
Boldak	2	18	3	91	20	-	85
Trinkkot	2	17	1	74	21	-	76
Shahidihassas	1	1	1	50	4	-	75
Dihrawud	1	9	2	82	8	-	78

Following additional steps taken for surveillance in difficult and to access and insecure areas:

- DPOs and DSTs are hired on permanent basis who are trained on AFP surveillance. They also help in conducting household survey and facilitate specimen collection and transportation. Also visit reporting volunteers where required.
- Provision of Transportation cost to bring the AFP case to health facility for investigation and specimen collection
- Training sessions with focus on search for AFP cases during house to house campaign
- Thoroughly investigated the reasons for zero dose and sharing the findings with Polio standing committee
- Carefully planned and organized response vaccination carried out in clusters of 10 zero OPV dose cases, covering almost 37,558 target children in accessible areas

- Shared information with NGOs to organize outreach or mobile routine EPI vaccination

### 6.4 Contact Sampling:

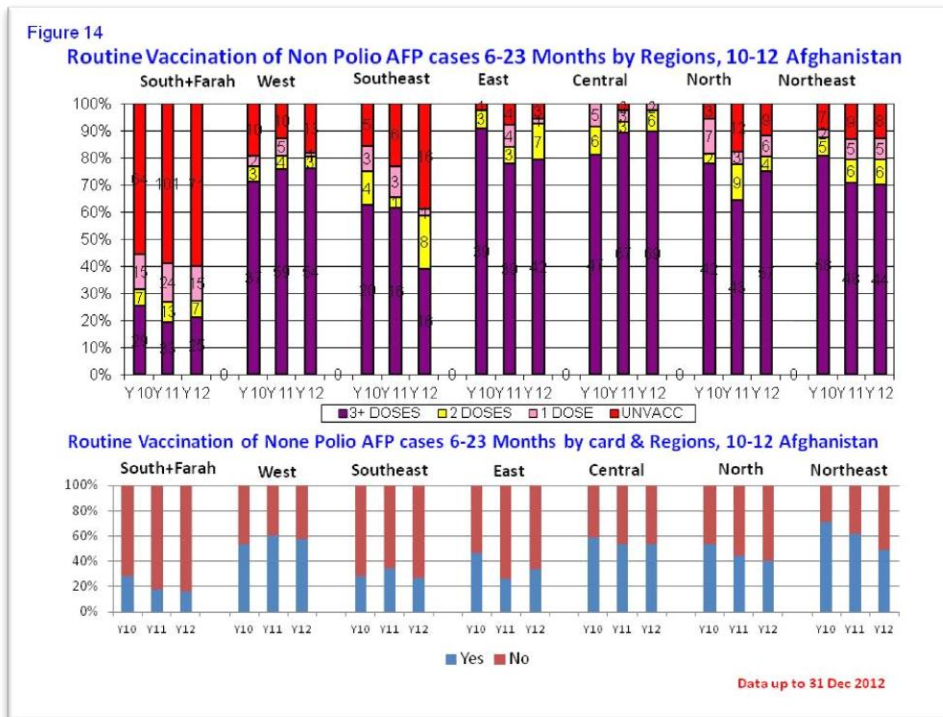
Program policy is to collect samples from 5 close contacts for each AFP case for whom samples are collected after 14 days (Inadequate samples). In addition to this, samples from close contacts of all AFP cases reported from areas of difficult terrain and access are also collected irrespective of specimen adequacy. These areas include Farah and Ghor provinces of Western Region.

### 6.5 Routine Immunization Status of AFP Cases:

The analysis of routine immunization status of Non AFP cases and comparison over period of years shows that overall routine immunization is above 70% in all the regions except Southern and South-eastern Region (Fig 14).

Percent of AFP cases between 6-23 months who has received at least 3 doses of OPV remains below 20% in Southern region. Looking at the routine doses of among AFP cases, one can attribute strong correlation between routine doses and established virus transmission.

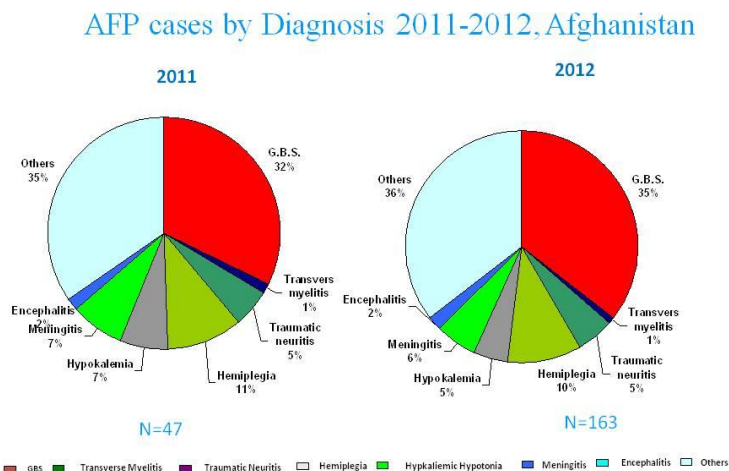
Because of better coverage reported from Central, Eastern and North Eastern poliovirus transmission could not be established even if there were few sporadic cases.



### 6.6 Diagnosis of Non polio AFP cases:

Three most common diagnoses of non-Polio AFP cases during 2012 were: GBS 35%, followed by others 36% and Child hood Hemiplegia 10%. Diseases under the category of others are; Cerebral Palsy, septic arthritis, injuries etc. Trend of diagnosis remained almost the same as of previous year when GBS was 35% and others were 36%. Proportion of good AFP cases during 2012 was 41% (GBS 35%, Traumatic neuritis 5% and Transverse myelitis 1%) compare to 38% during 2011 (Fig 15).

Figure 15



### 6.7 Quality of Active Surveillance and Zero Reporting:

Completeness of Active surveillance and Zero reporting was above 80% for most of the regions but the field reviews shows that quality Active Surveillance visits, documentation of active surveillance and Zero

reports need further improvement. Moreover it was also observed that the linkage between the focal points and community based reporting sites needs further strengthening.

In summary, reporting and distribution of AFP cases, analysis of AFP surveillance indicators, characteristics of AFP cases and detection of wild virus in some of the difficult security affected areas reflects the presence of an overall satisfactory performing system in the country.

### 7. Supplemental Immunization Days:

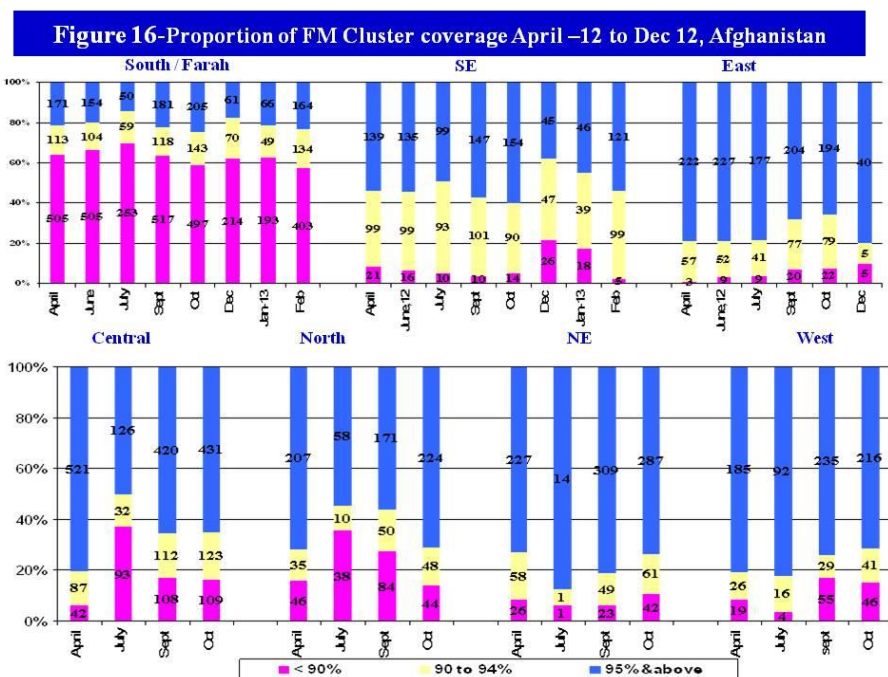
Campaign activities are monitored in three phases; Pre campaign looking at the preparedness like reviewing the micro-plans and the trainings of the vaccination staff. The campaign implementation days when the team visit house to house to vaccinate the target children that also require close monitoring and supervision to assess the ongoing process of campaign and take action in the field and the post campaign phase to assess the coverage estimates, identify low performing areas and take immediate corrective measures. Post campaign surveys include household coverage surveys and finger mark surveys for out of house children (Market Survey).

During 2012, 8 SIAs (4 NIDs and 4 SNIDs) and 2 mop-up rounds were conducted. Four rounds of NIDs were implemented using trivalent OPV (tOPV) in 2 rounds and bOPV in other 2 campaigns. Four additional rounds of Sub-NIDs using Bivalent (bOPV) in South (including Farah province) South-East and Eastern regions. NIDs were held during the months of March, May, September and October. SNIDs implemented during months of January, June July and December 2012

### 8. Post Campaign Coverage Assessments (PCA):

Independent monitors (University, Medical Schools Students, Teachers, and NGOs Staff) are trained according to guidelines to carry out PCA. All the districts are subjected to PCA with 100% clusters are sampled in districts labelled as “high-risk” and 25-50 % clusters in each of the non High Risk district. At least three team areas (Sub-clusters) are sampled within the selected cluster. Ten houses with eligible children are sampled in each team areas to assess the coverage.

Analysis of PCA data for the last 4 rounds conducted during the year 2012 in the country shows that overall quality of campaign in the country was of satisfactory level with most of the districts achieving coverage above 90% among children 0-59 months. However, the proportion of districts with PCA coverage less than 90% was consistently higher in Southern region and parts of Farah province (Figure 16). Generally the coverage among very young (0-11 m) children was lower compared to children of 12-59 months of age, particularly in Southern region, reflecting that this age group



was being missed by the teams due to different reasons mainly because of the teams' performance at household level where information about very young children is not inquired properly. Second cause of missing very young children is attitude of parents not to disturb their sleeping and newborns for vaccination. Another important reason can be the male teams who did not have access inside the house thereby missing young infants. However, coverage of mop-up rounds in North and North eastern region after confirmed case in April was satisfactory.

An in-depth analysis of SIAs data by cluster for the last ten rounds was carried out to assess the degree of homogeneity and coverage at sub-district (cluster) levels. Coverage of clusters are divided into three categories (<90%, 90-94.9%,  $\geq$ 95%) and comparison of transmission zone (South including Farah) with other bordering regions of East and South East as well as with regions in non transmission zone. The analysis indicates that most of the clusters in the transmission zone of South and Farah had compromised campaign quality and only 20% of the clusters had coverage above 90%.

An in-depth analysis of campaign quality in the 13 high risk districts of the Southern region also shows that none of the district achieved coverage of at least 90% in at least three rounds during 2012. In fact, most of the districts had inconsistent quality of campaign and the coverage well below the desired level of 90%

In contrast, the bordering regions of East and South East that are showing consistent high campaign quality with more homogenous coverage, more than 80% of clusters resulted into >90% sustained coverage over period of time. Proportion of clusters in Central, North, West excluding Farah most of the clusters (75-80%) had coverage above 90%. However, the same analysis for North Eastern region shows a slight increase in clusters coverage less than 90% in first few rounds and recovered in later rounds.

**In Summary**, the overall quality of campaign in Southern region did not show any significant improvement despite extra efforts in 2012 rather has shown a gradual increase in proportion of low performing clusters (coverage < 90%). The proportion of missed children is much higher among young infants of 0-11 months in general and in South in particular. Campaign quality in rest of the country is maintained to a level that prevented the establishment of poliovirus circulation. Security and management issues pose the biggest challenge and continuous innovative efforts are being carried out to overcome these issues to improve quality of campaign.

## 9. Cross Border Coordination:

Afghanistan & Pakistan, being considered as one epidemiological block, are maintaining high level of coordination by holding regular meetings at various levels, data sharing, synchronization of campaigns and sharing micro plans. More importantly are maintaining permanent cross border vaccination posts at points crossed by families travelling across both the countries. Main aim is to ensure that populations living in villages/areas on both sides of the border are vaccinated during each campaign and secondly, because of high population movement back and forth across the Afghanistan-Pakistan border, programs of both the countries administer additional OPV dose to children travelling with their families.

Approximately, more than 1 million children were vaccinated by Afghan teams at 11 cross border vaccination posts. Torkham border is the busiest point and most of the crossing children (0.8 million) were vaccinated at this point. The Afghan vaccination posts between Southern Region and Balochistan, on average 600-700 target children less than 5 years are vaccinated per day by these transit teams. In addition to these a vaccination post is established at Pule Reshem in Nimroz province on the border with Iran which covered about 6,000 target children in the year 2012. Similarly 3 border check posts are functioning in SER where an average of 2,000 children vaccinated each month, 24,000 during 2012.



Regular cross border meetings are held between bordering district teams to share the plans before each campaign: Peshawar and Jalal Abad teams meet at Torkham border while Spin Boldak and Killa Abdullah team hold their meeting at Friendship Gate. Teams of both countries also met in 24-25 July, 2012 in Kabul, Afghanistan Standardized procedure for cross-notification of acute flaccid paralysis cases are being observed by both the countries as agreed during last cross border meetings.

## 10. Polio Communication Activities:

The ‘Afghanistan Polio Eradication advocacy and social mobilization plan 2012-2013’, guides the current polio communication interventions in Afghanistan mainly focusing on Polio vaccination campaigns. During the year multiple strategic interventions were implemented to meet programme goals:

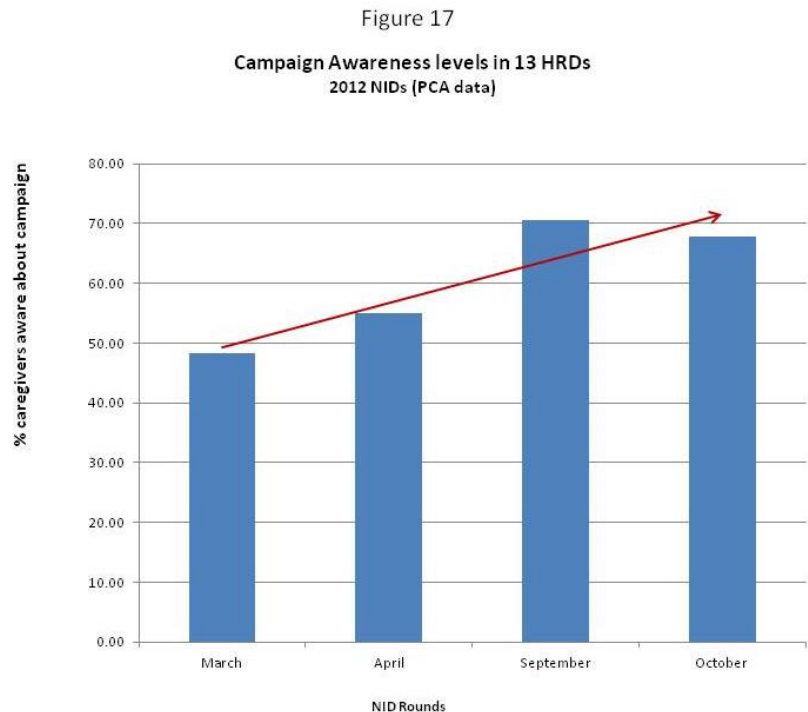
**10.1 Advocacy:** Advocacy efforts in 2012 focussed on increasing the government’s commitment not just at the national level but also at provincial and district levels through sensitization meeting with governors and community elders/ leaders. These efforts resulted in improvement in oversight of the work at all levels. These efforts have resulted in increased access to several previously inaccessible areas in Kandahar and Helmand with a steady decline in the number of inaccessible children from July to December 2012; although not much progress could be made in the Kunar province of the east region.

**10.2 Communication for program visibility:** During 2012, a new Polio communication campaign to address the lack of a coherent and recognizable polio brand for mass media activities and for Information, Education and Communication (IEC) materials was developed in 2012. The new campaign, ‘Ending Polio is MY RESPONSIBILITY’, aims to mobilize and motivate support and ownership from various stakeholders in polio eradication. The campaign aims to rally Afghans from all walk of line recognizing that they have a role to play in eradicating Polio from Afghanistan. In the initial phase the campaign focussed on caregivers and religious leaders.

The launch of the new campaign was accompanied by more systematic media plans at the national level and for local media in priority areas and has led to greater visibility of polio campaign activities. In addition to the Public Service Announcements, talk shows, round table discussions, and other programmes were run on national and local TV and radio channels.

Programme visibility was also enhanced through outdoor display using bill boards and IEC materials including posters, banners, leaflets, etc.; although distribution and proper display has been a challenge.

While evidence continues to be collected on the impact of these interventions, the awareness levels in the 23 priority districts in South region increased from 48% to 63% and in the 13 high risk districts of SR from 48% to 68% (Figure 17)

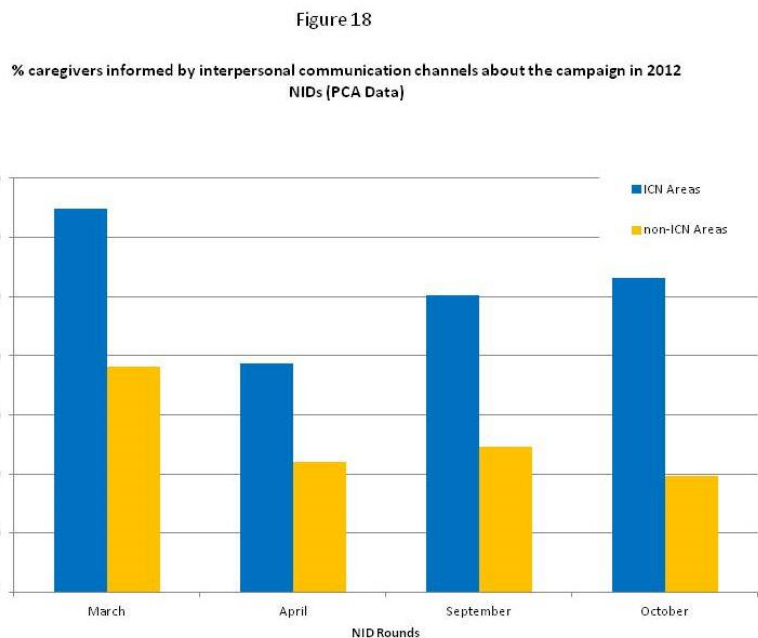


**Social mobilization in the high risk districts and provinces:** In the first quarter of 2012, restructuring plans for the Polio/ Immunization Communication Network (P/ICN) in the South Region were developed and roll out began in April 2012. In April 2012, network covered more than 50% of the high risk clusters (HRCs) and by the end of the year around 85% of the HRCs in 20 of the 23 priority districts. In addition, to the scale up to cover more of the high risk clusters (HRCs), the network was restructured to align and closely link the social mobilization and vaccination components of the programme. To this end, a social mobilizer (SMs) was assigned to each vaccination team. The SM conducts meetings with community influencers in the team-area prior to the campaign and accompanies the team for house-to-house visit during the campaign.

In October 2012, following the India example, three days of pre-campaign house to house visits for IPC with caregivers and dot-making was piloted in three districts in the South region and has been expanded to cover all 20 ICN district since then.

The IPC training module for both vaccinators and social mobilizers was revised and trainings conducted for all both cadres of workers in all priority districts (the newly identified LPDs) between September and December 2012.

During the year, the Polio/ Immunization Communication Network continued along the same lines as the years before in East region with only major change being some scaling down in some districts where both awareness levels and campaign coverage met the set targets and other sources of information were found to be effective. However, West region introduced the network in the 4 priority districts of the Farah province in the last quarter of the year along the same lines as the modified network in South Region, given the similarity between the two areas in terms of ethnic/ tribal groups, social norms, access into households, literacy levels, past impact of other sources of information etc.



As a result of the intensive focus on engagement of community influencers in the ICN areas, these interpersonal communication channels have been an effective source of campaign related information in the areas covered by the ICN as compared to one where the ICN is not operating. (Figure 18)

**10.3 Partnerships:** Partnership efforts during the year have resulted in more active participation of the line ministries and departments in the Polio eradication efforts. Efforts were made to involve various line ministries including education, religions affairs, women’s affairs department, rural rehabilitation and development to garner their support in raising campaign awareness and community engagement.

Involvement of the women’s affairs departments in Helmand and Kandahar resulted in a modest but important in the number of female social mobilizers from 4% to 7%. This will enable the SMs to speak directly to the mothers and gain access into households. In addition, schools through the education department has been involved in not only supporting increase in campaign awareness through sensitization of teachers and through them school children and caregivers, but also in monitoring of the campaign activities. At the national level and in the high priority provinces orientations of religious leaders were organised to motivate them to inform communities about the importance of polio vaccination through Friday sermons and mosque announcements.

Going forward and following establishment of the Inter-Ministerial Task Force (IMTF) at the national level and Inter-Departmental Task Forces (IDTFs) in priority provinces, four ministries will be the focus of the partnership efforts including education, religious affairs, women's affairs and rural rehabilitation and development.

**10.4 Monitoring and Evaluation of Polio communication Interventions:** To further strengthen monitoring of the restructured Immunization Communication Network (ICN) and assess performance, a monitoring and evaluation framework was finalized in September 2012. Given the human resource capacity challenges in Afghanistan, the reporting tools for ICN have been revised to make them more simple and workable.

To substantiate the PCA data and further explore breakdown of reasons of missed children, communication PCAs were conducted in selected districts of the south region. Based on the findings of communication PCA, the regional team increased the number of market teams and a significant number of out of house children were vaccinated. In addition to this, several small scale studies, surveys and rapid assessments were conducted during the year to better understand the social reasons for missing children, especially refusals.

Development of a central database to pool polio data from various sources, appropriately analyze it and generate actionable reports was initiated through the establishment of Polio Info database using DevInfo platform. An SMS data capture system is integrated with this database to facilitate real time data collection and action. Key staff from the Ministry of Public Health, WHO and UNICEF received preliminary training on the DevInfo admin and SMS data capture system.

A third party monitoring agency was hired to monitor the implementation of media plans during the SIAs to gather planned versus actual implementation; payments to the media buy-in agency and stations/ channels were made based on the results of the media monitoring exercises. In addition, tonality of media stories related to polio was also monitored by the agency.

A comprehensive Knowledge, Attitude and Practice survey to gather data on the knowledge, attitudes and practices of the caregivers of <5 years children regarding polio vaccination and routine immunization were conducted in the 13 High Risk Districts of South Region. The findings collated from survey of 2730 households, 225 key informants interviews and 28 Focus Group Discussions will be used to guide communication messaging and interventions.

## Plans and Goals 2013

Based on recommendations of the November 2012 Technical Advisory Group (TAG) Afghanistan and also in the light of October 2012 IMB Report, Afghanistan PEI programme has developed an accelerated plan for 6 months.

The 8 key activities that have been identified as of highest priority for implementation between January and June 2013 are:

1. *An intensive schedule of Polio Supplemental Immunization Activities (SIAs)/ campaign* in these 6 months of low transmission
2. *Enhancing capacity of District EPI Management Teams*
3. *Use of accountability framework* to assess performance and take follow up actions on monthly basis
4. *Revisions of High Risk Districts and Clusters and rename to "Low Performing Districts"*
5. *Engagement of Provincial and selected District Governors* through Focal Person at the Office of H.E President

6. *Functionalize Polio Control Rooms* in priority districts, provinces and at national level and revised dashboard (linked to district and provincial governor)
7. *Increasing Immunization Communication Network (ICN) coverage* to 90% of the high risk clusters
8. Identify and *address HR needs* of the 3 main implementing partners both in numbers and capacities of HR

## 1- Intensive scheduled of Polio SIAS/ campaigns January-June 2013

**Objectives and Overall SIAS Strategy:** The objective is to take full advantage of low transmission season to stop the outbreak in East (Kunar and Nangarhar province) and in South-East (Paktia, Khost) and more importantly to interrupt the poliovirus circulation from the area of continued indigenous circulation in Helmand and Kandahar by focusing on low performing reservoir districts. Last but not the least is to prevent circulation in rest of the country.

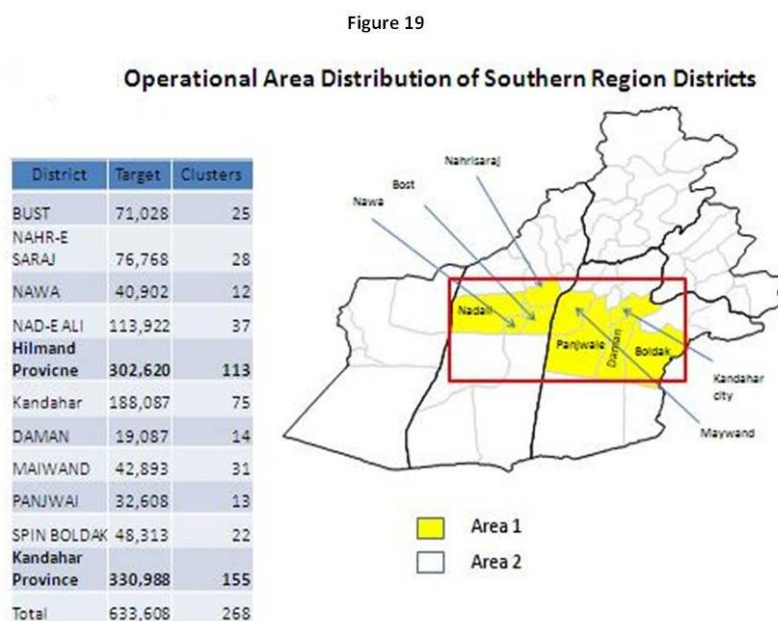
- **SIAs to stop outbreak in East (Kunar) and South East (Khost and Paktia):**

**Kunar (Eastern Region):** Four cases are reported from Kunar. Date onset of the last case was on September 21, 2012. There are three districts/areas in Kunar which remain inaccessible with 15000 children which constitute almost 10% of the total target of almost 114,000 children. From September to November three rounds using bOPV and one round of tOPV (NIDs) are conducted in Kunar. Program has planned two rounds in December 2012 and two in January 2013 to stop the outbreak in Kunar province of Eastern Region

- **SIAs Khost and Paktia (South-Eastern Region):** Two cases are reported from each Khost and Paktia provinces of South Eastern Region. Date onset of the last case was on November 9, 2012 and was secondary case (linked with the earlier case in Khost). From September to November two rounds using bOPV and one round of tOPV (NIDs) are conducted in Khost, Paktia and adjacent Paktika provinces. Program has planned two rounds in December 2012 and two in January 2013 to stop the outbreak in Khost and Paktia. Total target of Khost is 198,000 while Paktia is 155,000 children below 5 years of age.

### A- Interrupting Poliovirus circulation in the reservoir (low performing) districts of Kandahar and Helmand provinces of Southern Region by mid 2013:

Southern region in general while Kandahar and Helmand in particular have consistently low quality performance resulting in continued indigenous circulation in the country. Distribution of confirmed polio cases, reporting of Zero Dose AFP cases, coverage in number of last campaigns and routine EPI coverage indicates that a block of districts in Kandahar and Helmand serves as the main reservoir in the area. Considering the fact, Southern region can be divided into two operational zones (Figure 19)





**B- Operational Area 1:** This is block of 9 districts (4 in Helmand and 5 in Kandahar) which are the main reservoir and will require more aggressive and frequent SIAs with implementation of two SIADs (4 passages). The aim is to administer almost 8 doses of OPV within first 6 months of 2013 with the aim to stop the indigenous transmission.

**Operational Area 2:** The plan for the operation area 2 is to administer at least 4 rounds of SIAs in rest of the Southern region, as well as case response and district focus campaign, when required. This will assist in stopping the circulation from the reservoir districts in general and the entire southern region in particular

## 2- Enhancing capacity of District EPI Management Teams

To address the lack of permanent support and oversight and accountability of the program activities at district level in each of the high risk districts, a permanent district EPI/PEI Management Team (DEMT) was established in September 2012. The DEMTs are led by District EPI/PEI Manager on permanent basis. District Manager is supported by district level personnel supported by WHO (Districts Polio Officers) and UNICEF (Districts Communication Officers) and NGOs.

DEMTs received a 5 day training on operational & communication aspects (2 days) and leadership/ accountability/ management (3 days) in September 2012.

For further strengthening of the DEMTs another 5 days training is planned from 6<sup>th</sup> to 10<sup>th</sup> January 2013 to cover the following topics:

1. Polio Control Rooms
2. District dashboard
3. Preparedness assessment
4. Revisit strategy
5. ToRs of new permanent people (DST and SMs)
6. Performance appraisals
7. DEMTs revised ToRs
8. IPC plus new IEC material
9. ICM forms and mechanisms
10. Revised financial and transport forms
11. Inaccessibility reporting (format and Sops)
12. Low performing district plus cluster specific plans (micro planning session)
13. Routine EPI

Following this on the job training by PEMT, PPOs and PCOs will continue and SOPS for this will be developed and these personnel's ToRs will be revised accordingly.

### **3- Use of accountability framework to assess performance and take follow up actions on monthly basis**

An accountability framework has been developed that clearly identified the ToRs of each Polio manager at provincial and district level; it also identified reporting lines, process of performance appraisals against clear deliverables and follow up action based on the appraisal results.

The first appraisal reports have to be developed by the end of December 2012 through appraisals of relevant staff by all three implementing partners.

With revision of the revisit strategy, more focus on recording of the missed children, revision and addition to the ToRs of some cluster level persons and social mobilizers (to make them full time workers) clear accountability measures will be introduced for each team, social mobilizer and cluster level persons for use starting in February 2012 campaign.

### **4- Revision of High Risk District and Cluster**

Afghanistan had last revised the list of the high risk districts in September 2011. In the face of changing evolving epidemiology TAG has recommended a review of the criteria and revision of the high risk districts and re-labeling of these as Low-performing districts.

The process is underway and expected to be completed by Mid-January 2013.

In each Low-performing district, cluster specific plans will be developed with focus on clusters with performance issues.

### **5- Engagement of Provincial and selected District Governors through the Focal person at the Office of H.E the President**

The office of H.E the President of Afghanistan has assigned a Focal Person on Polio Eradication to provide liaison between the office of H.E the Minister of Public Health and H.E the president, engagement and accountability of the provincial and priority district governors and support and monitor support from PEI from other Ministries.

Provincial governors, particularly Governors of Kandahar, Helmand, Uruzgan, Kunar and Farah will lead to ensure high quality implementation of vaccination campaigns through engagement of district governors and members of Shura. Provincial governors will regularly submit report on each vaccination round to the office of President and Ministry of Public Health. Target is to receive monthly report from Governors of High Risk provinces by end of December and quarterly meetings with H.E President

### **6- Functionalize the Polio Control Rooms in priority districts, provinces and at national level and the revised dashboard**

The overall purpose of the Polio Control Rooms is to have a cell connected through mobile phone and link districts with provinces and provinces with national level in order to make real

time monitoring and provide proper feedback to field or program level workers to improve the quality of SIAs through this intervention.

Clear ToRs of the PCRs at district, provincial and national level have been developed and funds will be available early January 2013. PCRs in priority districts, provinces and at the national level should be functional – with needed HR, equipment, training etc.- before the February SNIDs.

#### **7- Increases the Immunization Communication Network coverage to 90% in high risk areas**

The Immunization Communication Network will be further expanded to cover at least 90% of the low performing and priority districts through both full time and campaign specific social mobilizers with different ToRs. As mentioned above the accountability frame work will be expanded to the field worker level in order to be able to hold vaccination team and social mobilizers accountable against specific deliverables in each Polio campaign.

#### **Acknowledgment:**

We are grateful to CIDA, CDC, Rotary International, USAID, JICA, BMGF, World Bank, AusAID and Government of UAE for extending financial support to implement activities reflected in this report.

Let us all take this opportunity to reaffirm our commitments and join hands towards achieving the goal of “Polio Free Afghanistan”



من یک واکسیناتور هستم.  
پایان دادن پولیو نزد اطفال  
مسئولیت من است.



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