

---

**AFGHANISTAN  
EMERGENCY ACTION PLAN FOR POLIO ERADICATION  
2012-2013**

**Table of content**

A.	<u>EMERGENCY ACTION PLAN:</u>	2
B.	<u>EPIDEMIOLOGICAL SITUATION</u>	4
C.	<u>ROOT CAUSES AND STRATEGIES</u>	5
D.	<u>CROSS-CUTTING INNOVATIONS:</u>	12
E.	<u>OVERSIGHT AND MONITORING TO TRACK PROGRESS</u>	14
F.	<u>CROSS BORDER COORDINATION</u>	14
G.	<u>LIST OF ANNEXS:</u>	15
	Annex I: Emergency Action Plan Monitoring indicators:	16
	Annex II: SIAs in Afghanistan in 2010-2011 by vaccine type, month and scale	18
	Annex III: Extrapolated estimates of reasons for missed children in SIAs including missed due to inaccessibility calculate based on PCA and reported inaccessible children	19
	Annex IV: Human Resource mapping for polio program, by agency by district for high risk districts and by cluster for high risk clusters	20
	Annex V: Complimentary strategy to support interruption of Polio virus circulation in Afghanistan	21
	Annex VI: The high risk cluster approach to support Polio Eradication in Afghanistan	24
	VII: Program Management Review	26

## A. EMERGENCY ACTION PLAN:

### 1. Emergency Context

Polio Eradication Initiative (PEI) in Afghanistan reported an average of around 20 wild polio virus (WPV) cases per year (ranging from 4 to 38) during the period of 2000 to 2010. The poliovirus circulation was limited to only one transmission zone<sup>1</sup> in Southern region and Farah province of Western region which has persistently remained polio-endemic, reporting cases every year. All other parts of the country, with more than 85% of the population and including the Eastern and South-eastern regions bordering polio-endemic areas of Pakistan, have remained free of endemic polio transmission. Additionally, the country has not reported any WPV type 3 case since April, 2010. Progress is well-monitored through Afghanistan's surveillance system for acute flaccid paralysis (AFP) and wild poliovirus. This system has been found to be sufficiently reliable and sensitive by several external reviews<sup>2</sup>.

A major setback for polio eradication in Afghanistan occurred in 2011. The country experienced its largest polio outbreak in a decade with a threefold increase in the number of reported polio cases (80 cases-all type 1) in 2011 compared to 25 in 2010. Events since August 2011 have led to a major shift in the epidemiological situation, with 68 confirmed cases reported within a short time span of 5 months (Aug-Dec '11). Although most cases (85%) are reported from the recognized transmission zone of South region and Farah province of West region, 13 cases were reported from 9 provinces in different regions of the country. Most of these provinces had been without evidence of poliovirus circulation for over 5 years. Genetic data indicates that circulation in the infected areas in Afghanistan represents both continued circulation of endemic strains and recent re-introduction of WPV1 from infected areas in neighbouring Pakistan.

### 2. Rationale Emergency Action:

**National Context:** The explosive outbreak and occurrence of cases in areas outside the conventional transmission zone can have serious public health consequences. The outbreak represents a serious decline in the quality of campaigns and routine EPI. The continuation of virus circulation in the Southern region carries high risk of geographic expansion to neighbouring provinces/ areas. Secondly, the detection of polio virus in the newly infected provinces may lead to re-establishment of circulation causing infection and paralysis among a high number of children. There is also risk of potential spread to the neighbouring countries, particularly towards Central Asia. Last but not the least, the current level of funding may not persist, which may adversely affect the eradication activities.

MoPH thoroughly reviewed the situation in last Polio Policy Dialogue Group meeting, chaired by the Minister of Public Health and constituted a task force for development of an emergency action plan. MoPH, WHO and UNICEF, in consultation with members of joint partner's mission having representatives of donor community, prepared an emergency action plan to stop poliovirus transmission in the country by 2013.

**Global Context:** A total of 650 wild poliovirus cases were reported by the Global Polio Eradication Initiative (GPEI) in 2011, of which 341 (52%) were reported by Pakistan, Nigeria and Afghanistan, the last three countries with endemic poliovirus transmission. Similar to Afghanistan, Nigeria and Pakistan have also experienced a significant increase in WPV cases

---

<sup>1</sup> Transmission zone in document refers to the Southern region and Farah province

<sup>2</sup> Most recent international AFP surveillance review took place in September 2010

in 2011 compared with 2010. India, until recently the fourth endemic country, has met the end-2011 milestone of stopping all virus circulation<sup>3</sup>.

In April 2011, the GPEI's Independent Monitoring Board (IMB) stated that "*completing the eradication of polio is a global health emergency*". In November 2011, the WHO's main global advisory group on immunization, the 'Strategic Advisory Group of Experts on Immunization' (SAGE) endorsed the findings of the IMB and concluded clearly "*that the risk of failure to finish global polio eradication constitutes a programmatic emergency of global proportions for public health and is not acceptable under any circumstances.*" The 130th session of the WHO's Executive Board (EB) in January 2012 adopted resolution EB130.R10, declaring the completion of poliovirus eradication a "***programmatic emergency for global public health***". The WHO EB has recommended the adoption of this resolution to the World Health Assembly's (WHA) upcoming meeting in May 2012. The resolution urges countries with poliovirus transmission to consider such transmission as national public health emergencies, and develop and fully implement emergency action plans, to be updated every six months, until such time as poliovirus transmission has been interrupted.

In response to the evolving polio epidemiology in 2011 and the IMB's recommendations, the GPEI developed a Global Polio Emergency Action Plan 2012-2013. The main goal of the plan is to support Nigeria, Pakistan and Afghanistan in implementing corrective actions to achieve, by end-2012, the coverage levels needed to interrupt poliovirus transmission in each of the remaining infected areas.

In due course, and to respond to the worsening polio situations in their countries, and to address the recommendations from the IMB, the Governments of Nigeria and Pakistan have developed or updated 'national emergency action plans' for polio eradication; the Head of State in each country appointed a focal point to oversee national efforts and established monitoring mechanism through high-level Emergency Taskforces to hold local authorities accountable for the performance and quality of activities.

In light of the worsening polio situation and the implications nationally and globally, and to urgently address programme risks, the Government of Afghanistan has also developed an emergency plan. The main goals of the plan are to:

- Stop WPV transmission in the Southern region and Farah province
- Prevent establishment of WPV circulation in the rest of the country
- Maintain a sensitive surveillance system

The specific objectives of Afghanistan Emergency Action Plan are to:

- Identify existing program gaps, scale up successful current strategies and implement new strategies to ensure the highest quality and coverage of polio vaccination activities in all parts of Afghanistan, particularly in the highest risk districts of the transmission zone in the Southern region and Farah province
- Mobilize all available resources by the Government and stakeholders to support the polio eradication activities
- Closely monitor implementation of the plan at all levels, assess progress, and take corrective measures with strengthened accountability processes

The major process indicators (MPI) to monitor and track the progress towards the overall goals include:

- Coverage of >90% in high risk districts (HRDs) in at least 4 of the SIAs in a year
- <5% inaccessible children in each high risk district
- Awareness levels increased from 50% to 90% at the national level

---

<sup>3</sup> India's most recent case had date of onset of paralysis on 13 January 2011.

- Zero Dose AFP cases reduced by 50%<sup>4</sup>
- Among all the unvaccinated children, <10% missed due to “no team visit”
- Reduction in total missed children and refusals by at least 50% in the country with special focus on 28 High Risk Districts.

---

## **B. EPIDEMIOLOGICAL SITUATION**

- **Distribution of cases:** As noted, majority of cases reported in Afghanistan during 2011 (67 of 80) and in 2012 to date<sup>5</sup> (4 of 5) occurred in the transmission zone: Kandahar (35 cases), Helmand (19 cases), Uruzgan (5 cases), Zabul (3 cases) and in Farah province, Western region (5 cases). Within these provinces, transmission is concentrated in and around 28 known high-risk districts<sup>6</sup> (of the total 397 districts), with 58 of 67 cases reported from these districts.
- **Newly infected provinces:** In 2011, 13 polio cases were reported from 9 provinces outside the country’s transmission zone (South and Farah province), representing all 7 remaining regions of the country. Genetic sequencing indicates that the majority of cases occurring outside of the transmission zone in 2011 were importations: 5 from Pakistan; 4 from the Southern region transmission zone including one from Farah province. The remaining four cases were secondary cases as a result of the initial importation into the Central region (Parwan) and North region (Faryab)
- **Supplementary Immunization Activities (SIAs):** In 2011, a total of 8 SIAs were conducted with 4 nationwide and 4 sub-national rounds in Afghanistan. Trivalent oral polio vaccine (tOPV) was used in two of the NIDs, one in the first part of the year and the other in the later half. Bivalent oral polio vaccine (bOPV) was used in the remaining 6 campaigns i.e 2 NIDs and 2 SNIDs. In addition to these campaigns, short interval additional doses<sup>7</sup> (SIADs) and case response vaccinations were conducted in selected districts mainly with bOPV. Details of the campaigns conducted in 2010 and 2011 by scale, type of vaccine and month is Annexed (Annex II).
- **Age and vaccination status of cases:** In 2011, 48 out of the 80 confirmed polio cases (60%) were between 12 and 36 months of age (median age of confirmed cases: 24 months). More than 50% of cases were reported to have received less than 3 total doses of OPV (median number of OPV doses: 2). Sixty of 80 cases (75%) reportedly did not receive any routine OPV dose, while 30% of cases did not receive any OPV dose ('zero dose'), neither through routine nor SIAs.
- **Assessment of 'population immunity':** The programme uses the OPV vaccination status of AFP cases (aged 6 - 23 months) to estimate levels of population immunity achieved through vaccination in the various regions of the country.
  - **OPV history of AFP cases:** the proportion of children (6-23 months) who received 3 or more OPV doses through routine EPI declined from 63% in 2010 to 57% in 2011 nationally, and from 23% (2010) to 15% (2011) in the Southern Region.
  - The **proportion of 'zero dose'<sup>8</sup> AFP cases** (6-23 months) was 2.5% nationally in 2010 and has increased to almost 7% in 2011, indicating a decline of routine coverage as well SIA quality in the country, **most prominently in the South region where the proportion of 'zero dose AFP cases' has more than doubled from just under 9% in 2010 to 21% in 2011**

---

<sup>4</sup> Baseline: % of zero dose AFP cases in 2011

<sup>5</sup> 8<sup>th</sup> May 2012

<sup>6</sup> Selection criteria for high risk districts included in Annex IV

<sup>7</sup> Brief definition of SIADs

<sup>8</sup> Zero-dose refers to any child with no history of receiving any OPV doses, regardless of age or strategy of administration.

- **Post-campaign coverage assessment (PCA)**<sup>9</sup>: Over the 6 subsequent SIA rounds conducted before the March 2012 NIDs, the coverage for the Southern region and Farah province remained sub-optimal, with more than 60% of SIA 'clusters' (sub-district units) achieving coverage less than 90% in every SIA. Post-campaign coverage evaluation in most of the other provinces infected in 2011, particularly in Badghis and Faryab (north-west), and in Parwan and Kapisa (central/north) also showed a decline in coverage and SIA quality.

---

### C. **ROOT CAUSES AND STRATEGIES**

The 2011 outbreak and continued transmission of WPV in Afghanistan are a result of the the *existing and increasing* immunity gap in 2011 highlighted above. This immunity gap resulted in accumulation of children susceptible to poliovirus infection over time as a result of failure to reach and vaccinate children with a sufficient number of doses of OPV. The overall decrease in the number of OPV doses received by children is due to deterioration in both routine immunization coverage and continued sub-optimal quality of SIAs, in several areas of the country, primarily in the transmission zone of Southern region and Farah province but also in other provinces, where limited secondary transmission following importation was observed, such as Badghis, Faryab, Parwan and Kapisa. Additionally, the large outbreak in 2010 and 2011 in neighbouring Pakistan, which is considered to be part of the same epidemiological block, also had a spill over effect with an increase in the number of WPV importations from Pakistan into areas outside of the transmission zone of Afghanistan.

External and internal reviews, discussion with field staff, review of AFP, SIA and routine immunization data indicates that the likely reasons of unvaccinated children in Afghanistan, especially in the Southern region, during polio vaccination activities are the following:

- 
- *Management and accountability gaps*
  - *Inaccessibility*
  - *Communication and demand gaps*
  - *Weak routine immunization*

In order to bridge the existing immunity gap, to stop transmission and protect against new outbreaks following importations, it will be critical that the Afghanistan polio eradication program urgently responds to and systematically addresses each of these causes. The following sections will discuss the root causes, “causes of the causes”, behind each of the above reasons contributing to the immunity gap and describe strategies which should be implemented to address each cause.

---

#### **1 Management and accountability gaps**

Currently in Afghanistan, the Ministry of Public Health (MoPH) provides overall leadership and direction to the program activities with considerable support from WHO and UNICEF. H.E. the Minister of Public Health chairs regular meetings of the Polio Policy Dialogue group which includes the Representatives of WHO and UNICEF. Task force on emergency action plan, chaired by Director General- Preventive Medicine meets fortnightly. National Standing Committee (NSC), chaired by National EPI Manager, discusses PEI issues and tasks are prioritized to address key actions. WHO and UNICEF teams are co-located and conduct joint planning with the Ministry of Public Health outlining roles and responsibilities of all the partners in program activities.

---

9

Management issues, particularly in the transmission zone, have repeatedly been highlighted as a significant cause of the continued failure to interrupt WPV transmission in Afghanistan. A review of Post Campaign Assessment (PCA) data in accessible areas of the Southern region and Farah province shows that, in assessed areas, an average of up to 30% of unvaccinated children report that 'team did not visit'. A further 40% of children were unvaccinated because they were reportedly 'not available' at home on the day of the campaign. Over the past 2-3 years, these areas witnessed a significant decline in quality. The reported findings, even in 'accessible' areas, are suggestive of serious managerial problems, including lack of oversight, supervision and monitoring of campaign field staff, with direct negative impact on SIA 'quality' and coverage.

**a. Causes of management and accountability gaps:** While the polio program has a well-developed management system at the national and regional levels with some variation at provincial levels, considerable challenges exist at district and field level. The causes behind the management and accountability gaps are:

- Lack of permanent support and oversight: oversight and accountability of the program activities are weak at district level and variable at provincial level. MoPH contracts with non-governmental organizations (NGOs) for delivery of the Basic Package of Health Services (BPHS) at the peripheral level. Except in few districts in Southern region, there is virtually no full-time representative of the MoPH at the district level. Micro-planning and implementation of immunization campaigns activities is the responsibility of provincial health team which comprises the PEMT-MOPH, PPO-WHO, PCO-UNICEF,<sup>10</sup> BPHS-NGO. Campaign service providers (District coordinators and cluster supervisors and vaccinators) are hired only for the duration of the campaign. District and cluster supervisors' short term involvement (4 to 8 days) in the campaigns adversely affects the campaign quality. The situation is further complicated in the highest risk districts of the Southern region due to insecurity and instability.
- Role and responsibilities, Terms of Reference (ToRs), performance review: Although roles and responsibilities of provincial team members and their ToRs are outlined clearly but a system of regular performance reviews, assessment and accountability is lacking.
- Field staff capacity: campaign managers and supervisors at the field level (district level and below – the 'cluster' levels), particularly in the transmission zone are often of lower capacity and semiliterate or even illiterate, yet expected to regularly manage both financial and human resources and provide supervisory support. The managers running the programme at the provincial level are often technical staff with a medical and public health background; however, many have limited capacity for managing the programme.. The selection process of the field staff is often not transparent and does not always comply with the specified criteria.
- Stakeholders: The performance and contribution of the BPHS implementing NGOs to immunization activities is variable. For more than two years, full responsibility for campaign planning and implementation in a number of highest risk districts in the Southern region had been transferred to BPHS NGOs, in an effort to compensate for the weak performance of provincial health offices. Unfortunately, the performance of the BPHS NGOs was disappointing, and the 'campaign takeover' by BPHS NGOs was discontinued. However, BPHS NGOs remain key partners to support polio field activities at the peripheral level. However, their engagement in monitoring of activities, involvement of CHWs etc remains inadequate and passive. Additionally, other government departments- district governors, local shuras, police, education, agriculture - present at the district level are often not fully involved in supporting immunization activities particularly in high risk areas. In many of the high risk areas, the vaccination activities are also influenced by the anti-government elements (AGE). The program has

---

<sup>10</sup> PEMT- Provincial EPI Management Team; PPO- Provincial Polio Officer, PCO- Provincial Communication Officer.

made efforts to engage with all local stakeholders but has not always succeeded and in some instances has not selected the most suitable individuals or mechanism.

- Financial bottlenecks: Lack of transparency in the distribution of resources, delays in the disbursement of payments to the field staff (including to vaccinators) and low incentives for NID service providers result in further deterioration or stagnation in quality of activities and demoralization of field staff.

It is important to note that issues of management and accountability impact the quality of all immunization activities, routine and campaign, in both accessible and inaccessible areas. Resolving these issues will have a significant impact on improving overall quality and immunity.

**b. Priority strategies to improve management and accountability:** Responding to the described main problems, the following will be priority strategies, under the national emergency action plan, to reduce the number of children missed due to gaps in management and accountability:

1. Strengthen capacity and management at district level with focus on high risk areas: In each of the high risk districts, a permanent/ full time district EPI/PEI Management Team (DEMT) will be established. The DEMT will have permanent representative of MoPH, technical personnel supported by WHO and UNICEF and NGOs with clearly described roles and responsibilities (ToRs) and mechanism of performance appraisal linked with an accountability framework. In the first phase, the DEMTs will be established in selected high risk districts of Kandahar, Helmand, Uruzgan and Farah provinces. All DEMT members will be held responsible for achieving the level of quality of activities necessary for stopping transmission in the district. The district team will work full time and be responsible for the micro-planning, team and cluster supervisor selection as per criteria, trainings, intra and post campaign corrective actions and transparent disbursement of the incentives with more priority focus on the high risk clusters (HRCs). The district team will report to Provincial EPI Management Team (PEMT) on the campaign preparedness and will give recommendations regarding the deferment of activities, where applicable, if preparedness level is found to be inadequate. The DEMT will also update the district governor on a monthly basis on the Polio status. The hiring of the temporary staff, District Campaign Coordinator will be discontinued.
2. Provincial management will closely monitor district performance (at cluster level) and ensure accountability by conducting review of campaign preparedness, implementation and post campaign evaluation for each round with district teams. All provinces should establish/operationalize their Provincial Immunization Teams, under the leadership of the Provincial EPI Management Team to review progress on polio and take corrective measures in the field. These teams should also set up monitoring systems to report on and resolve any payment delays and ensure transparency. The Polio Provincial Officer (PPOs) will be responsible for the identification of the independent monitors, training them, identification of the areas for the monitoring, as well as receiving and compiling the data.
3. Conduct a program management review to define/ assess the accountability framework and revise, if needed, the terms of reference (ToRs) of all existing capacity in the field to clarify roles and responsibilities and ensure strong management of the existing structures.
4. Conduct learning and needs assessment and management training down to provincial and district level managers.
5. Conduct regular performance evaluations for all staff of various organizations like MoPH, BPHS-NGOs, WHO and UNICEF on a quarterly basis at all levels. Strengthen the role of the Grant and Contract Management Unit (GCMU) in this process.

6. Strengthen reporting and monitoring of programme activities in all areas, particularly in conflict affected areas with access problems, by exploring various mechanisms such as:
  - Improve the recording and follow-up by vaccination teams of any missed children during the campaign. This should be strengthened urgently.
  - Remote post campaign monitoring through telephonic survey for assessing (i) campaign awareness, (ii) if teams visited the household of the responder and (iii) to request the respondent to check 5 neighboring household to identify any unvaccinated children. The programme can use existing contact lists from other programs such as education, local Community Development Council (CDC), sanitation, shuras, Youth Information Contact Center (YICC), literacy centers, etc.
  - Lot Quality Assurance Surveys for assessing SIAs coverage and awareness levels in priority polio-infected districts especially where independent monitoring results are discrepant from the epidemiological situation.

## 2 Inaccessibility

Vaccination teams in Afghanistan continue to have problems in accessing children in conflict-affected areas. Absence of law-and-order and on-going conflict, particularly in the Southern region and in parts of the Western and Eastern region, continue to be one of the main reasons for children not being vaccinated during immunization rounds. During every SIA, a variable number of clusters and districts are partially or totally excluded because the areas are considered to be too dangerous for vaccinators to operate in.. For example, almost 20% (270,000) of the total target children <5 years of age in the Southern Region were considered inaccessible in the September 2011 SIA.

**a. Causes for 'inaccessibility'.** The reasons for children being reported as being inaccessible for vaccination vary considerably. The program has identified the following main reasons for reported failure to access children during immunization activities:

- Insecurity due to active conflict in an area: this can range from limited local disputes to wide spread, open, active fighting.
- Change in the leadership of local AGE
- AGE not permitting (blocking) vaccination campaigns without giving any specific reason.
- Staff selection: At times, local AGE leaders do not allow immunization activities in their area because they disapprove of the campaign staff selected by the provincial health team
- Environment of fear: Even without active conflict, vaccinators may not enter an area because of a pervading 'climate of fear', or because they want to avoid being harassed by one of the conflict parties. Unfortunately, reports of such harassment, whether by anti-government elements or government security forces, are received almost during every SIA. Other scenarios associated with an 'environment of fear' which may cause vaccinators not to enter an area are the suspicion that an area may be mined, have on-going military search operations or fear of AGE or other military forces present in the area.

Conflict and security problems make existing managerial problems worse. Both open conflict or just a 'climate of fear' can seriously reduce the mobility of campaign coordinators and supervisors, thereby making the supervision and monitoring of all phases of SIA implementation significantly more difficult compared to secure/stable areas, particularly for non-local or international staff. This also complicates the verification of the reported reasons for inaccessibility and may prevent possible activities to gain access into an area.

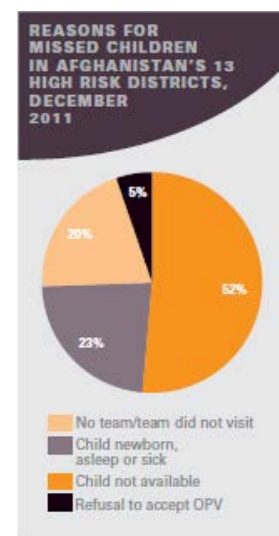
The program has continued efforts to address issues of inaccessibility through various strategies including: the use of local level access negotiators; engagement of local leadership and stakeholders; and partnership with international humanitarian organizations that work in



the conflict-affected areas. Success has been variable largely because, for example, sometimes inappropriate persons were selected as access negotiators and are not well supervised.

**b. Priority strategies to respond to access problems:** The following will be priority strategies, under the national emergency action plan, to reduce the number of children missed/not-vaccinated due to ‘inaccessibility’:

1. Small-scale immediate immunization response like Short Interval Additional Dose (SIAD) strategy will be adopted in such areas as soon as they may become accessible: During and after each vaccination round the number of children missed due to inaccessibility by cluster will be documented, as well as the reasons for inaccessibility. This more detailed documentation will assist in prioritizing areas (clusters) with the largest number of children, particularly if areas have been repeatedly inaccessible, to target them with response strategies. All necessary resources (funds, vaccines, communication) will be readily available at provincial level to implement immunization response when such areas become accessible, even if there is no campaign planned during those days. These activities will be documented and their impact in reducing the number of children missed due to inaccessibility closely monitored.
2. On-going efforts to provide at least four OPV doses for each child under 5 years in high risk areas: The program will use a new strategy of supplementary polio vaccination through newly recruited '**permanent polio teams**' (PPTs) in selected high-risk districts of the southern Region. Adequate supervision and management capacity will be ensured to support this activity (PPT at annex IV and list of monitoring indicators indicators at annex I). This low profile vaccination activity expectedly will be less affected by the insecurity.
3. In areas controlled by the AGE efforts by all stakeholders need to continue to directly or indirectly coordinate the selection of campaign field staff, the implementation and monitoring of activities. Partners such as ICRC and Afghan Red Crescent will continue to have a key role to play.
4. Review performance of local level access negotiators and monitor their impact by tracking the number of children reported as accessible in their areas.



Source: Post Campaign Monitoring data

### 3 Communication and Demand Gaps

Post campaign assessment (PCA) shows that overt refusals of vaccination by caretakers is responsible for only a very small percentage of missed children in Afghanistan, with only about 5% of missed children in the original 13 high risk districts not vaccinated for this reason. But variations among the districts are significant. Reasons for refusal in the conflict affected Southern region of Afghanistan are diverse, and empirical evidence on social issues does not yet exist in sufficient depth. Spin Buldak, one of the high risk districts in the Southern Region, has repeatedly reported very high percentage of missed children due to refusals.

In Afghanistan another key reason for missed children is because they were newborn, sick or sleeping. In December 2011, 23% of missed children in the 13 High Risk Districts were not vaccinated because they were new-born, sick or sleeping. When combining missed children due to refusals with new-born, sick and sleeping category, social reasons have accounted for over 25% of missed children in high risk districts over the past year.

The post campaign assessment data also indicates that a growing proportion of children are being missed each month because they are unavailable when teams visit the household. Between 50% - 60% of children are missed for this reason.

**a. Causes for existing social reasons for missed children:**

- PCA data shows that campaign awareness levels in Afghanistan are the lowest among the polio priority countries. In the 13 high risk districts, only half of caregivers have reported having heard of the polio campaign before vaccinators arrive. In areas where the Polio Communication Network (PCN) is operating, awareness is higher, at 70% on average, with over 35% identifying community mobilizers as their primary source of information compared to only 11% in non-PCN areas.
- PCN covers less than 30% of high risk areas in the Southern region and so the programme is still not reaching enough people with information that campaigns are happening, and why they are important amidst many other competing priorities in this war-torn area.
- Experience in Afghanistan has shown that it is a common sight to see the vaccination teams in front of doorways, surrounded by children holding up younger children for vaccination. Due to cultural norms, women rarely answer the door to men, so it is the older children who bring their siblings out to the mostly male vaccination teams. There is a serious communication gap between the caregivers, especially the mothers, and the service providers (the teams). Teams often do not spend enough time asking caregivers about all children under 5 years of age and when they do, they often do not have the appropriate IPC skills to communicate with families to identify and vaccinate all target children.
- Anecdotal data from the field suggests that children are often at relative's homes, traveling, or in the market when the teams arrive. This is related to a mix of social and operational factors which will need to be addressed.
- The quality and availability of social data and management issues are serious challenges. With high rates of staff turnover amidst a volatile environment, the PCN urgently needs higher quality standards and protocols that respond to evidence-based analysis.

Some of these causes are related to a mix of operational and communication challenges in the field. Therefore, it remains critical to first and foremost address operational challenges linked to existing management and accountability gap in the program.

**b. Priority strategies to respond to social reasons for missed children:** The Advocacy and Social Mobilization Plan 2012-2013 for Afghanistan draws heavily on the assessments, reviews, surveys and field observations pertaining to both, the current communication activities and the unmet and emerging programme needs. The following will be priority strategies, under the national emergency action plan, to reduce the number of children missed due to social reasons:

1. New multi-media polio communication campaign will aim at increasing campaign visibility and awareness with clear messaging regarding the need to vaccinate all children under 5 years of age especially the newborn, sick or sleeping. This will include development of standardized branding framework and production of a range of communication materials including audio visual, print and digital content for awareness generation about SIAs and for use by various stakeholders for demand generation, mobilization and advocacy.
2. Partnerships with religious leaders, schools, youth and women's groups will explore targeting high risk groups with a focus on generating demand. The program will map all possible partners who can engage with communities for social mobilization and for monitoring and evaluation of the PEI program and prioritize those who can reach the high risk groups such as women, inaccessible and nomadic populations in the South region and identify strategic areas of convergence/ integration with focus on priority areas for polio eradication efforts. In addition to strengthening existing partnerships and clarifying the

roles and responsibilities of the various cadres<sup>11</sup>, the program will explore new partnerships to engage Youth wings of ARCS, influencers among nomadic populations identified by WHO's community surveillance network and Afghan Academy of Pediatrics.

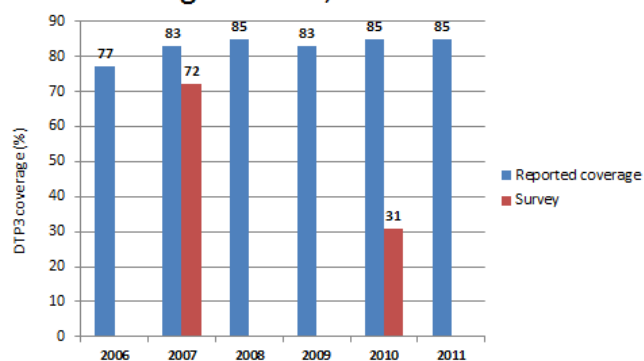
3. Enhanced interpersonal communication training for vaccinators and social mobilizers through the following activities:
  - Conduct learning and needs assessment to guide the revision of the IPC component of trainings for various cadres keeping in mind that a significant proportion of these workers are not literate. As a result the program will also develop new training and teaching aids and ensure use of standardized IPC training methodology.
  - Develop IEC tools with clear messaging to target high risk groups and address issues related to missed children due to newborn, sick or sleeping and child not available.
  -

The implementation of the above activities will be depends on reviewing the management and structure of the existing Polio Communication Network .

#### 4 Weak routine immunization coverage

Routine immunization is one of the four strategies of polio eradication. The weak routine immunization system in Afghanistan has contributed significantly to the existing immunity gap. While reported DTP3 coverage remains above 80% since 2007, recent survey results show that the actual routine immunization coverage is much lower and is on decline in the last few years (Figure 1: NRVA 2007/ 2008 & MICS 2010)

DTP3 coverage: reported vs survey  
Afghanistan, 2006-2011



The majority (>75%) of confirmed polio cases in 2011 did not receive any routine OPV doses. Similarly, the immunity profile of non-polio AFP cases based on routine doses is showing a declining trend. The situation is the worse in the Southern region. Outbreaks of measles and pertussis and the reporting of polio cases from all region of the country in 2011 further confirmed this immunity gap.

#### Reasons for weak routine immunization:

- Insufficient infrastructure and unsustainable financing: EPI programme has very limited infrastructure in many districts. Between 15-25% of population have no access to immunization services and 7 districts have no EPI centres at all. Nearly 2/3rd of the vaccination is carried out through outreach and mobile services but implementation of regular outreach sessions in 2011 remained a challenge due to various reasons, including accountability and also financing problems.
- Weak monitoring mechanisms: Routine immunization services in Afghanistan are part of the BPHS delivered through NGOs. There is no effective monitoring by/of NGOs in the field.
- Suboptimal cold chain and logistics: There is inadequate cold chain capacity and logistics management for traditional and new vaccines. Afghanistan is planning to introduce pneumococcal vaccine in 2013 and rotavirus vaccine in 2014/15.

<sup>11</sup> Vaccinators and volunteers, community mobilizers, community influencers, cluster supervisors, medical professional (doctors, nurses, hakims), health workers (Community Health Supervisors (CHs), Community Health Workers (CHWs), mid-level health managers (Members of provincial and regional EPI management teams) and influences (Mullahs, teachers, community leaders), women groups? Midwives?

- Data quality challenges: There are significant discrepancies between reported and survey coverage data linked to inadequate use of the data at all levels, infrequent reviews and weak supervision.
- Lack of community engagement, awareness and demand for routine immunizations services.

**b. Priority strategies to respond to the weak routine immunization:** In order to help address the existing immunity gap in Afghanistan, the Emergency Action Plan identifies the need to intensify efforts to strengthen routine immunization all over the country. This will be guided by the recent introduction of the 3-month accelerated EPI plan (Annex XI) which will be regularly reviewed and expanded focusing on the high risk districts in the first phase. The following will be priority strategies, under the national emergency action plan, to reduce the number of children missed by routine immunization:

1. Quarterly EPI performance review meetings with all BPHS NGOs under the leadership of GCMU.
2. Monthly coordination and dialogue between national EPI and GCMU on BPHS NGOs' performance in the priority areas. BPHS NGOs (AHDS, BRAC, and CHA) responsible for South region will also be expected to submit Routine EPI plans for the next 3 months.
3. Establish clear linkages between polio and routine immunizations such as:
  - AFP surveillance data and active surveillance visits will be used to monitor and provide regular feedback on RI performance of BPHS NGOs.
  - Using AFP and Polio programme capacity and resources to monitor routine immunization coverage and increase awareness and demand. This includes using existing monitoring systems (PCA) and polio communication network.
  - The EPI review planned for 2012, should also include a component to review polio program activities and assess established linkages between the two.

---

#### **D. CROSS-CUTTING INNOVATIONS:**

The program has developed several new cross-cutting approaches to accelerate the closing of the existing immunity gap with a focus on high risk areas. These include some new pilots which have been launched in 2012 which will need further evaluation prior to scaling up in scale and geographic scope.

##### ***Permanent Polio Teams***

To address the current limitations in both routine immunization and SIAs, a concerted effort is being made to ensure that every child under five years of age is provided with at least a minimum of 4 OPV doses during the period of a year to ensure that no zero dose children remain in the high risk populations. Weak management, lack of accessibility and insecurity often make it impossible to cover all areas during Polio SIAs. Therefore, it is being proposed that a permanent team that has 3 months to cover every child in its catchment areas will be much more likely to find windows of opportunity to reach areas that are insecure/ inaccessible for varying periods of time. This activity will be in addition to routine immunization and all Polio SIAs (NIDs, SNIDS, and SIADs etc.) and tOPV will be administered. These teams will also be able to engage communities and their leaders in dialogue in cases of resistance or refusal for vaccination and to increase community awareness and demand for routine immunization.

The newly proposed strategy will work as follows:

1. Provide at least one dose of OPV to every child under the age of five years in a catchment area once every three months. This will be done through a house to house strategy, while ensuring cold chain and appropriate recording, with the goal of giving each child at least 4 doses in a year.

2. Development of quarterly plans for each team to visit each village at least once every three months in every priority district or part of it.
3. Number of district team will be according to the microplan based on catchment area and target population. The daily achievable target, given the terrain and the population density in the area.
4. The catchment area will be defined based on climatic, political boundaries, number of households and overall target population.
5. The activity will be closely supervised at all levels with a designated full-time supervisor, weekly reporting, monitoring and tracking of activities. Specific monitoring indicators will be used to assess the impact of this approach

It is envisaged that the presence of these teams and their engagement of communities will have a synergistic effect on the polio SIA activities through updating of maps, micro plans and messages to encourage parents to seek routine EPI services. To ensure families are aware that PPT is not a replacement of Routine EPI antigens or SIA doses, a strong communication plans with clear messaging and tailored training activities will be developed.

For more details on this strategy including planning, implementation and monitoring see the attached concept paper (Annex V).

#### **District Focused Planning & High risk cluster approach (Annex VI)**

District focus through district specific plans and increase in human and financial resources has shown mixed results. Increasingly, it is felt that the need is to focus on high risk clusters (HRCs) within these districts in Southern region for focused interventions for improved campaign and routine immunization planning, implementation, community mobilization and engagement and monitoring.

Identification of high risk clusters was carried out by the regional/provincial teams using a standard criteria based on review of various data sources including AFP (polio, zero-dose), PCA data (coverage and communication) and inaccessibility. A sub-set of these high risk clusters are categorized as high risk clusters for communication (HRC-C) based on another criteria using awareness and social reasons for missed children.

Once a cluster is categorized as high risk the following procedures are adopted for operations:

- At the onset, the regional/ provincial team review plans and available data (AFP, PCA, inaccessibility) to identify critical issues to focus on in the next 3 months.
- Progress against plans will be revised every 6 weeks at the regional level with district teams and every three months with district & cluster teams. The program will closely monitor preparedness as well as implementation and take corrective measures as needed.
- A data review (using the same indicators used for identification of HRCs) will be conducted every 6 months. A cluster may be removed from the list of HRCs provided that the problems have been addressed and at least four SIAs had >90% coverage as assessed through independent monitoring.
- New clusters may be added to the list during the course of the year, based on the mentioned criteria.

The additional activities that will be conducted in HRCs for communications include:

1. Intensified support provided to HRCs from districts, provincial and regional levels for planning, implementation and monitoring of activities.
2. All new strategies for PEI will be implemented in these HRCs on priority basis. This will include introduction of new monitoring strategies, additional capacity and intensified access negotiations, where needed.
3. Cluster teams will develop/ revise micro plans to resolve the issues identified using AFP data and data from prior rounds of polio campaign.

4. The cluster supervisors and volunteers (team members) will be trained to improve their Inter Personal Communication skills.
5. Each team in these clusters will have two vaccinators (as in all teams) and an additional member (a social mobilizer) to support community's awareness, acceptance and demand for vaccination.
6. The cluster supervisor, in addition to the vaccination team members, will be responsible for supervision of the social mobilizers (SMs). In these areas TORs of the cluster supervisor will be revised accordingly.

For more details regarding this strategy, please see the attached note (Annex VI)

---

#### **E. OVERSIGHT AND MONITORING TO TRACK PROGRESS**

A key component of this action plan, highlighting its urgency, is close oversight and regular monitoring of progress at all levels and by all stakeholders involved.

- The **district polio coordination committee**, which will be chaired by representative of MoPH in DEMTs with membership by the partners and a representative of the Governor, department of education, shuras, and other stakeholders. The Forum will review the progress of the each campaign phase and taking corrective action
- The district polio team will report to the **Provincial Immunization Team** chaired by the PEMT with membership from partners and all stake holders including other line departments.
- Within the **Ministry of Public Health**, the polio program will be declared a priority across all departments with the goal of strengthening management through improved coordination with the different levels and overall management of GCMU and close monitoring and support of front line activities.
- The **Polio Policy Dialogue Group (PPDG), Chaired by H.E. Minister of Public Health** will monitor the performance indicators of this emergency action plan and identify bottlenecks and propose solutions on a monthly basis.
- At national level, a **Task Force** to monitor implementation and progress of the emergency action plan through specific indicators will established. The Task Force will be chaired by the DG MoPH with extended membership to all key stakeholders including partners, donors, NGOs. The Task Force will meet on a monthly basis and review outcome of the PPDG and identify corrective measures to address bottlenecks in progress.
- The Task Force will provide monthly updates summarizing the key monitoring indicators of the emergency action plan to the **President's office**. To further harness all the needed support from the various line-departments, regular updates on the plan's progress will be shared with the **Cabinet** and polio added to the agenda. Corrective measures will be decided on and communicated to the field to resolve bottlenecks with a focus on achieving better performance and strengthening management and accountably.
- Maintain sensitive **AFP surveillance**: AFP surveillance is one of the most effective and reliable monitoring systems for the polio program. It is of utmost priority that the program focuses on strengthening the link between the district AFP focal persons and community-based reporting and improving the quality of active surveillance visits. Program plans to conduct orientation seminars for reporting volunteers at district level and in the first half of 2012 and formal training for AFP focal person and Provincial Polio Officers in the second half of 2012.

#### **F. CROSS BORDER COORDINATION**

Afghanistan and Pakistan share a long and porous border with high population movement across it. Over 3 million Afghan Refugees live in Pakistan and process of repatriation is ongoing leading to returnees from different parts of the Pakistan. Based on the population

movement and genetic mapping of poliovirus, both countries are considered as one epidemiological block. There are 11 vaccination posts established at important crossing points between Afghanistan-Pakistan border. Over 1 million children below 5 years of age are vaccinated each year by these border vaccination teams.

- **Maintaining close and regular cross border coordination** is important and both programs exchange information on weekly basis on the situation update and share the campaign report after each SIAs.
- **To further strengthen this coordination**, program plans to hold cross-border meeting between the country and provincial teams. The meeting of bordering provinces between Southern Region of Afghanistan and Balochistan Province of Pakistan is regularly held before each campaign but due to insecurity, these meetings are not held for Khyber Pakhtoonkwhah and Federally Administered tribal Areas (FATA) areas of Pakistan and its adjoining Eastern region of Afghanistan. Next cross border meeting is planned in July 2012.

#### G. **LIST OF ANNEXS:**

- I. Emergency Action Plan Monitoring Indicators
- II. Supplementary Immunization Activities in Afghanistan 2010-2011 by vaccine type, month and scale.
- III. Extrapolated cumulative reasons for missed children in Afghanistan
- IV. Human Resources supporting polio program at all levels and across all agencies (district and above for high risk districts, cluster and above for high risk clusters)
- V. Permanent Polio Teams strategy
- VI. High risk cluster approach
- VII. Program Management Review ToR
- VIII. Accountability Framework
- IX. Tabulated Activity Plan
- X. Budget

## ***Annex I: Emergency Action Plan Monitoring indicators:***

### **National level:**

- Update on status of Polio Emergency Action Plan implementation submitted to the President's Office (monthly) – Initiate by end May 2012
- Polio update including contributions of line Ministries and departments provided at the Cabinet meeting (quarterly) – Initiate by end May 2012
- Policy Dialogue Group meetings chaired by Minister of Public Health to address Policy level issues (monthly)
- Task Force meeting on emergency action plan to track progress (Fortnightly)
- National Standing Committee Meeting (weekly)
- Accountability framework, with key monitoring indicators of performance for all relevant personnel of each Organization (MoPH, WHO, UNICEF, NGOs) at all levels. Framework in place by May 2012 and appraisal starts in June 2012.
- Monthly Reporting on accountability framework to national level and detailed appraisals every quarter for all relevant staff at all levels. To start from June 2012
- Number of actions taken by each level towards campaign personnel due to lack of improvement in performance by type of action (notice, warning, dismissal), by level, by partner. June 2012
- By end 2012, awareness levels for Polio campaign are increased from 50 to 90% at the national level
- By the end of 2012 at least 95% of the caregivers are aware that the threat of Polio is preventable through Polio vaccination
- Total missed children and refusals are both reduced by at least 50% in the country with special focus on 28 High Risk Districts.

### **Sub-national levels:**

- Provincial Governors (focus on high risk provinces) submitting provincial EPI and polio situation report through the General Directorate for local governors to the President office ( monthly or after each campaign)
- Regular meeting of the regional standing committee on Polio/ EPI (weekly)
- Pre-campaign preparedness assessment based on the logbook/ check list in every province- 10 days before every campaign)
- Monthly performance review meetings of immunization activities including Routine Immunization, SIA and PPT for high risk districts of the 3 priority provinces at provincial/regional level.
- Regular use of accountability framework for staff at regional and provincial levels and those with reporting lines to these levels (every month against the key indicators with detailed appraisals every quarter Starting in early May 2012)
- Number of actions taken by each level towards campaign personnel due to lack of improvement in performance by type of action (notice, warning, dismissal), by level, by partner.
- Regional and Provincial level Social Mobilization Working Groups established and functional in all priority regions (South, West and East regions) and all priority provinces (Kandahar, Helmand and Uruzgan in South and Farah in West)

### **District level:**

- % of high risk districts with DEMA constituted. 50% of districts by June and all districts by September 2012.
- % District Governor submitting report on EPI and polio situation to the provincial governor- (monthly or campaign based).
- % District with PEI/ EPI Coordination Committee constituted and functional. 50% by June and 80% by September 2012.

### **PCA analysis**

- % of children missed by cluster by campaign (<10% in each campaign)
- % Clusters inaccessible before and during the campaign
- % of inaccessible children <5% in each district
- Among all the unvaccinated children, < 10% missed due to no team visit in each campaign
- Among all the unvaccinated children, < 10% missed due to social reasons (Sleeping, Newborn, refusals) by district in each campaign
- % awareness about the campaign prior to team's arrival increased from 50% to 90%
- Reduction in Zero-dose children:
  - number of zero-dose AFP cases by district, by month
  - number of zero-dose children identified based on PPT by district by PPT catchment area by month

### **Cluster level:**

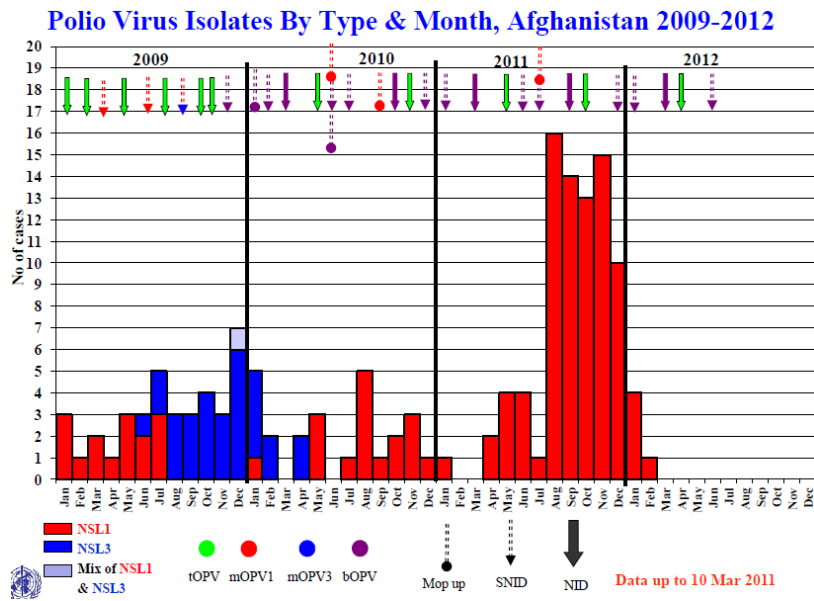
- % villages inaccessible before and during the campaign
- % Clusters inaccessible and are vaccinated as soon as there is window of opportunity before the next campaign.
- Number of zero dose AFP cases by cluster and by month
- % of clusters reporting <90% coverage based on finger-marking
- Among all the unvaccinated children in HRCs, < 10% missed due to no team visit in each campaign



- Among all the unvaccinated children in HRCs, < 10% missed due to social reasons (Newborn, sick or sleeping & refusals) by district in each campaign
- Awareness about the campaign in HRC increased from 50% to 90%

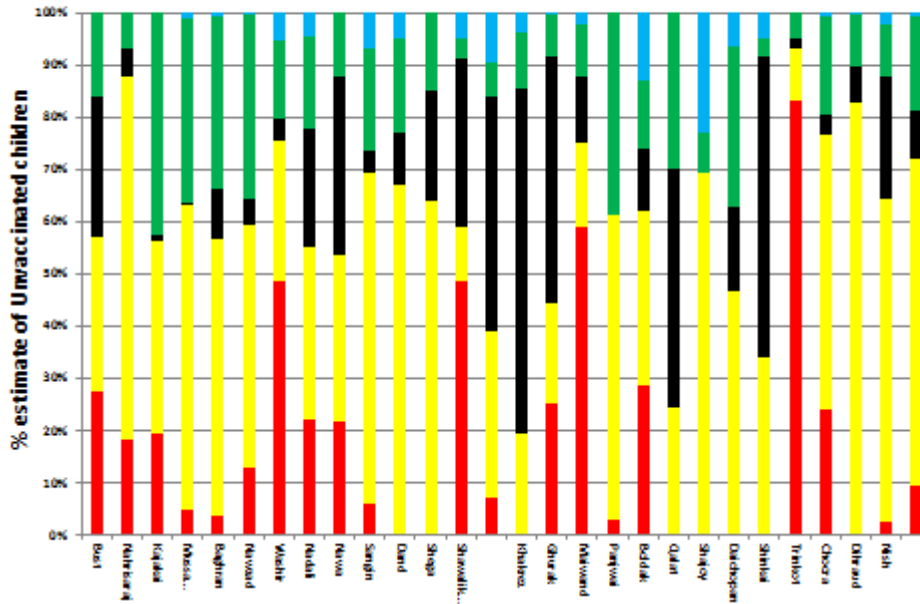
Annex II: SIAs in Afghanistan in 2010-2011 by vaccine type, month and scale

2010			2011		
Month	SIAs	Type of OPV	Month	SIAs	Type of OPV
Feb	SNIDS	bOPV	Feb	SNIDS	bOPV
March	NIDs	bOPV	March	NIDS	bOPV
May	NIDs	tOPV	May	NIDS	tOPV
June	SNIDS	bOPV	June	SNIDS	bOPV
July	SNIDS	bOPV	July	SNIDS	bOPV
Oct	NIDs	bOPV	Sep	NIDS	bOPV
Nov	NIDs	tOPV	Oct	NIDS	tOPV
Dec	SNIDS	bOPV	Dec	SNIDS	bOPV



*Annex III: Extrapolated estimates of reasons for missed children in SIAs including missed due to inaccessibility calculate based on PCA and reported inaccessible children*

Extrapolated estimates of reasons for missed children in SIAs including missed due to inaccessibility  
November 2011, Southern Region, Afghanistan



- Missed due to Refusal based on recall
- Missed due to NSS based on recall
- Missed due to NT based on recall
- Missed due to NA based on recall
- Missed due to inaccessibility

**Annex IV: Human Resource mapping for polio program, by agency by district for high risk districts and by cluster for high risk clusters**

AFGHANISTAN												
POLIO ERADICATION INITIATIVE												
District wise information of Human Resources in High Risk Districts of Afghanistan												
S.No.	Province	District	Target Population	Human Resources								
				Available					Planned			
				Provincial level		District level			Provincial level		District level	
PPOs	Access Negotiator	PPCO	DST	DC	DCFP	PPCO	DPOs	DCFP				
1	Kandahar	Kandahar city/Dand	190250	3	2	1	6	7	3	0	2	
2		Panjwai	25988				2	2	1		1	
3		Daman/Shega	20375				1	2	1		0	
4		Spin Boldak	48930	1			1	3	1		1	
5		Shawalikot	31989	1			2	3	1		1	
6		Arghandab	22955				2	2	0		0	1
7		Khakriz	8716	1			1	0	0		1	
8		Maiwand/Zehrai	43975	1			2	4	2		1	
9		Ghorak	7335				1	1	0		0	1
<b>Kandahar Provincial Total</b>			<b>400513</b>	<b>6</b>	<b>2</b>	<b>1</b>	<b>18</b>	<b>25</b>	<b>9</b>	<b>0</b>	<b>6</b>	<b>3</b>
10	Helmand	Lashkar Gah	73007	1	2	1	2	3	1	0	1	
11		Nawa	40508				1	1	1		0	
12		Nahreseraj	77315				2	3	1		1	
13		Mosa Qal	52967	1			2	3	1		1	
14		Sarban Qala	30550				1	2	1		0	
15		Kajakai	33904	1			1	2	1		1	
16		Baghran	45874	1			2	3	0		0	1
17		Nad -e- Ali/Marja	101655				2	4	2		1	
18		Nawzad	42921	1			1	3	1		0	
19	Washir	15511	1	1	2	1	0					
<b>Helmand Provincial Total</b>			<b>514212</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>15</b>	<b>26</b>	<b>10</b>	<b>0</b>	<b>5</b>	<b>1</b>
20	Urozgan	Terinkot	41820	1	2	1	2	2	1	0	0	
21		Dehrawood	22159				1	2	1		0	
22		Shaheed Hasas	22336	1			1	0	1		1	
23		Nesh	9568	1			1	0	0		1	
<b>Urozgan Provincial Total</b>			<b>95883</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>5</b>	<b>6</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>2</b>
<b>Regional Total</b>			<b>1010608</b>	<b>11</b>	<b>6</b>	<b>3</b>	<b>38</b>	<b>57</b>	<b>21</b>	<b>0</b>	<b>12</b>	<b>6</b>
Note: At Regional												
24	Farah	Purchaman	16,044	1	0	0	2	2	0	1		1
25		Gulistan	13,702				2	3	0		1	1
26		Bakwa	24,803				2	5	0		1	1
27		Balabluk	27,040				2	3	0		1	1
28		Farah	43,684				0	3	0			1
Total West region			125,273	1	0	0	8	16	0	1	3	5
<b>G. Total of 28 HRDs</b>			<b>1135881</b>	<b>12</b>	<b>6</b>	<b>3</b>	<b>46</b>	<b>73</b>	<b>21</b>	<b>1</b>	<b>15</b>	<b>11</b>
PPOs - Provincial Polio Officer (mostly looking after more than one district)												
PPCO - Provincial Polio Communication Officer												
DST - District Support Team (Campaign specific - engaged for 7 - 10 days)												
DC - District Coordinator (campaign specific - engaged 5 - 7 days)												
DPO - District Polio Officer												
DCFP - District Communication Focal person												
Note: At Regional Level WHO Kandahar has One Medical officer, One RPO, One ARPO and one SIAs Coordinator from WHO Side and 1 Polio Manager, 1 polio officer & 1 Regional communication officer from UNICEF Side.												

## *Annex V: Complimentary strategy to support interruption of Polio virus circulation in Afghanistan*

### **Background:**

Polio Eradication Initiative (PEI) in Afghanistan has entered perhaps the most crucial stage since its launch in 1997. While at July and Sep 2011 meetings of the Independent Monitoring Board (IMB), Afghanistan was applauded for continued innovative approaches for interruption; but still not on track to interrupt the virus circulation by end 2011. This is in view of the events of the last few months during which a Polio outbreak has been reported in the Southern part of the country – whereby 54 out of 68 confirmed cases of Polio have been detected with a period of four months (August-Nov 2011). As of 11 Jan 2012, Afghanistan has reported a total of 76 confirmed cases of Polio compared to 25 cases at the same time in 2010. In addition, Polio cases have been detected in 14 provinces scattered in all regions of the country some of which had been Polio free for over a decade!

The assessment that Afghanistan is no longer on track to interrupt WPV circulation by the end of 2012 has led to introduction of a number of innovative approaches aiming at increasing the access to the children in the conflict affected 13 high-risk districts, strengthening district level campaign management capacity, special communication strategies to increase the demand for Polio vaccination and introduction of Short Interval Additional Dose (SIAD) strategy<sup>12</sup>. Afghanistan re-initiated the SIAD strategy in June 2011 in Farah province following reports of a case after almost a year. The strategy has since been used in Zabul, Kandahar, Helmand Parwan and Nangarhar provinces. Case response has also been conducted as indicated in various groups of districts. Last two years, Afghanistan has conducted four National Immunization days and 4 sub-National Immunization Days in South, South east, East regions and Farah province. Management channel was changes from MOPH to NGOs in selected districts of three provinces where BPHS NGOs were given the fund as part of decentralization. The recent spike in cases points to continued gaps and sub-optimal quality of the supplemental immunization activities to reach all targeted children. While a host of factors contributes to this. Two reasons that account most for this failure are weak and ineffective management of campaigns and related activities and inaccessibility to some areas due to a combination of insecurity, conflicts and compromised capacity of the implementers. Afghanistan especially its South is a complex area and efforts to identify and correct management gaps will need to continue in an intensified manner.

Immunization status of polio confirmed cases:

Out of the 76 cases of Polio, 49 have zero EPI routine doses, while 20 of them didn't receive OPV through SIAs.

-

Justification for new initiatives:

- These findings underscore the need to explore additional ways and means to reach the missed children. Continued virus circulation in Polio high risk districts is evidence that despite intensive efforts children in the target age group continue to be missed during the NIDs/ SNIDs.
- Recent review of Afghanistan's coverage data shows decline in routine coverage.
- There is need to ensure that every child is reach at least a minimum of 4 time during the period of a year with 4 doses of OPV to ensure that no zero dose children remain in the high risk populations. Weak management, lack of accessibility and insecurity often make it impossible to cover all areas during Polio SIAs. Therefore, it is being proposed that a team that has 3 months to cover every child in its catchment areas will be much more likely to find windows of opportunity to reach areas that are insecure/ inaccessible for varying periods of time. These teams will also be able to engage communities and their leaders in dialogue in cases of resistance or refusal for vaccination. These contacts will also be used for increasing community awareness and demand for routine immunization.

### **Proposed new strategy:**

The newly proposed strategy will work as follows:

1. Provide at least one dose of OPV to every child under the age of five years in a catchment area once every three months.
2. House to house strategy will ensure that each child gets at least 4 doses in a year.
3. This will be done through development of quarterly plans for each team to visit each village at least once every three months in every priority district or part of it.
4. Number of district team will be according to the microplan based on catchment area and target population. The daily achievable target given the terrain and the population density in the area.

Note: This activity will be in addition to routine immunization and all Polio SIAs (NIDs, SNIDS, and SIADs etc.) and tOPV will be administered.

---

<sup>12</sup>The Short Interval Additional Dose (SIAD) is an intensified approach to deliver two successive doses (passages) of monovalent Oral Polio Vaccine (mOPV) or bivalent OPV (BOPV) within a period of a few days (usually less than 2 weeks). PPT vaccinator will use tOPV but during the training team will elaborate on required gap between two

5. The catchment area will be defined based on climatic, political boundaries, number of households and overall target population.

It is also envisaged that the presence of these teams and their engagement of communities will have a synergistic effect on the Polio SIA activities through updating of maps, micro plans and messages to encourage parents to seek routine EPI services.

**Planning:**

- Human resources: Identification, recruitment and training of both PPTs will be done by a joint team of district SIA manager, PPO, BPHS NGO and PEMT.
- The teams could be identified from within the local community in full consultation with community leaders and or districts Shura. The person should be accepted by community at both sides of the conflict and be able to work at both side.
- Team members should not be withdrawn from SIAs and routine vaccination program and also the PPT should not get involve at any other EPI/PEI activities.
- The PPT teams will work under direct supervision of district SIAs manager or PPO while SIA manager does not exist.
- Provincial immunization teams (PIT) will decide whether to use district SIA manager or district coordinator or both. PPO of WHO will be used while there is no district SIA manager.
- TORs for each polio vaccinators (PPT):
  - o Maintain cold chain and collect required vaccines and other supplies.
  - o Inform community about his/her job and plan
  - o Community awareness about polio, routine, hygiene, sanitation and safe drinking water
  - o Register/record and vaccinate children
  - o Trace defaulters and drop outs
  - o Report on refusal
  - o Report monthly coverage
  - o Make map of the villages
- TORs for district manager in regards to PPT (if PIT want to continue district SIA manager):
  - o Monitor cold chain and PPT performance in regards to cold chain.
  - o Provide vaccine and other supplies to some remote and large village agreed up on with PEMT.
  - o Conduct on-job training for PPT through at least one visit per month to each team
  - o Verify the monthly report
  - o Monitor the performances
  - o Report about the area for routine and SIAs if not reached yet
  - o Deal with refusal and negotiate for access.

Training to be organized for both vaccinators and district manager: Training on micro planning and mapping house to house, recording and reporting of data, defaulter tracing, communication, social mobilization and addressing refusals, cold chain maintenance will be conducted at the provincial level for all PPT members.

Recording and reporting:

- The PPTs will register eligible children in each house. Record name, father name, age, sex, village/mosque name, dose, date and remark. Registration book will be developed.
- Monthly report sheet will be developed based on registration.
- The monthly report will be verified by district SIA manager and PPO and forwarded to PEMT.

Supervision and Monitoring:

- Supervision of PPT will be done by district SIA manager who will cover maximum 6 teams. SIA manager is already deployed through SIAs for high risk district. Where there is no SIA district manager WHO PPO will take his/her responsibilities. This additional job should be added to his TOR. District SIA manager will be responsible to report on monthly performance of the team/individual by the defined criteria.
- The criteria are as follows:
  - o Monthly visit to each village and household as planned for that particular month
  - o Registration of each eligible child
  - o Vaccination of each eligible child (95% coverage)
  - o Monthly report
  - o Report date of routine outreach visit to the village if applicable
  - o Number of meetings with village shura or village elders while no Shura exists
- The existing mechanism of monitoring will be used; post campaign assessment (PCA) and specifically planned visit by PPO, PEMT and BPHS.
- This strategy will be assessed by provincial team on quarterly bases with reports to the province and national levels to evaluate the output of the program. A written mechanism need to be developed for this assessment.
- Also vaccination status of any AFP case reported from these districts will also be used as a monitoring tool.

Communication and social mobilization:

Communication strategy for PPT:

- o Introduce himself and explain his/her TOR to village shura.
- o Explain about SIA and routine to the village shura that both of the strategy will be continued. Dates of NIDs will be communicated with community
- o Deliver message of safe drinking water and sanitation (messages need to be considered at the communication package going to be developed. Also WASH will be in the training agenda).

- Refer if any AFP cases
- It is proposed that, key messages, communication and related training material be developed at the national level and adapted to local needs as / when needed.
- PPT members will be also trained on basics IPC skills.

Logistics: Cold Chain and transport:

- Supplies delivery to hard to reach area will be considered at microplanning (who should be responsible to deliver).
- Given that each district will have approximately 6 teams each team will be using vaccine carriers, collect vaccines from EPI fixed center. In case the area is far from a fixed center, will use cold box and collect vaccine weekly bases from related center.
- District SIA manger who is doing monitoring will require transportation cost for at least one visit per month per team. Cash of AFS 500/day will be granted to the supervision/monitoring visits as per agreed microplan.

Financial implications:

- It has been proposed that the PPT members be paid a monthly salary of \$ 150, while on quarterly best performance \$100 per person will be paid. For no progress same amount of \$150/month/person will continued but for poor performance provincial team should look for replacement.

**Monitoring indicators:**

Impact indicators

- # of Polio confirm cases decreased at the district level compare to the same time of last year
- AFP case report as per standard
- Reduce polio zero cases through SIA and routine immunization
- No refusal
- Reduce drop out and defaulter of routine, SIAs and PPT strategy

Geographical focus: Depend on successful implementation the strategy will be expanded in three phases to reach all 28 high risk districts in 2012. Name and list of the district identified with provincial teams.

**Kandahar:**

1. Spinboldak
2. Shahwalikot
3. Kandhar City

**Helmand:**

1. Nadali
2. Marjah
3. Bust/Lashkargah

**Farah:**

1. Balabulak
2. Khake safid
3. Bakawa

**Follow up actions with timeline:**

1. *Approval and financial commitment of the strategy by MOPH, WHO and UNICEF Dec 2011.*
2. *Meeting with provincial team (PHD, PEMT, and RPO/PPO of WHO and UNICEF, BPHS NGO 11 Jan 2012.*
3. *Finalize costing estimates of piloting the strategy and finalized guidance document detailing the new strategy- before 11 Jan 2012.*
4. *Develop SOP (standard operational procedures) by 20 Jan 2012*
5. *Registers and Reporting formats by 20 Jan 2012*
6. *Adapt training package by 25 Jan and share with the provinces*
7. *Selection of staff by 25 Jan*
8. *Conduct training 28-30 Jan (duration will be defined by local team)*
9. *Send supplies with each team 30 Jan*
10. *Microplan to be prepared during the training*
11. *Launch of activity on first Feb 2012*
12. *PEI partners will jointly develop a funding proposal to explore funding for the new strategy- potential donors to be approached and proposal to be submitted by end December 2011*

## ***Annex VI: The high risk cluster approach to support Polio Eradication in Afghanistan***

### **Background**

Afghanistan is administratively divided into 7 divisions and 34 provinces, which are subdivided into 347 districts<sup>13</sup>. Diverse in nature, South and West are the largest regions in terms of area; while the most densely populated areas of the country are found in the Central and Eastern region, as well as some parts of the West and North.

South Region of the country which has 17% of the country's population is a highest priority area for polio eradication in Afghanistan given that virus circulation has never been interrupted in this region. During the last year 85% of the cases (67 out of 80) were reported from 3 provinces (Kandahar, Helmand and Urozgan) from this region. Another area of concern is the geographically connected Farah province of the West region that reported 5 cases during the last year. Together these 4 provinces are the highest priority areas for PEI in Afghanistan.

To address the specific needs of areas where the program has not been able to achieve much success, the Polio partners in Afghanistan adopted the high risk areas approach to ensure focussed and intensified implementation of special activities in priority areas. For the last 2 years the program had focussed on 13 high risk districts in the Southern region only as these reported the most of the cases in the country due to the security and access issues that led to poor campaign quality. In September 2011, following an internal program review, the list of high risk districts was revised to 28 to include the priority districts from Farah province and new districts in South region that had either been identified as high risk or were surrounded by high risk districts. These 28 districts are spread as follows: 9 in Kandahar, 10 in Helmand, 4 in Urozgan and 5 in Farah.

District focus through district specific plans and increase in human and financial resources has shown mixed results. Increasingly need is felt to focus on high risk clusters (HRCs) within these districts for focussed interventions for improved campaign planning, implementation, community mobilization and engagement and monitoring. This note explains how the high risk districts and high risk clusters have been identified and what special interventions will be implemented in these to interrupt Polio virus circulation.

### **Criteria for identification of high risk districts<sup>14</sup>:**

- Districts having reported confirmed polio cases. (*Weekly polio surveillance update*)
- Districts having reported 0 dose AFP cases. (*Weekly polio surveillance update*)
- Districts facing security and accessibility issues. (*Reports from the field number of missed children, clusters, villages during the campaign*)
- Districts situated in the epidemiological block of high risk districts for polio. (*geographic situation of the areas*)

Using the mentioned criteria, the following 28 were identified as high risk districts for intensified support and implementation of new strategies (like SIAD).

**Table 1: Revised list of High risk districts:**

S. No	Region	Province	No. of districts	Districts
1	South	Kandahar	9	Spinboldak, Daman, Panjwai, Maiwand/Zahray, Kandahar/Dand, Arghandab, Shawalikot/Mianashin, Khakriz and Ghorak
2		Helmand	10	Baghran, Kajaki, Mussa Qala, Sangin, Nawzad, Washir, Nahr e Saraj, Lashkargah/Bust, Nawa Barikzai and Nad Ali/Marja
3		Urozgan	4	Dehrawod, Trinkot, Shahid Hassas and Nesh
4	West	Farah	5	Purchaman, Gulistan, Bakwa, Balabluk, Farah

### **Prioritization of High Risk Clusters**

To have focussed interventions for improved campaign planning, implementation, community mobilization and engagement and monitoring, increasingly need is felt to focus on the High Risk Clusters (HRCs) within these high risk districts. Identification of high risk clusters was carried out by the regional/provincial teams, through review of data of the 5 preceding campaign rounds. However, in very exceptional cases, regional/ provincial team also recommended addition of some cluster subjectively thought to be at high risk due to field observation and knowledge. The criteria are uniformly being used at the field level for identification/prioritization of the HRCs within the high risk districts.

### **Criteria for selection of HRCs**

Any cluster with one or more of the following conditions is categorized/ prioritized as HRC.

<sup>13</sup> There are various district lists in use by the Afghanistan Chief Statistical Office, Ministry of Public Health and others etc. The number used here reflects the one used by the National EPI Cell of the MoPH.

<sup>14</sup> Exercise conducted by WHO in September based in data from January 20122 on wards



1. Vaccination coverage of less than 80% (verified by presence of finger marking and in accessible areas) in any 2 or more campaigns among the last 4 Polio SIAs.
2. Confirmed case (s) of Polio during the year.
3. Zero-dose AFP case (s) during the year.
4. 100 or more children missed due to inaccessibility.

Of all the clusters identified as HRCs for the programme, all those that meet any one or more of the following three criteria are categorized as high risk clusters for communication (HRC-C):

1. An average awareness level about the campaign is less than 55% in the last 4 Polio-SIAs.
2. Irrespective of the total number if average refusals in the last 4 Polio SIAs are more than 5% of the total missed children.
3. Irrespective of the total number, average new-borns, sleep and sick children refusals in the last 4 Polio SIAs are more than 15% of the total missed children.

As already mentioned, in addition to the above, if the regional / provincial teams felt that a particular cluster (clusters having areas of active fighting, land mines, military search operations, history of teams and supervisors harassed or intimidated during the last 6 months, issues with team and supervisor selection, less than 90% team selected through the agreed criteria, and non-local teams or supervisors) should be included in the list, on exceptional basis such cluster were also categorized as HRCs.

#### **Standard Operating Procedures (SOPs) for interventions in HRCs**

Once a cluster is categorized as high risk, the following procedures are adopted for operations:

- It will remain a priority cluster for at least 6 months.
- The regional/ provincial team review plans at the onset, identify critical issues to focus on in the next 3 months.
- Progress against plans will be revised every 6 weeks at the regional level with district teams and every three months with district & cluster teams.
- A data review (same as the one used for identification of HRCs) will be conducted every 6 months. A cluster may be removed from the list of HRCs provided that the problems have been addressed and indicators improved.
- New clusters may be added to the list during the course of the year, based on the mentioned criteria.

The additional activities that will be conducted in these HRCs include:

- Intensified support provided to HRCs from districts, provincial and regional levels for planning, implementation and monitoring of activities.
- All new strategies for PEI will be implemented in these HRCs on priority basis. This will include introduction of new monitoring strategies and intensified access negotiations, where needed.
- Cluster teams will develop/ revise micro plans to resolve the issues identified using data of prior rounds of polio campaign.
- The cluster supervisors and volunteers (team members) will be trained to improve their Inter Personal Communication skills.
- Each team in these clusters will have two vaccinators (as in all teams) and an additional member (a social mobilizer) to support community's awareness, acceptance and demand for vaccination.
- The cluster supervisor, in addition to the vaccination team members, will be responsible for supervision of the social mobilizers (SMs). In these areas TORs of the cluster supervisor will be revised accordingly.

## **VII: Program Management Review**

### **TERMS OF REFERENCE (TOR) - Management review Polio Eradication Initiative Afghanistan**

#### **1. Background:**

Polio eradication efforts in Afghanistan have been on-going for over a decade with both successes and drawbacks seen since its launch in 1994. However, 2011 was one of the toughest years for the programme. After reporting only 25 cases localized to 15 districts in 6 provinces – all in South, West and East region of the country in 2010, a massive Polio outbreak occurred in 2011 with 80 cases reported from 34 districts of 14 provinces in all regions of the country. Although the outbreak was concentrated in the known high risk areas of south and west regions, sporadic cases were reported in some areas that had been polio free for over a decade.

Polio partners are identifying and addressing all possible areas of weakness in the programme that contributed to the outbreak. Review of data from various sources shows that between 100,000 to 200,000 children were missed in the South region alone due to inaccessibility and insecurity issues; and routine vaccination coverage of OPV has declined in the recent past. Even in accessible areas the quality of campaigns deteriorated in some areas as shown by the Post campaign assessments (PCAs). The situation is aggravated further due to the deteriorating routine immunization coverage in the country. Among the various reasons for the sub-optimal quality of polio immunization activities, management and accountability challenges are the most significant ones. Management and accountability are also related to capacities and selection of human resources at all levels, poor quality of training, lack and ineffectiveness of the supervisory and monitoring activities, lack of financial transparency etc. The limited managerial capacities at field and mid-levels have also been identified as an area of concern

Polio programme has been functional in Afghanistan for over 15 years and although managerial structures and roles has developed and expanded to address the programme needs throughout this period, an independent review of how the programme is managed especially at the mid and field levels has not been conducted. The need has specifically risen in light of recent setbacks to polio programme and acknowledgement that underlying management weaknesses contribute significantly to weak performance of field coverage. Program management reviews have successfully been used in private sectors to improve institutional and program performance, effectiveness and potential to achieve results in private. Management reviews do so through identifying gaps in more effective use of all resources including finances, human resources, time etc. through a review of key managerial areas: Policy and Planning, Financial Planning and Management, Human Resources Planning and Management, Governance and Accountability, Planning and Management of programme (campaign) implementation, and Managing programme performance through information. Such reviews are increasingly being used in public sectors including Health sector, as well. Polio Programme review conducted in Pakistan, Afghanistan, Nigeria and India in 2009 identified management problems as the biggest barriers to achieving program aim.

#### **2. Justification for the management review:**

Management issues have repeatedly been highlighted as a significant cause of continued inaccessibility in some areas and poor quality of campaigns in Afghanistan. Managers at field level (cluster and districts levels) in PEI are often illiterate or can barely read and write and are yet required to manage both financial and human resources and providing supervisory support. Managers at mid- level (provinces, region and national level) are often technical staff with medical and public health background but spend more time in managing the programme for which they may have only limited capacity.

Some level of poor and ineffective management is seen in field at all levels. The Independent Monitoring Board (IMB) in its report of October 2011 high-lighted that ‘Afghanistan’s programme is strongly managed and innovative, but is still unable to reach one-third of children in 13 high-risk districts’ and that ‘*The programme’s primary problems are at district and local level rather than national or regional.*’ However, it went on to note that technical capacities in the programme management are strong and weakness lies in the managerial capacities as if often the case in change management programmes saying PEI ‘*will succeed if its vast array of individuals are motivated, organized, well-linked, and well-led.*’ It raised some tough but very pertinent questions like:

- How can it be that individuals known to be tired and ineffective are allowed to remain in key leadership positions?
- How can it be that front-line positions in some countries remain so under-rewarded that they are not attractive to the kind of workforce that the GPEI needs?
- How can it be that some people are not held accountable for poor performance?
- How can it be that some vaccinators are not paid the money that they are promised?
- How can it be that some team leaders are not capable of quality assuring the work they are supervising?

The External Polio communication review conducted by 6 international experts in September 2011, that among other things looked at Afghanistan’s 2000 person strong Polio Communication Network (PCN), identified poor management of PCN as a major factor in insufficient progress in community mobilization and engagement.

### 3. Scope and focus

A management review to assess management practices at all levels especially provincial and district levels is recommended to identify management issues that lead to poor programme performance. The review will look at:

- What the PEI partnership, under the leadership of the Government of Afghanistan, expects from management at each level and what actually happens
- What are the structural needs of the programme and how/ whether current structures, staffing and competencies adequately respond to these needs
- Current and desired programme performance in key management areas:
  - Policy and planning
  - Financial planning, management and transparency
  - Human resources planning and management
  - Governance and accountability
  - Planning and management of programme (campaign) implementation
  - Managing programme performance through information

Of these, the area of governance and accountability need special focus given the lack of formal mechanisms for both and often highlighted issues in programme fund management and expenditure tracking, human resource management, etc.

- Effectiveness of coordination mechanisms across all partners at sub-national , national, regional and global levels ranging from technical partners to donors
- Existing and desired competencies and skills
- Geographic scope
  - National level
  - South, east and west regions
  - 4 key provinces: Kandahar, Helmand, Uruzgan, Farah
  - 28 priority districts

The review's major output will be concrete and feasible recommendations, specific tools and products for the Polio programme to consider for use and roll-out at all levels with focus on provincial and district level in order to achieve programme objective. The implementation of the program review should help to strengthen program management and establish a clear accountability framework to implement the highest quality polio campaigns with >95% coverage of all children under 5 years of age in all areas. The review will support streamlining of the various functions of the program and ensure that the different arms of the program (operations, communication, etc) are operating harmoniously, efficiently and at maximum capacity.

### 4. Process and recommended methodology

It is recommended that an external party (international) led by a consulting firm with experience of conducting management reviews in private and public sectors and in health and non-health sectors be hired jointly by key partners (UNICEF/ WHO) to conduct the management review. It is also recommended that the external part have one or two advisors on PEI (WHO/ UNICEF/ BMGF/ CDC) to support the review team.

#### Step 1: Review of available information

The review team will analyze the following information and additional key documents:

- Polio Eradication Initiative in Afghanistan and its goals and objectives.
- Human resources in place at national, regional, provincial, district and sub-district (cluster) level s to support the programme implementation
- Terms of reference of various staff involved in polio activities at all levels and key tasks that need to be performed at all levels
- Terms of reference of the coordinating bodies (National/ Regional/ Provincial Standing Committee on Polio, Social Mobilization Working Group etc)
- Competencies and skills that are need to perform the job/ tasks.
- Current organograms of key partners at least – MoPH/ DoPH, UNICEF, WHO, NGOs;
- Annual reports on PEI in Afghanistan
- IMB reports for 2011 and 2012 on progress towards PEI in Afghanistan
- CDC and UNICEF quarterly assessment reports
- International Polio Communication Review (2011)

#### Step 2: Gathering and review additional information:

The review team may choose to gather data through the following mechanisms;

- Key informant interviews with team leads and other key persons in key partner organizations at all levels
- Focus group discussions with members of key coordinating and decision making persons and committees at various levels
- Questionnaire to be completed by all levels of managers to self-identify areas of weak management

- Discussions with donor on key perceptions on programme management
- Field missions during Polio campaigns to observe management of the pre-campaign and campaign activities

**Step 3: Prepare recommendations and revised products:**

- Develop recommendations based on the finding of the review process with focus on structures, terms of references, reporting lines and mechanisms, accountability frame work for all Polio related personnel etc.
- Develop the following products including
  - Revised structures for effectively supporting Polio programme with clear reporting lines
  - Revised terms of reference for personnel supporting Polio Eradication efforts at various levels
  - Proposed accountability framework with indicators
- Propose plan for implementation of the recommendations and monitoring indicators for assessing implementation

**Step 4: Presentation of the findings and draft recommendations for consensus building:**

Presentation of findings and draft recommendations and products at provincial level in 4 key provinces and at the national level for consensus building and incorporation of stakeholders inputs.

**5. Final products:**

- A final report on the management review including background, purpose, process, findings, products and recommendations. The report will include the following:
  - Table of contents, Executive summary, introduction, background, methodology and findings
  - Structures for supporting Polio programme with clear reporting lines
  - Terms of reference for personnel supporting Polio Eradication efforts at various levels
  - Accountability framework with indicators
  - Plan for implementation of the recommendations and monitoring indicators for assessing implementation

**6. Duration of review:**

6 weeks

**Additional note on Management functions:**

(Note: These will need to categorizes based on whether they are applicable to all levels or specific levels like national, provincial, district or sub district. The list is not exhaustive.)

- **Policy and Planning**
  - Local policy/ strategy development (adjusting national policies to be applicable to the district, and/or developing additional local policies)
  - Strategic (medium-term) planning & setting priorities for the provincial and district levels
  - Financial forecasting for the programme
  - Support to operational (annual or shorter period) planning
- **Financial Planning and Management**
  - Budget development
  - Budget allocation to services and activities planned
  - Monitoring expenditure against budget
  - Adjustment between budget lines during the campaign and during the year
- **Human Resources Planning and Management**
  - Deciding the number and mix of staff required for the programme
  - Hiring and firing staff/ Selection and recruitment of appropriate staff
  - Setting staff salaries and allowances
  - Deployment of various levels
  - Development of job descriptions
  - Performance assessment
  - Making decisions on retention or termination of staff
  - Training needs assessment
  - On the job education/ training
  - Setting and awarding district health staff incentives - financial
  - Setting and awarding district health staff incentives - non-financial
  - Mentoring and coaching of staff to keep the morale high
  - Supportive supervision
- **Governance and Accountability**
  - Establishment of governance or management structures
  - Deciding on inclusion of community members in cluster and district structures
  - Interaction with the community - seeking information on and responding to community's suggestions
  - Ensuring the community has information on importance of vaccination, service delivery points etc.
  - Intersectoral collaboration

- Negotiating donor support/ fund raising
- Defining the role of the private sector in PEI
- Ensuring that regulation and standards are followed
- Assessment of constraints to performance
- **Planning and Management of programme (campaign) implementation**
  - Development of list of logistics and ensure proper logistics management
  - Development of performance standards for the district
  - Develop of plans specific to that level
  - Procurement of vaccine, cold chain and non-vaccine supplies
  - Compilation and dissemination of relevant information and best practices
- **Managing programme performance through information**
  - Maintaining coverage, integrity, timeliness and quality of routing information on programme
  - Monitoring of performance standards
  - Monitoring coverage by poor and vulnerable groups
  - Monitoring adverse events following immunization
  - Monitoring community engagement
  - Monitoring relevant indicators
  - Monitoring referrals to and from polio campaigns to routine immunization
  - Monitoring vaccine stocks and availability
  - Surveillance for AFP
  - Aggregation of data from lower levels and feedback to them
  - Assessment of effective coverage
  - Reporting on campaign performance to upper level
  - Reporting on campaign and programme performance to stakeholders