

# NATIONAL EMERGENCY ACTION PLAN FOR POLIO

Islamic Republic of Afghanistan

*2016-2017*

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## Acronyms

AFP	Acute flaccid paralysis
AGE	Anti-government element
BMGF	Bill and Melinda Gates Foundation
bOPV	Bivalent oral polio vaccine
BPHS	Basic package of health services
CBT	Cross border team
CCL	Cold chain and logistics
CDC	Centre for Disease Control and Prevention
CHV	Community Health Volunteer
DDM	Direct disbursement mechanism
DPO	District Polio Officer
EMR	Eastern Mediterranean Regional
EOC	Emergency operations centre
EPI	Expanded programme on immunization
FATA	Federally Administered Tribal Area
FLW	Front-line worker
FP	Focal point
GIS	Geographic information system
GPEI	Global Polio Eradication Initiative
HR	High risk
HRD	High risk district
IC	Intra-campaign
ICM	Intra-campaign monitor/monitoring
ICN	Immunization communication network
IHR	International Health Regulations
IMB	Independent Monitoring Board
IPV	Inactivated polio vaccine
IVR	Interactive voice response
KAP	Knowledge, attitude and practice
KP	Khyber Pakhtunkhwa
LPD	Low performing district
LQAS	Lot quality assurance sampling
MA	Monitoring and accountability
MOPH	Ministry of Public Health
mOPV2	Monovalent oral polio vaccine type 2
NCC	National Certification Committee
NEAP	National emergency action plan for polio
NIUG	National Islamic Ulema Group
NPAFP	Non-polio acute flaccid paralysis
NRRT	National rapid response team
OPV	Oral polio vaccine
PCA	Post-campaign coverage assessment
PCM	Post-campaign monitoring
PCO	Provincial Communication Officer
PEI	Polio Eradication Initiative
PEMT	Provincial expanded programme on immunization management team
PPO	Provincial Polio Officer
PPT	Permanent polio team
PTT	Permanent transit team
RCC	Regional Certification Commission
RI	Routine immunization
SIA	Supplementary immunization activity
SIAD	Short interval additional dose
SOP	Standard operating procedure
TAG	Technical Advisory Group
tOPV	Trivalent oral polio vaccine
TOR	Terms of reference
UN	United Nations
UNICEF	United Nations Children's Fund

VDPV	Vaccine-derived poliovirus
VDPV2	Vaccine-derived poliovirus type 2
VHR	Very high risk
VVM	Vaccine vial monitor
WHO	World Health Organization
WPV	Wild poliovirus

**Note:**

- For the NEAP 2016-2017,
  - LPD 1 and 2 districts have been renamed as 'Very high risk districts' (VHR) and LPD 3 as 'High risk districts'
  - PCA has been renamed as 'Post campaign monitoring'

## Background and context

Afghanistan remains one of only two polio-endemic countries in the world together with Pakistan, the two countries forming one epidemiological block. Polio eradication is at the top of Afghanistan's health agenda. In 2015/16, the Government of Afghanistan scaled up its efforts to accelerate polio eradication in the country amidst multiple complex challenges, including increasing conflict and insecurity in many parts of the country.

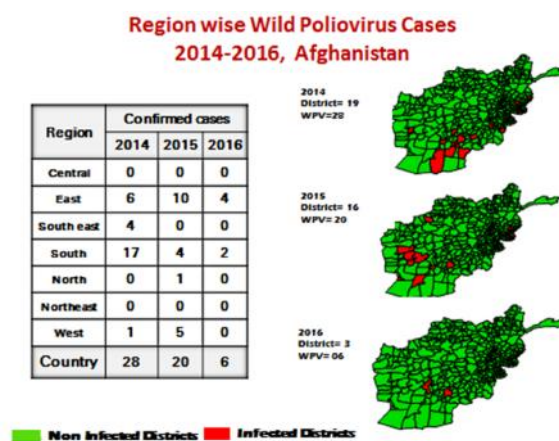
The National Emergency Action Plan for Polio (NEAP) continues to serve as the guiding document for polio eradication activities in Afghanistan. A number of new developments have taken place during the low season for polio transmission to accelerate progress towards stopping transmission. Emergency Operation Centers (EOC) were established at the national and regional levels in late 2015 with the aim to intensify, guide and coordinate efforts of all partners for NEAP implementation under one roof.

Most areas of Afghanistan are polio-free, but wild poliovirus (WPV) continues to circulate in some parts of the country, particularly in the Eastern and Southern Regions. In 2015, Afghanistan reported 20 polio cases (due to WPV) in 16 districts of the country, compared to 28 cases in 19 districts in 2014. To date in 2016, the country has reported a total of 6 WPV cases in 3 districts. It is important to highlight that 4 of the cases in 2016 are from a small geographical area of Sheegal district, Kunar province (Eastern Region) which has remained inaccessible for vaccination activities since 2012.

Afghanistan has continued to expand its environmental surveillance system which now comprises of 14 sampling sites in 5 provinces. In 2015, a total of 37 WPV isolates (?) were reported from environmental samples. As of to date in 2016, no wild or vaccine-derived poliovirus has been detected in environmental samples.

An extensive risk categorization process was undertaken in 2015, based on polio virus epidemiology and other factors. A total of 47 districts were classified as 'low-performing districts' (LPDs, priority 1 and 2), based on epidemiology of WPV transmission, poor routine EPI and SIA coverage, gaps in population immunity and access challenges due to insecurity. These 47 districts contributed 84% of all WPV polio cases in the past 7 years.

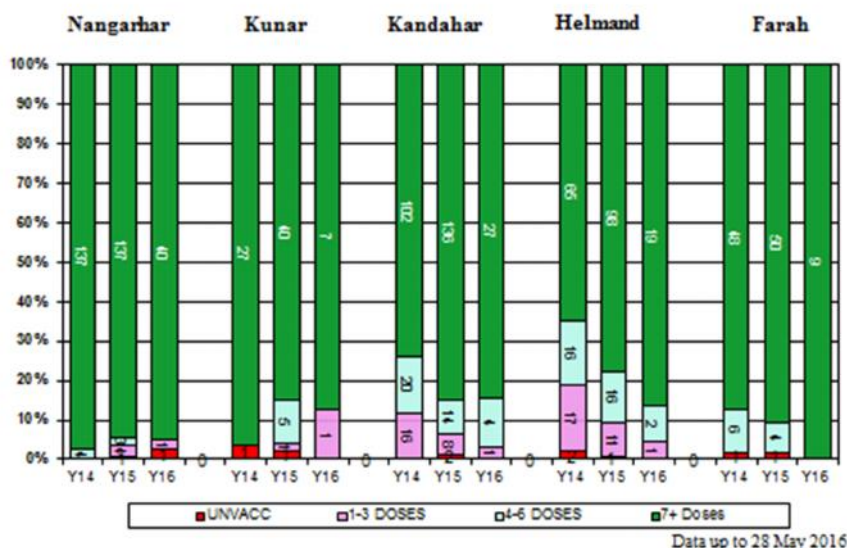
Afghanistan has continued to implement an intensive SIA schedule in 2015-2016; led by the EOCs, a number of new initiatives to further improve SIA quality were put in place during the low transmission season (end of 2015 and early 2016). These initiatives included the roll-out of a new frontline worker (FLW) training curriculum; a modified re-visit strategy (see below); the development of district profiles and district-specific plans; the in-depth investigation of reasons for 'lot failure' in Lot Quality Assurance Sampling (LQAS) surveys; the strategic use of IPV; and microplan validation and revision.



The Programme has focused the implementation of these initiatives in the 47 prioritized districts. These initiatives are starting to translate into improvements in the quality of SIAs. Between November 2015 and May 2016, the number of failed lots assessed through LQAS in priority 1 and 2 LPDs has decreased from 42 to 17%.

Over time, the 'immunity profile' (history of OPV doses received) of non-polio AFP cases has continued to show improvement, as seen in the graph below for 5 high risk provinces.

**Vaccination status of Non Polio AFP cases 6-59 Months- Nangarhar, Kunar, Kandahar, Helmand and Farah Provinces 2014-2016**



Afghanistan shares a long border with Pakistan, forming one common reservoir of poliovirus circulation. There are two epidemiological corridors: an eastern corridor which extends from the greater Peshawar – Khyber area of Khyber Pakhtunkhwa (KP) province and the Federally Administered Tribal Area (FATA) in Pakistan into Nangarhar and Kunar provinces of the Eastern Region of Afghanistan. The southern corridor extends from the Quetta Block of Baluchistan province, Pakistan, into Kandahar and Helmand provinces of southern Afghanistan.

Since the establishment of the polio eradication EOCs, coordination with the Pakistan national polio EOC has been strengthened, including regular cross-border coordination meetings at all levels; harmonization of the target age group for cross-border vaccination; improved cross-notification of AFP cases; microplanning and sharing of data of districts on both sides of the border; production of common communication materials and messages used in both countries and synchronization of campaign dates.

The National Emergency Action Plan for polio eradication (NEAP) has been updated for the period from July 2016 to June 2017 in order to further enhance polio eradication efforts and ensure that Afghanistan achieves the goal of stopping WPV transmission. Focus of the NEAP 2016/17 will be on consolidation and strengthening the quality of the new initiatives which are starting to yield results. These initiatives will be supplemented by full-time household and community engagement approaches, with prioritization of all activities in the very high risk districts (formerly categorized as

LPD 1 and 2). In 2016/17, emphasis will also be placed on the implementation of an accountability framework at all levels.

### Progress during the implementation of the NEAP 2015-2016

The Programme has made significant progress in 2015-2016 through consistent implementation of the NEAP, guided by strong government leadership and through strengthened coordination between partners, following the establishment of the EOCs.

During the January 2016 meeting of the Technical Advisory Group (TAG), experts acknowledged the significant improvement in programme oversight, management and coordination through establishment of National and Regional EOCs, which has greatly strengthened the partnership between Government, UN agencies, and other polio partners. The TAG noted significant programmatic progress, while cautioning that eventual interruption of WPV transmission will require that progress be further fast-track.

The following table describes the key progress in the implementation of the 2015-2016 NEAP.

Area	Progress
Governance and coordination	<ul style="list-style-type: none"> <li>• Polio Steering Committee was formed and first meeting chaired by H.E the President</li> <li>• Regular Meeting of Polio High Council enhanced involvement of line ministries and building of partnerships with relevant departments</li> <li>• EOCs established at National level and 3 high risk regions including the East, West and South.</li> <li>• Governance of PEI was restructured to make communication between regional and national level smoother</li> <li>• Roles and responsibilities of Polio High Council, presidential focal point, minister's focal point and EOCs are clearly defined to avoid overlap</li> <li>• Neutrality of Programme was maintained</li> <li>• Provincial Polio Coordination units in 5 high risk provinces established</li> <li>• Strong coordination among implementing partners, under government leadership</li> <li>• Sanctioning of various managers at different levels, who were relieved from their position due to poor performance</li> </ul>
Focus on LPDs	<ul style="list-style-type: none"> <li>• Method of identifying LPDs modified; 47 LPDs identified as very high risk, responsible for 84% of cases in past 7 years.</li> <li>• Interventions for improving quality of SIAs prioritized and focused particularly on LPDs</li> <li>• District profiles and district-specific plans developed for 47 LPDs 1 and 2.</li> </ul>
Improving quality of SIAs	<ul style="list-style-type: none"> <li>• Revisit strategy modified to include a 4<sup>th</sup> day revisit. This has been scaled up nationally.</li> <li>• Microplan validation and revision completed in 37 of 47 LPDs.</li> <li>• FLW training module revised and all FLWs throughout the country have been trained using the new curriculum.</li> <li>• Supportive supervision from national level has been standardized and strengthened</li> <li>• Post-campaign review conducted, followed by corrective actions to</li> </ul>



	<p>resolve local problems, to improve SIA quality</p> <ul style="list-style-type: none"> <li>• Intra-campaign monitoring strengthened, with real-time data transfer using IVR</li> <li>• Post-campaign assessment (henceforth called Post-Campaign Monitoring) strengthened by expanding it to include all clusters in VHR districts</li> <li>• Use of LQAS expanded to all priority 1 and 2 LPDs, wherever feasible, and where security permits</li> </ul>
Data flow and utilization	<ul style="list-style-type: none"> <li>• Pre-, intra- and post-campaign evaluation data are collected, processed and presented in a timely manner through pre-, intra- and post-campaign dashboards</li> <li>• Administrative coverage data and intra-campaign monitoring information in 5 priority provinces are collected timely and used for action</li> <li>• Post-SIA monitoring data available to Programme within 10 days of the end of every campaign</li> </ul>
Access in security compromised areas	<ul style="list-style-type: none"> <li>• Threat of ban on SIAs in southern region successfully averted on three occasions</li> <li>• Systematic reporting on accessibility shared with partners.</li> <li>• Programme neutrality maintained</li> </ul>
Complementary immunization activities	<ul style="list-style-type: none"> <li>• Review of PTT and PPT strategies conducted.</li> <li>• PPTs reactivated in the southern region</li> <li>• Strengthened PTT and deployment of PTTs in newly inaccessible areas</li> <li>• Cross-border team operations harmonized with Pakistan</li> </ul>
Communication and social mobilization	<ul style="list-style-type: none"> <li>• Findings from Harvard KAP study used for guiding communication strategy</li> <li>• ICN expanded and TOR modified to engage for whole month</li> <li>• Religious leaders sensitized through Ulema's conference at National level and in Southern &amp; Eastern regions</li> <li>• Ongoing social mobilization embedded in district-specific plans</li> </ul>
Cross-border coordination with Pakistan	<ul style="list-style-type: none"> <li>• Quarterly face-to-face meetings between both country teams, and video-conferences at the National level</li> <li>• Monthly meetings at regional and provincial level conducted</li> <li>• SIA calendar synchronized between both countries</li> </ul>
Surveillance	<ul style="list-style-type: none"> <li>• AFP surveillance sensitivity maintained, with all key indicators meeting global standards at National and Regional levels</li> <li>• Reporting network further expanded</li> <li>• AFP focal persons re-oriented</li> <li>• Surveillance review conducted in June 2016</li> </ul>
Cold chain and vaccine management	<ul style="list-style-type: none"> <li>• Global guidelines for VVM &amp; CCL rolled-out</li> <li>• Training of cold chain officers in prioritized regions conducted in June 2016.</li> <li>• tOPV-bOPV switch conducted successfully on 23<sup>rd</sup> April</li> </ul>

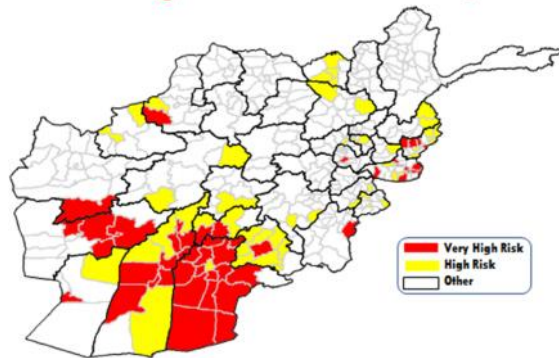
## High risk areas and population groups

The Programme continues to focus attention and resources on high risk areas and populations for achieving the goal of stopping transmission of WPV. There are certain geographical areas and population groups which are more vulnerable to polio transmission and have played a vital role in sustaining the transmission over time.

### Geographical-High risk areas

Based on polio virus epidemiology and other factors including access for implementation of SIAs, population immunity, presence of refugee/IDPs, Afghanistan has identified 5 provinces which are at higher risk of sustaining poliovirus transmission. Disaggregated district-level analysis shows that some districts are at increased risk of polio transmission, and that 47 districts are at very high risk and have been responsible for >84% cases for the past 7 years.

Risk categorization of districts, 2016



The 5 high-risk provinces which are a priority for the Programme are:

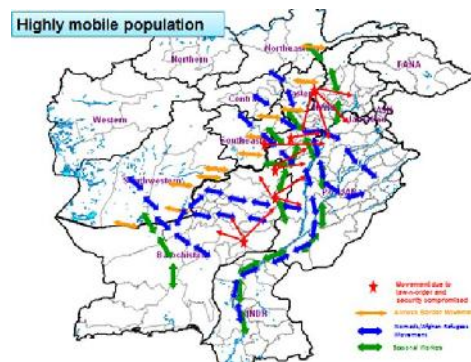
1. Kandahar
2. Helmand
3. Nangarhar
4. Kunar
5. Farah

### High risk population groups

Epidemiological data of polio cases and genetic analysis of isolated viruses show that there is sharing of polio virus circulation among distant areas within the country as well as across the border in Pakistan. This indicates that transmission of virus is being sustained and that virus is being transmitted from one area to another through population movements of different groups of people who are continuously on the move. There is strong evidence to indicate that mobile/migrant populations play an important role in sustaining and spreading poliovirus transmission.

Migrant/mobile and transit populations may vary in different parts of the country; some common types of mobile/migrant population groups are:

- Nomadic populations - who have low socio-economic status and are largely dependent on their livestock, moving from one place to another depending on weather and availability of silage for their livestock.
- Seasonal / economic migrants - who belong to varying socio-economic groups and migrate according to the seasons to support their



livelihood.

### Challenges in access

Access to children for vaccination remains a bottleneck in stopping transmission of WPV, as a large number of children are missed from vaccination during SIAs due to insecurity. Access issues are mostly due to the inability of vaccination teams to reach children in security-compromised areas. There are also areas where it is possible to implement the campaign, but with limitations in the Programme oversight and management.

The Programme has established four categories to designate the access status of districts, which are divided accordingly as follows:

**Category 1- Fully accessible:** These are the districts which are fully accessible for all components of PEI Programme implementation.

**Category 2- Partially accessible:** These are the districts which have some parts which are not accessible for implementing vaccination campaigns, while in other parts of the same district campaigns are conducted.

**Category 3- Accessible with limitations:** These are the districts where implementation of vaccination campaign is possible. However, movement of non-resident supervisors and monitors is not without risk; thus, there are limitations and restrictions on effective monitoring of the performance of all phases of SIA implementation - including FLW selection, training, supervision and monitoring of campaign activities.

**Category 4- Inaccessible:** These districts are fully inaccessible for vaccination campaign implementation.

The cause of inaccessibility as in category 2 and 4 is usually either due to active fighting nearby, or 'bans' on immunization campaigns imposed by local authorities. The number of inaccessible children, and the area of inaccessibility, varies from campaign to campaign, owing to the dynamic security situation on the ground.

In category 3 districts, getting accurate and objective information about the quality of campaigns remains one of the critical challenges for the program. Monitoring and accountability officers are being hired in very high risk districts of this category, to provide information on key indicators of the quality of campaign.

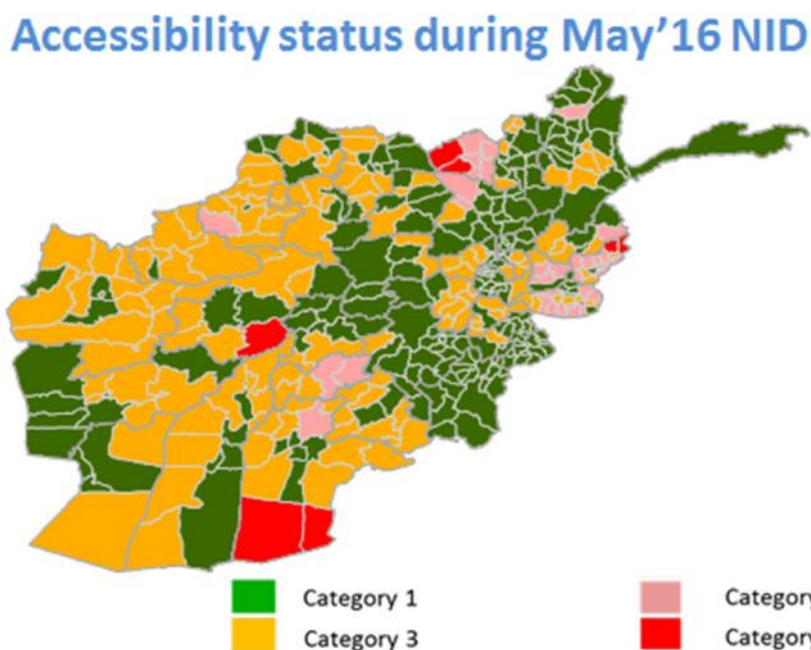
Though the number of inaccessible children varies from campaign to campaign due to the continuously evolving security situation, the table below highlights the number of children in inaccessible areas during SIAs in 2016. Access has deteriorated in the past year, particularly in the Eastern and Northeastern regions.

**Inaccessible children: June 2015 to May 2016 SIAs**

Regions	2015					2016				
	June	August	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Central	17,523									
East	32,799	51,327	61,910	57,232	138,359	41,744	22,938	25,869	30,555	131,781
North		18,880		22,756						3,376
Northeast		6,386		173,818		65,584	97,998	146,810	106,281	165,333
South	584,752	17,830	15,563	51,105	43,424	12,335	7,079	11,684	56,662	22,811
Southeast	450	830	1,793	2,020	91		380		380	400
West	26,935	672								25,410
<b>AFGHANISTAN</b>	<b>662,459</b>	<b>95,925</b>	<b>79,266</b>	<b>306,931</b>	<b>181,874</b>	<b>119,663</b>	<b>128,395</b>	<b>184,363</b>	<b>193,878</b>	<b>349,111</b>

As seen in the table above, access has deteriorated during SIAs conducted since June 2015, particularly in the Eastern and Northeastern regions.

The following map shows the access status according to the four access categories highlighted above.

**Lessons learnt in 2015-2016 period**

The Programme has reflected on key lessons learnt during the implementation of the NEAP 2015-2016 to guide the development of the updated NEAP 2016-2017. Key lessons learnt include:

- Strong coordination at all levels, with clear accountabilities, is critical to achieving results. Results can be achieved most effectively by working as *one team* to deliver *one plan*;
- The Programme needs to continuously adapt to the rapidly changing security context. The Programme must particularly focus on devising and implementing alternative approaches to

gain access to children in inaccessible areas of the Eastern and Northeastern regions , in view of the developments resulting in increased inaccessibility in these areas;

- The Programme needs to put more emphasis on strictly maintaining neutrality;
- Going back to programmatic basics and ensuring high quality, focused activities can yield strong results. New approaches and innovations are needed to overcome challenges, however they need to be targeted to address particular issues;
- Experience from other countries needs to be adapted to the local context. Having issue-specific plans tailored to the local context has proven to be an effective approach to reaching more children;
- The Programme needs to think beyond just gaining access in Southern/Western regions and start putting more focus on rapidly improving quality in all security-challenged areas; and
- Frontline workers (FLWs) are the cornerstone to achieving high quality campaigns. Continued focus and accountability should be placed on ensuring the right selection, on achieving high quality training and sustaining the motivation of FLWs.

### Challenges for 2016-2017

The Programme continues to face a number of challenges to achieving results, including:

- A volatile security situation in many areas, resulting in the inability to access children in key regions of the country, particularly the eastern, southern and northeastern.
- To maintain strict programme neutrality to ensure vaccination activities reach every child across the country;
- Limitation in supervision and monitoring in some areas of the high risk provinces resulting in suboptimal campaign quality;
- Full implementation of the accountability framework at all levels remains a challenge;
- Sustaining motivation and commitment of FLWs and of all stakeholders; and
- Possible funding gap

## Goal

To stop wild poliovirus (WPV) transmission in Afghanistan by the end of December 2016, with no new WPV1 cases from January 2017 onwards.

## Strategic approach

1. Maintain Programme neutrality and gain access to **reach all children with OPV, irrespective of area where they reside.**
2. Implementation of alternate strategies i.e. use of 'Polio Plus' interventions and PTT particularly in inaccessible areas.
3. Focus on identified **high risk provinces/ districts** and areas where children are missed **persistently.**
4. All strategies to be underpinned by strong household and community engagement.
5. Enhanced monitoring and accountability of all stakeholders, at all levels.

## Objectives

1. To interrupt the circulation of indigenous WPV1 in the Southern Region of Afghanistan by the end of December 2016.
2. To interrupt WPV1 circulation in the Eastern Region by the end of December 2016.
3. To rapidly increase the population immunity in high risk provinces and districts by conducting high quality SIAs and complementary vaccination activities.
4. To rapidly and effectively respond to any importation of WPV1 and/or emergence of VDPV2 into polio free areas of Afghanistan, to prevent the establishment of virus circulation.
5. To maintain high levels of surveillance quality across the country, and to ensure all provinces reach and maintaining surveillance quality indicators meeting the global standards.

## Targets and milestones

1. Conduct 4 SIAs in the second half of 2016 and 5 in the first half of 2017.
  - a. Each SIA to reach >90% children as per the monitoring data;
  - b. Improving the quality of campaigns particularly in very high risk districts, with no more than 15% of LQAS lots getting rejected.
2. All very high risk districts to complete one IPV-OPV SIA by end-September 2016.
3. Microplans of all very high risk districts to be revised by end-July 2016.
4. Full-time ICN (Immunization communication network) fully operational in all very high risk districts by end-August 2016.
5. Maintaining an annual non-polio AFP rate of >2 cases/100,000, with adequate stool specimens collected from >80% of AFP cases in every district across the country.
6. Full implementation of the accountability framework by end August 2016.

## Governance and coordination

Improving Programme management and operational implementation was a significant focus of the 2015-16 NEAP. An overall governance framework for the Polio Eradication Initiative (PEI) in Afghanistan was established to encourage evidence-based decision making, improved situational awareness, early problem detection and a coordinated response by both government and partners.

The updated 2016/17 NEAP strongly emphasizes the importance of the governance of the PEI in Afghanistan, with clearly defined roles and responsibilities, and supported by a defined accountability framework.

As highlighted in the NEAP Plan 2015-16, and in order to ensure data-driven and quick evidence-based decision making and timely communication, the governance of PEI has been restructured during the 2<sup>nd</sup> half of 2015, by assigning the core role of PEI management to the national polio Emergency Operations Center (EOC). The following section outlines the renewed structure of governance and coordination.

## Leadership & Coordination

### National Level

Afghanistan's polio Programme has strong support of the highest political leadership of the country. There is direct oversight of polio eradication efforts by H. E. the President of the Islamic Republic of Afghanistan, who continued to monitor and oversee the implementation of the NEAP through to the National Polio Eradication Steering Committee and the Presidential Focal Point for polio eradication. In the first steering committee meeting of 2016, H.E the President emphasized on the importance of maintaining the neutrality of the polio and other health programs.

At the national level there are a number of bodies that continue to govern and oversee the implementation of the NEAP. These include:

- The Polio Steering Committee: The Polio Steering Committee is the highest forum used by the national leadership to support the polio program. The committee is chaired by H.E the President of the Islamic Republic of Afghanistan, and members are H.E the Chief Executive and cabinet members. Meetings of the national steering committee take place on a biannual basis to ensure that the polio eradication initiative is seen and treated as a national public health emergency, with full support from all line ministries whenever and wherever required. The forum brings all involved parties under the umbrella of the accountability framework. The Forum provides overall oversight to the polio programme in Afghanistan.
- The Polio High Council: The Polio High Council meets during the first week of every quarter. This forum is chaired by the Presidential Focal Point for Polio Eradication, with participation by the Minister of Public Health, line ministries and line departments, the polio team and representatives of donor and partner agencies.
- Presidential Focal Point for Polio Eradication: in the presidential palace, H.E the president of the Islamic Republic of Afghanistan assigned a focal point for polio eradication to represent the presidential palace, to provide day-to-day required support through line ministries and governors and to regularly update H.E the President on the progress of the program. The Presidential focal point has regular meetings with line ministries and departments and governors of high risk provinces

to ensure multi-sectorial support for polio Programme at national and provincial level. Recently the office of presidential focal point enhanced the accountability of governors and line ministries.

- The Ministry of Public Health (MoPH) plays the lead role in polio eradication efforts in the country, with an overall responsibility to coordinate and communicate with all partners. The MoPH ensures effective leadership and coordination of bodies established to manage and oversee the programme. The Minister of Public Health appointed a Senior Advisor to the Minister of Public Health as Focal Point (FP) for the PEI, who has close oversight on the day-to-day management of the Programme on behalf of the Minister of Public Health of the Islamic Republic of Afghanistan. The Polio Focal Point ensures that all departments of the ministry of public health provide full support to the program. He has been authorized to hold everyone, in the structure of MoPH, accountable for their role in polio eradication. MoPH will continue to provide overall leadership of the National EOC.

#### Regional, Provincial and District Level

- Recently there has been more active engagement of provincial and districts governors in the polio program, particularly in the high-risk provinces of south, east and western regions. Multi-Sectorial meetings chaired by the provincial governors have been regularly conducted before each round of campaign in Kandahar, Helmand, Nangarhar and Kunar.
- During the 2<sup>nd</sup> half of 2016, the polio team will ensure that in all 5 priority provinces and 47 Very high risk districts, provincial and district polio task forces (multi-sectorial meetings) are fully functional. TORs for provincial and district taskforce will be revised by the end of July 2016 and operationalization will begin by the August NIDs.

### Engagement of line departments and ministries in the Polio Program

Line Department	Area of Engagement
<b>Malaria Department of the Ministry of Public Health</b>	Bed-net distribution to the community will be coupled with vaccination in VHR and HR districts
<b>BPBS implementer NGOs</b>	<ul style="list-style-type: none"> <li>- Polio-plus and health camps interventions in category-2 and category-4 inaccessible districts.</li> <li>- Increasing number of out-reach and mobiles sessions in areas where house to house vaccination is not possible</li> <li>- Working closely with BPBS implementer NGOs for improving routine immunization coverage in 47 VHR districts.</li> </ul>
<b>Ministry of Education</b>	<ul style="list-style-type: none"> <li>- Engagement of school students and teachers in social mobilization and tracking of missed children at community level.</li> <li>- Engagement of Village Education Shuras in the monitoring and accountability of the program</li> </ul>
<b>Afghan Red Crescent Society</b>	<ul style="list-style-type: none"> <li>- Introducing Monitoring and Accountability officers in VHR districts</li> <li>- Health camps and mobile clinic activities in the inaccessible areas</li> </ul>



## Engagement of line departments and ministries in the Polio Program

<b>Afghanistan Telecommunication Regulation Authority</b>	<ul style="list-style-type: none"> <li>- Supporting Polio Programme in Remote Monitoring through mobile technology</li> <li>- Tracking of Post Campaign Monitors in the field through mobile technology</li> </ul>
<b>Ministry of Rural Rehabilitation</b>	<ul style="list-style-type: none"> <li>- To support EOC in recruitment M&amp;A officers</li> <li>- To engage village Shura in Polio SIAs</li> </ul>
<b>Ministry of Haj and Awqaf (Religious Affairs)</b>	<ul style="list-style-type: none"> <li>- To help PEI clear misconception on religious ground and persuade communities for vaccination through engagement of religious scholars</li> </ul>

### Management of the polio eradication initiative

#### Emergency Operation Centers (EOCs)

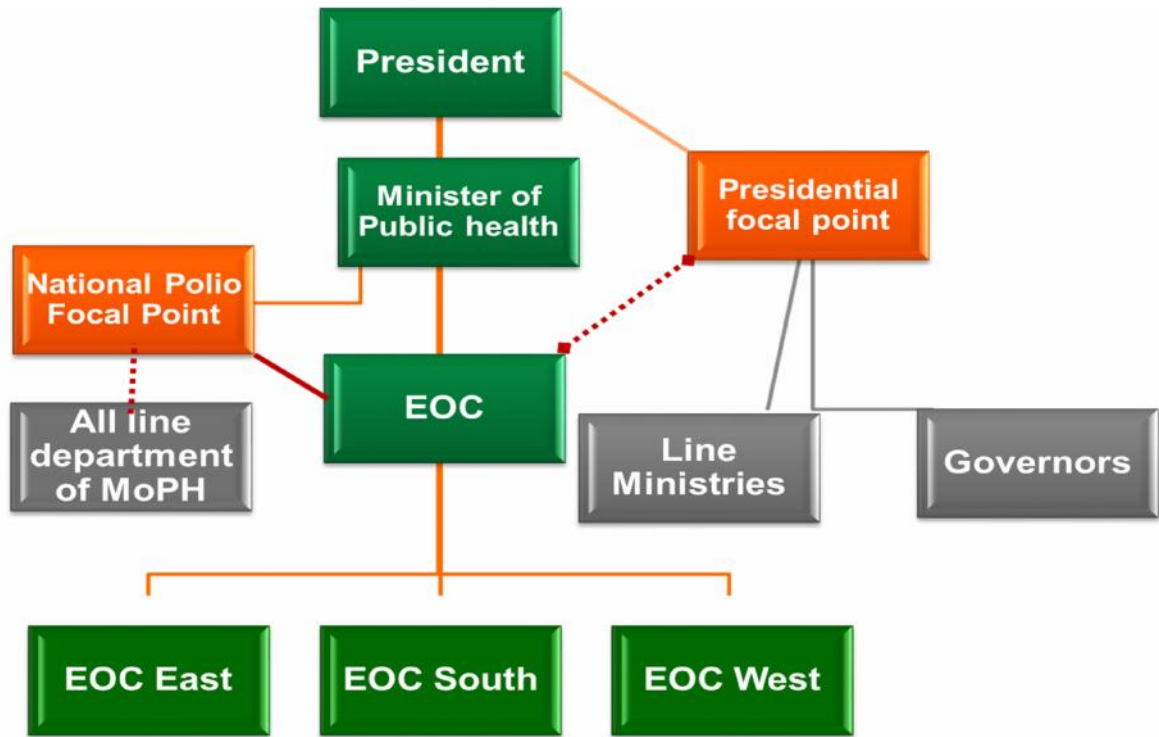
Daily operation of Afghanistan's polio Programme is managed by the Emergency Operation Centers. In line with the recommendations of the global Independent Monitoring Board (IMB) and Technical Advisory Group (TAG), and in order to ensure quick evidence-based decision making and timely communication, EOCs were established at the National level and in priority regions of the country in the last quarter of 2015. Three regional EOCs are functional in Eastern, Southern, and Western regions. The EOC is a coordination body which brings all implementing partners of the Polio Eradication Initiative under a single roof to plan, organize, and implement polio eradication activities. The EOC maximizes the use of existing PEI assets, rather than creating a parallel structure.

The EOC brings together all polio partners to work in the same physical setting for better coordination, information sharing, quick decision making and joint Programme management.

In order to ensure timely communication between districts, provinces, regions and the national level, the EOC cuts across all the red-tape of the government bureaucracies. After the establishment of the EOCs, polio eradication is a nationally-driven program: national EOC has direct reporting and commanding relationship with all regional EOCs, REMTs and PEMTs.

The National EOC has the main stewardship role of the Programme and has the responsibility to define sets of strategies, identify high risk areas, develop tools, evaluate Programme and track performance of districts. The National EOC will continue to ensure that all strategies developed at national level are shared with provinces and take their consultation before finalization. Whilst regional EOCs have some autonomous decision making jurisdiction, their main role is to coordinate and execute the strategies set at national level.

In addition to the EOCs, provincial coordination units were established during the first quarter of 2016 in five priority provinces (Kandahar, Helmand, Farah, Nangarhar and Kunar) to support data management.



## Key strategies

### Focus on high risk areas

Analysis of past cases in Afghanistan has shown that more than 80% of cases have come from 5 provinces which are Kandahar, Helmand, Nangarhar, Kunar and Farah. These provinces are considered as 'High risk provinces'.

Further disaggregated analysis at district level shows that 47 districts of the country have been responsible for 84% of cases in the past 7 years. These districts are called 'Very High risk districts (VHRDs)'. There are another 49 districts which are at relatively lower risk and are called 'High risk districts (HRD)'.

The geographical focus for 2016/17 takes into consideration the above risk categorization. All the key strategic interventions will have special focus and prioritization in these 5 high risk provinces and 47 VHR districts. All 47 VHR districts have been profiled and district-specific polio action plans have been developed, based on the locally specific issues and challenges.

The district profiles and district-specific plans will be further strengthened and updated after every SIA, to address the challenges/ bottlenecks identified during each campaign.

The analysis to identify high risk districts will be conducted again in December 2016 to adjust for changing epidemiology and emerging scenarios.

### Supplementary Immunization Activities

In 2016/17 the Programme will continue to follow an intense OPV SIA schedule - 2 NIDs and 2 SNIDs in the second half of 2016; and 2 NIDs and 3 SNIDs in the first half of 2017. The SIA dates will be synchronized with Pakistan.

For every new case detected, the Programme will conduct 3 case response campaigns targeting at least 500,000 children surrounding the area where the case has been detected.

### *Inactivated Polio Vaccine (IPV)*

All the VHR districts which have IPV SIAs planned for 2015-16 will complete the campaigns by the end of Q4 2016. IPV campaigns will also be planned for every newly accessible area which has been inaccessible for more than 6 months and/or 3 vaccination opportunities (Annex XXX). Currently the 276,000 target children < 5 yrs in 31 districts meet this criterion. The Programme will also consider using IPV in selected areas, if any new transmission is detected in a high risk area with security challenges.

In 2017, the Programme aims to conduct IPV-OPV SIAs in the remaining 13 very high risk districts, apart from Kabul, where such campaigns were not yet conducted in 2015-2016. The list of districts is as follows:

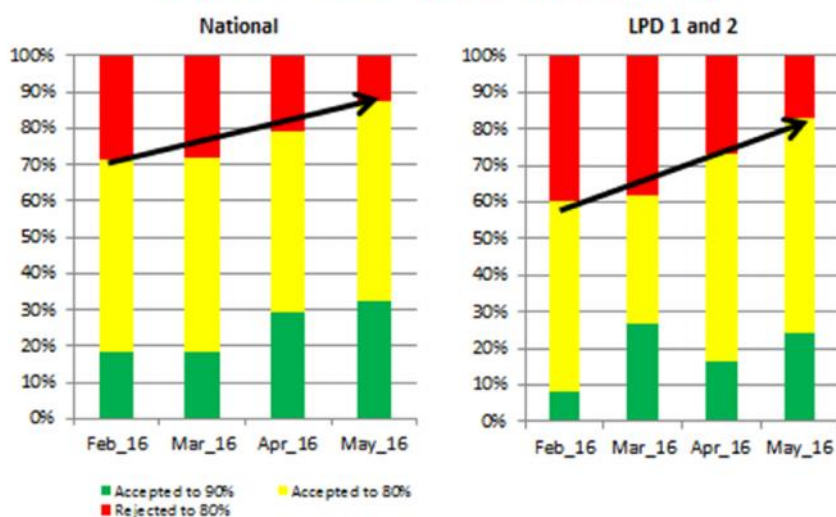
Region	Province	District	Target
East	Nangarhar	Behsud	117,210
East	Nangarhar	Jalalabad	57,559
North	Faryab	Qaysar	46,578
South	Helmand	Lashkargah	56,024
South	Helmand	Musaqalah	26,493
South	Helmand	Nad-e-Ali	120,835
South	Helmand	Nahr-e-Saraj	63,484
South	Kandahar	Kandahar	162,873
South	Nimroz	Zaranj	49,974
South	Uruzgan	Dehrawud	26,010
South	Uruzgan	Tirinkot	50,448
South	Zabul	Qalat	29,339
Southeast	Paktika	Bermel	19,286

### Enhancing campaign quality

The figures from the Post Campaign Monitoring Survey shows that during 2015, around 7% of target children were missed owing to gaps in the quality of campaign. The proportion of missed children was even higher in southern regions with approximately 10% children being missed during each round of SIAs. LQAS results showed that around 30% of across lots across the country were rejected during any given round of SIAs in 2015.

There has been significant improvement in recent past and proportion of rejected lots has reduced from 30% to 12% in the country, whilst in focused areas, the proportion of failed lots reduced from 40% to less than 20%.

## Progressive improvement in SIA quality LQAS results (Q1-Q2, 2016)



The Programme has identified a number of interventions to improve the quality of campaigns and these will be prioritized in the 5 high risk provinces and VHR districts.

The focus of the Programme is now on identifying chronically missed children and taking steps to identify and reach them.

Key interventions for improving quality are:

### **Revision of microplans**

Microplans of all the districts will be regularly updated to include new settlements. Microplans of all 47 VHR districts are being revised using GIS maps and field validation to develop integrated microplans. The aim of this exercise is to ensure that:

- All the settlements are included in microplan;
- There is a rational distribution of workload of vaccination teams, by supervisors and district coordinators;
- Team and Supervisor maps are available for all areas, including major land marks and social components i.e. key influencers and mobilizers, important sites (mosques, schools, markets, gathering places), high risk population groups, etc.; and
- Microplans include information and plan for vaccination at major transit points as well as for mobile population groups where applicable.

As of June 2016, the process of updating microplans in all VHR districts has been completed in 37 districts and is in process in 10 districts. The process will be completed in all the remaining VHR districts by the end of Q3 2016.

The microplan validation process will be reviewed and strengthened even further in 2016/17 to improve quality. Microplan validation with the revised methodology will be conducted in a phased manner also in all 49 High Risk (HR) districts in Q4 2016 and Q1 2017.

### **Frontline workers selection, motivation and capacity building**

Front-Line Workers (FLWs) are the key polio field staffs, who actually deliver polio immunization services to the population. Poor team performance often manifests itself as 'child absent' and 'households not visited' during campaigns. Efforts in the next year will be focused on improving team performance by ensuring FLWs are carefully selected using a transparent and criteria-based approach; will be equipped with the appropriate skills, information and materials to optimally perform their job; and are kept motivated.

In the first half of 2016, the FLW training curriculum was revised based on the results of a training needs assessment that was undertaken in 2015. All frontline workers across the Programme were trained in the new curriculum which was based on adult learning principles.

In 2016/17 the programme will pay particular attention to improving the selection process of FLWs as well as to improve their capacity through ongoing training. Major relevant activities will include:

#### *Improving team selection*

- The basic principle will be that all FLWs should be selected from and within communities based, on merit. This pre-requisite applies to both accessible and inaccessible areas.
- Efforts will be made to engage female vaccinators, preferably community health workers (CHWs) wherever available and feasible.
- Each two member team should have at least one team member who is able to read and write.

*Improving the quality of training*

- All vaccinators will be trained, using the revised training curricula, ahead of every second SIA.
- The quality of training in VHR districts will be monitored from province/ regional level and feedback will be provided back to the national level; and
- The National EOC will track training attendance and quality (training attendance to be >90%).

*Monitoring and performance management*

- Performance of vaccinators and supervisors will be tracked over the campaigns, particularly in all VHR districts;
- As per the accountability framework, well- performing FLWs will be recognized/ incentivized and poor performers will be sanctioned.

*Ensuring timely payment of FLWs*

There have been concerns regarding payment to FLWs both in the terms of amount and also the timeliness of distribution. In view of this, rates for FLWs have been revised in Q2 of 2016 to ensure parity across the country.

Currently the programme is using two methodologies for financial transactions. One is the Direct Disbursement Mechanism (DDM), which makes payments available directly to target beneficiaries using the banking system or mobile phone technology (M-Paisa). The other method is cash distribution to FLWs following a cash transfer to the local polio partners' joint account. Currently XX% of beneficiaries are being paid through DDM. Distributing cash to FLWs, in every province and locality, should only be undertaken in the presence of financial committee representatives. In 2016/17:

- The Programme will aim to ensure the payment of vaccinators within 30 days of the end of every campaign;
- Payment of vaccinators will be tracked from the national level and corrective actions will be taken on any delayed payment;
- The Programme will strictly apply a 'zero tolerance policy' related to any misappropriation of payments and PEI resources.

**Intensified supportive supervision**

Supervision of all phases of a campaign will be intensified by systematically engaging National, regional and provincial level Programme staff including EOC members for supervision in the field- particularly in the 5 focused provinces and VHR districts. To meet these expectations, the following interventions will be implemented:

- Identification of national and regional level monitors from different agencies, who will be trained on supportive supervision, standard tools and Programme oversight.
- Deployment of these monitors to high risk provinces to oversee and take corrective actions during the pre-campaign phase and for the whole duration of the campaign.

- Concurrent feedback and corrective action at local level along with daily feedback to regional and national EOC. A final debriefing at national level will be held with a focus on follow up actions discussed during the post campaign review meeting.

The quality of supervision by frontline supervisors (cluster supervisors) will also be enhanced by:

- Rationalizing the workload of Cluster Supervisor by ensuring each Cluster Supervisor covers a maximum of five teams;
- Intensive training of Cluster Supervisor on supportive supervision techniques;
- Enhanced supervision of Cluster Supervisors by District Coordinators and Intra-campaign Monitors (ICM);
- All supervisory checklists to be analyzed at Provincial Level; and
- Tracking of performance by cluster supervisor area including all components (i.e. PCM, training attendance, missed children).

### Revisit strategy

In early 2016, the Programme has modified and expanded the 'revisit strategy' (i.e. strategy for the vaccination team to revisit households where one or more resident children were missed from vaccination during the first team visit) as recommended by the Technical Advisory Group (TAG). Key changes in the revised revisit strategy include:

- Strengthening the team revisit during campaign days through improved planning, closer monitoring and supervision, and
- Increasing the time gap between the first visit and revisits during and after campaigns.
  - Days 1-3: During campaign days, the team to return to follow up and vaccinate all missed children in the afternoon after a break (after 2:00 pm), following the same route as in the morning to maximize the amount of time for missed children and/or caregiver to return.
  - Day 4: One day break to ensure adequate planning is done for the post-campaign revisit
  - Day 5: Post-campaign revisit day to fall on a Friday to maximize the number of children and caregivers found at home.
  - ICN mobilizers to follow up on outstanding missed children before the next campaign.
- Supervision and Intra-campaign Monitoring (ICM) has been modified to incorporate the revised revisit strategy.

The Programme will further strengthen the revisit strategy by:

- Full implementation of this strategy across the country;
- Tracking the impact of the revisit strategy by doing disaggregated data analysis and taking corrective actions in areas with poor impact.

### Enhanced monitoring

It is very important to systematically monitor all phases of every campaign, including pre-, intra-, and post-campaign, to take corrective actions for improving the quality of SIAs in the ongoing and subsequent campaigns.

There is an established system of Intra-campaign monitoring (ICM) and of post-campaign monitoring using 'Post-campaign monitoring surveys', LQAS surveys and 'out of house' surveys.

The Programme has implemented the following interventions to strengthen monitoring:

- Use of IVR technology for real time data collection from ICM;
- ICM checklist and guidelines have been revised;
- Expansion of LQAS to all LPD 1 and 2, wherever feasible and where security permits;
- 100% of clusters (supervisory area) are surveyed during the PCM in VHR where accessible; 50% of clusters are sampled in other districts;
- Monitoring of monitors doing PCM;;
- Detailed field investigation of all lots failed in LQAS or clusters with more 3 children missed in PCM;
- Disaggregated information of 'children missed due to refusals' has been initiated to differentiate between hard core refusals against children missed due 'new born, sick or sleeping'; and
- PCM and LQAS data are being made available to the Programme within 10 days at the end of every campaign.
- Deployment of Monitoring and accountability officers in selected LPDs (1 and 2).

The programme will continue to systematically monitor key activities throughout the campaign cycle to guide corrective actions for improving SIAs in the ongoing and subsequent campaigns. The data team at the EOC will update the campaign dashboards on a timely basis and collect information from the provincial level.

To further enhance understanding of the situation on the ground for corrective actions, Monitoring and Accountability (MA) officers are being deployed in the VHR districts.

The concept of deploying Monitoring and accountability officers to the very high risk districts is to strengthen the monitoring of pre-intra-post campaign activities to ensure that there are no impediments to the implementation of high quality SIAs. Cadres of independent officers are being deployed to collect and verify timely and reliable information at the district for transmission directly to National EOC.

- To date, 11 MA Officers are working in selected districts of Kandahar.
- Plans to expand to all 47 VHR districts
- National EOC will have 4 MA focal persons to collect, compile and present the information to EOC for corrective action.

For further strengthening of monitoring mechanism and use of information for corrective action, the following activities are envisioned:

- Pre-campaign monitoring
  - National level monitors will be deployed to priority provinces and very high risk districts to monitor the pre and intra campaign phases during every SIA.
  - Use of standardized checklists and concurrent feedback system will be further strengthened.



- Pre campaign dashboard: National EOC will receive regular feedback from regions/provinces on the preparatory status of campaigns and ensure corrective actions are taken as needed, including possible postponement of a campaign based on preparedness.
- Intra-campaign monitoring
  - Improving the selection and training of ICM staff to ensure well trained, high quality ICMs.
  - Increasing the number of ICM in 47 VHR districts to have 1 ICM for every 5 cluster supervisor
  - Ensuring ICM data is collected in real time using IVR technology in the VHR districts and shared immediately for corrective action;
  - Intra-campaign dashboards will be made fully functional and used for corrective actions on a daily basis.
  - Complete ICM data will be collected and analysed at national and regional levels for corrective actions in subsequent campaign.
  - ICM data will be used during the evening meeting and post campaign review meetings
- PCM
  - PCM will continue to target 100% of clusters in 47 VHR districts and 50% of clusters in other districts
  - Selection and training of PCM monitors in 5 high risk provinces will be directly overseen by the national level.
  - The system of monitoring of monitors (in process and after the monitoring) will be institutionalized to ensure quality of monitoring. This will include using mobile technology for verification of quality of monitoring. A total of 5% of monitors/surveyors will be cross checked by PPO/PCOs and DPO/DCOs during monitoring activities. As well 5% of formats submitted will be validated in the field for correctness. Any discrepancy to be documented including corrective actions taken.
  - The performance of monitors will be tracked over the round and 'zero tolerance' policy will be used for any defaulters.
  - The PCM data will be made available to the Programme within 10 days from the end of the campaigns.
  - Detailed analysis of PCM data including reasons for missed children by district will be used during the post campaign review meeting for corrective actions.
  - For any cluster area where PCM detects that >3 children were missed
    - A detailed field investigation to be conducted by a joint team (UNICEF, WHO, MoPH) using a standard tool to identify and document key root causes of poor performance and to plan for corrective actions for subsequent campaigns.
    - Concerned area will be recovered to reach missed children.
  - In districts containing both government and AGE areas, the PCM will be conducted in both areas of influence (if allowed) and results analyzed separately.
- LQAS
  - LQAS will be further expanded to include all VHR & HR districts wherever security situation allows.

- The current system of LQAS surveyor's engagement will be reviewed and if necessary and feasible, 3<sup>rd</sup> parties (contractors) will be engaged.
- To ensure high quality of LQAS, 10% of surveyors to be cross checked by PPO/PCO during monitoring activities. In addition, 10% of completed forms will be validated in the field for correctness. Any discrepancy to be documented including corrective action taken.
- For every failed lot in LQAS:
  - A detailed field investigation will be conducted by a joint team (UNICEF, WHO, MoPH) within 7 days using a standardized tool to identify and document key root causes of poor performance and to plan for corrective actions in subsequent campaigns.
  - Concerned area will be recovered to reach missed children
- LQAS results will be available to the Programme within 10 days from the end of campaigns.
- Out of house surveys
  - Out of house surveys at market places/ other public places will be continued and enhanced in 5 high risk provinces
  - It will have more focus in access-challenged areas
- Innovative technology for monitoring
  - Use of mobile technology for monitoring of monitors (PCM and LQAS monitors)
  - Use of IVR to collect real time information from ICMs
  - Use of mobile technology for fast tracking PCM and LQAS data from 5 high risk provinces
  - Remote monitoring using telephonic surveys will be conducted in access compromised areas to assess coverage.
  - Use of mobile technology for tracking the performance of ICM.

### **Campaign coordination and review meetings**

Campaign review/ coordination meetings take place during the pre-campaign phase for ensuring good preparedness, during the campaign for concurrent corrective action and after the campaign for using the lessons learnt to improve the quality of the subsequent campaign.

#### ***Pre-Campaign Coordination Meetings***

- Prior to a vaccination campaign, coordination meetings will be held at the National, regional and provincial levels, with participation from polio partners, the provincial health office and BPHS NGOs.
- Depending on the frequency of campaigns, the coordination meeting will be conducted between two and four weeks prior to the campaign.
- At National level, the meeting will focus on:
  - Support to be provided to regions/ provinces for ensuring good quality preparation
  - Lessons learnt from past campaign and corrective actions to be taken
  - Calendar of activities for National and regional level
  - Deployment of National monitors for support in the preparatory phase.
- Pre-campaign preparedness will be monitored closely on a daily basis by the National EOC, using the pre-campaign dashboard.

- Key components tracked will be microplanning, FLWs training, Social mobilization and V&L availability.
- The state of readiness will be assessed at 10/7/3/1 day prior to every campaign
- Corrective actions required will be taken including support from National EOC including the deployment of additional national monitors.
- If the district/s are not found to be adequately prepared by 3 days prior to implementation, the campaign will be postponed by the National EOC and support will be provided to ensure full preparedness.
- At regional level the meeting will focus on
  - Development of a schedule of activities including training plans
  - Plan of action to address challenges identified in the previous campaigns.
  - Deployment of regional/provincial staff to support field preparation
- Meeting at high risk regions/provinces will be attended/ supported by representatives from the National EOC.
- Provincial and district taskforce meetings will be held before every campaign chaired by provincial and district governors respectively.
  - Participants of the Provincial Taskforce will include the PEI/EPI team, provincial public health director, representatives of line ministries and departments and governors of high risk districts.
  - The primary focus of these taskforce meetings will be to ensure the full engagement of all line departments and to strengthen accountability at all levels.
  - The Provincial task force meeting will be held 2 weeks before every campaign
  - Provincial task force meeting will be followed by the district taskforce meetings which will take place one week prior to every campaign.

#### ***Intra-Campaign Review Meetings (Evening meetings)***

- The polio programme has been conducting evening review meetings of campaign organizers and monitors (including IC monitors) at the district level at the end of each campaign day to review the day's activities and plan corrective action to respond to identified problems.
- In the first half of 2016, the Programme has enhanced its focus on closely tracking the evening review meetings. The focus of 2016/17 will be on improving the quality of these meetings. A standard matrix will be used to register the findings of evening review meetings and to note the actions to be taken to respond to reported issues and problems.
- Intra-campaign reviews will also be done at National, regional and provincial level during which the core team will review the progress, key challenges and take necessary corrective actions.
- Daily feedback will be taken from ICM (data) and National/ regional monitors in field along with the operational feedback from EOCs and PEMT.

#### ***Post-Campaign Review Meetings***

- Post campaign reviews are conducted National, regional and provincial level to identify the key challenges encountered during the campaign and to develop a plan of action to address them in subsequent campaigns.
- It is envisioned that post campaign review meetings will be conducted at National/Regional/Provincial level within 15 days after the end of each campaign.

- In five high risk provinces, these meetings will have representation from the National EOC for support and inputs.
- The campaign data including pre-intra-post campaign information will be reviewed to identify key issues to inform updated plans of action. These plans will be, shared with National EOC. This forum will also update the 'District profile and plan of action' for the 47 very high risk districts.
- The National EOC will track the outcomes of these meetings and follow up on progress and support required.

### Community health volunteer (CHV) strategy

The Programme has initiated an innovative approach for improving the quality of campaign in selected areas. The CHV approach is to deploy local female/male permanent community volunteers to conduct social mobilization, reach and vaccinate continuously missed children.

This strategy is being piloted in Behsud district of Nangarhar and is showing promising results. As recommended by the TAG in January 2016, another pilot is being planned for Spin Boldak of Kandahar, which represents the challenges of 'very high risk districts'

As recommended by the TAG, results of the pilot will inform decisions on possible future expansion.

### Data collection, collation, transmission and use

Data and analysis provides the foundation for evidence-based decision making and corrective actions that will address persistent gaps in Programme performance. Afghanistan's polio Programme collects different streams of data in different phases of campaign and uses it for corrective action and accountability. Dashboards have been developed for easy visualization, analysis and tracking of the key indicators in the Pre-intra-post campaign phases.

Key data streams/information collected and analyzed by the Programme are as follows:

- Pre-campaign:
  - Information on preparation including training, microplanning, social mobilization, vaccine & logistics delivery
  - Pre-campaign coordination meeting
- Intra-campaign:
  - Administrative coverage including missed children covered during revisit
  - Intra-campaign monitoring data
  - Data/information on evening meeting
- Post-campaign:
  - Post campaign monitoring data
  - LQAS results
  - 'Out of house' survey results
  - Administrative coverage

The following table shows the source and timeline of availability of different data/information

	Data	Source	Timeline
Pre-campaign			

1	Preparation of campaign	EOC/PEMT	2 weeks, 1 week, daily in last week
2	Coordination meeting	EOC/PEMT	10 days before SIA
<b>Intra-campaign</b>			
3	Administrative coverage	EOC/PEMT	Next day afternoon
4	ICM	EOC/PEMT	Next day afternoon
5	Evening meeting	EOC/PEMT	Next day afternoon
<b>Post-campaign</b>			
6	Administrative coverage	EOC/PEMT	10 days after SIA
7	PCM	WHO	10 days after SIA
8	LQAS	WHO	10 days after SIA
9	Out of house survey	WHO	10 days after SIA
10	Compiled ICM data	EOC/PEMT	10 days after SIA
11	Access data	EOC/PEMT	10 days after SIA

### Data collation, analysis and Dashboard

All the data collected from different sources will be fed into an EOC database where it will be analyzed and displayed through a series of dashboards to guide decision-making.

The team responsible for maintaining the EOC database will have representation from government and partners.

### Use of mobile technology for fast tracking data transmission

Programme has started using IVR technology for real time data transfer from ICM from selected areas.

Use of mobile technology for real time transfer of administrative coverage, ICM, PCM and LQAS will be explored and expanded by the December 2016.

### Strategies for access challenged areas

The Programme has been making efforts and aims to reach all children with vaccine irrespective of area where they live in by maintaining Programme neutrality, negotiations at different levels through local mediators, conducting catch up campaigns in newly accessible areas, permanent vaccination points around inaccessible areas and implementing polio plus strategy.

For 2016-2017, throughout all polio activities and for the day-to-day management of the Programme the 'ground rule' of strictly maintaining the neutrality of the Programme will continue to be maintained.

### Areas inaccessible for vaccination

In the category 2 and 4 districts, the Programme will continue and reinforce following interventions:

- Negotiations at different level through neutral and credible mediators to help in gaining access to children in the inaccessible areas
- Cluster and village level mapping of accessibility and conducting campaigns in all the areas accessible.
- Deployment of PTTs on all the entry and exits routes of inaccessible areas, vaccinating all eligible children to create a firewall of immunity around the inaccessible areas;

- Using a 3 phased approach of SIADs with one round of OPV+IPV round in the area, to boost the immunity of children in the newly opened area. Age group of one of the campaign will be increased to target children up to 10 years of age.
- Scaling up polio plus initiatives (Add on services along with polio vaccine e.g. EPI services, outreach health services, hygiene kits, bed nets etc. depending on the local context and community demand) in and around inaccessible areas to respond to other felt needs in these communities where feasible and to pull people out of inaccessible areas.
- Ongoing community engagement activities including with local elders.

An updated report after each SIA will be shared with polio partners which highlights the location and size of inaccessible areas, including the assumed underlying causes, and outlines actions taken and planned to re-gain access.

### Areas accessible with limitations

The Programme will intensify its focus in the areas where vaccination campaigns are feasible however there is limitation in oversight and Programme management due to insecurity and interference (Category 3). Key interventions planned are:

- Negotiations at all levels with key authorities/stakeholders on the quality of campaigns and independence in monitoring.
- Deployment of monitoring and accountability officers in all the 47 very high risk districts including the districts with this specific challenge to provide information on key indicators.
- Sharing the feedback on the gaps in quality and operations with concerned authority.
- Remote monitoring of quality of campaigns using mobile technology.

### Complementary immunization activities

The Programme continues to implement a range of special complementary immunization activities to ensure that special populations on the move are reached during and in-between polio campaigns. Complementary immunization activities include special activities planned around the inaccessible areas, at busy points, at the border crossings and for nomadic populations. Efforts will be made in 2016/7 to improve the quality of these activities and to expand the scale and scope of these activities according to programmatic need. The strategies include:

#### Permanent Transit Teams (PTTs)

PTTs are established to vaccinate children on the move and for children moving in and out of inaccessible areas. A total of 6.3 million children were vaccinated by PTTs during 2015, whereas 3.8 million children have already been vaccinated by PTTs in the first 4 months of 2016. The number of PTTs has been revised from 62 in 2015, to 264 during 2016.

In 2016-2017, the Programme will

- Continue to assess and modify the number and location of PTTs as per need of the Programme and evolving accessibility situation.
- Strengthen supervision and monitoring of PTTs with close tracking from National EOC on monthly basis.

### Permanent Polio Teams (PPTs)

Based on the concept developed for PPTs, these are to provide OPV to target age children on a continuous basis in their assigned catchment area, over and above the planned house to house vaccination during SIAs.

In 2016-2017, the Programme will:

- Review the performance of the existing PPTs and plan for expansion where feasible
- Track and monitor the output of PPTs through regional EOC.

### Cross Border Teams (CBTs)

A total of 16 border points have been identified along the border with Pakistan where large numbers of children cross on a regular basis. The cross border teams provide OPV to all children crossing on either side of the border, on a permanent basis. The target age for vaccination of children at these points has been increased to 10 years and fingermarks are applied to the left thumb.

The Programme aims to:

- Continue the cross-border teams
- Monitoring of the performance of CBTs by independent monitors
- Full synchronization with vaccination operations on the Pakistan side of the border.

### Special Campaigns for nomads and other underserved population groups

There will be special campaigns in the South-Eastern, Southern and Western Regions targeting nomads who are entering Afghanistan from Pakistan and move widely in the country before returning to Pakistan. Their movement routes and seasons are known to regional polio teams and dates for special campaigns targeting children of nomadic groups are adjusted accordingly.

- Special population (Nomads) plan will be developed by the Provinces and shared with country office (point of entry to the area, duration of stay, next destination, number of families, number of eligible children) and
- Special campaign will be conducted targeting this population group.

Vaccine utilization reports (VURs) of PTT, PPT and CBT to be submitted on a monthly basis to ensure that this informs accurate vaccine forecasting.

### Building demand and trust in immunization

Intensive efforts will be made to scale up household and community engagement approaches in the prioritized low performing districts to reduce missed children and build demand for overall immunization. Absent children remains the major reason for missing children nationwide and across all priority provinces according to PCM data. In April 2016, children not available represented around 75% of missed children in Kandahar, 90% in Hilmand, 60% in Nangarhar, 75% in Kunar), recognizing that non availability may be used as an excuse to covertly refuse vaccination in some areas. In Kandahar and Hilmand, there are an alarming number of districts that consistently show over 8% absolute refusals at any point in 2016 (Baghran, Garmser, Reg, Khakrez, Shahwalikot, Panjwayi, Miyanshin, Arghestan, etc.). This is nearly 10 times the global average in polio priority countries. Addressing the unsupportive social context rooting refusals and children not available in Afghanistan, and in particular in the Southern region, will be the number one priority of the communication focus in the next year.

Afghanistan's polio communication framework identifies the main strategic objectives, principles and approaches which will guide all communications work, including media and advocacy, social mobilization, household and community engagement including partnerships with religious leaders, medical professionals, development of education and edutainment materials, and training / empowerment of frontline workers and civil society. By bringing all communication interventions under one strategic umbrella, the programme will ensure that they are integrated, complementary, and mutually supportive of the operational strategies to reduce the number of missed children in Afghanistan.

Understanding that building trust is the cornerstone to successful community engagement, the main strategic thrust will be to create an enabling environment to facilitate acceptance and trust in the vaccine during and in-between campaigns. Communication activities will aim to shape an environment where continuous vaccination against polio is embraced and accepted as an important social and individual goal by all community stakeholders. Experience has shown the significant impact can be achieved by developing locally appropriate communications plans that include targeted household and community engagement approaches during and in-between polio campaigns.

Key activities:

**Focus on reducing chronically missed children through strengthened household & community engagement approaches:**

- Developing evidence based communication plan as part of the district specific plan in every high risk district, including a focus on activities in the high risk clusters to address the locally specific reasons for missed children;
- Social elements to be included as part of the integrated microplan as prioritized in the VHR districts;
- Household and community engagement will be spearheaded by the 8000+ members of the Immunization Communication Network (ICN), field work will be conducted by fully trusted, capable, and professional frontline workers to mobilize caregivers, religious and community leaders, and key influencers to understand, accept and support the work of vaccinators and uptake of OPV. This engagement will not only happen during vaccination days, but be a constant conversation with the community that feeds back into making the programme even more effective. Please note that ICN will not be deployed in areas which are implementing the CHV strategy and vice-versa.
- Rigorous follow up on the register of all missed children during and in-between campaigns by members of the Immunization Communication Network (ICN), and ensure vaccination in coordination with the local health facility.

**Strengthened partnerships with key influencers including religious leaders, health workers and other stakeholders to help overcome issues of mistrust and suspicion at the local level;**

- In 2016 and 2017, focus will be placed on expanding the engagement of religious leaders at all levels, particularly at the local level in the VHR districts in a more systematic way building on the NIUG platform that was established in early 2016.
- Local level scholars will be mapped and included in the district specific plans. District focal persons will ensure the engagement of key religious leaders across the district.
- National and provincial level workshops will be held to ensure the consistent engagement of key religious leaders at all levels.



- The programme will continue to disseminate information and guidance to inform religious leaders about the importance of immunization. Through their Islamic teachings, religious influencers will facilitate broader support for polio and child health.
- Voices of key religious influencers will also be strategically incorporated into mass media content and platforms to expand the public narrative on immunization.
- The programme will organize workshops for seeking support of doctors and other health workers in the programme at all levels.

#### **Improving external relations and partnerships to promote an environment of trust**

- Creation of partnerships with media and other stakeholders to strengthen communication and media interaction to ensure a better understanding of polio eradication. Key activities to facilitate improved partnerships with media will include:
  - regular media briefings and trainings, ensuring regular interactions with key reporters, editors and talk show hosts;
  - Engaging editors of religious publications in social mobilization and advocacy for polio vaccination in high-risk areas to complement the engagement of religious leaders and institutions in advocacy and community engagement.
- Development and dissemination of awareness raising materials for print and electronic media platforms to encourage increased public trust and support for local health service delivery, during and in-between campaigns.
- Increased emphasis will be placed on creating a truly national programme which includes other sectors, stakeholders and voices, including medical professionals. Other sectors including Ministry of Education and Ministry of Rural Development have pledged their support to the polio programme through the Polio High Council. Efforts will focus on ensuring full support of these and other sectors, including NGOs.
- Campaign inauguration ceremonies will be held one day ahead of each round of SIAs at provincial level to increase awareness and acceptance of immunization at community level. Focus will be placed on ensuring participation of community influencers including medical doctors, religious scholars, community elders as well as polio survivors and their families.

**Data Collection and Generation of Evidence.** Effective implementation of the previous components relies on continuously updated evidence. Critical data collection includes the study of the attitudes and behavioral issues which are barriers to the vaccination campaigns, as well as the assessment of the effectiveness of the ongoing interventions, especially specific social mobilization models, partnerships and tools, to continuously improve the network's operations.

- Focus will be on implementing a second poll to further understand shifts in attitudes and perceptions
- Third party monitoring –both qualitative and quantitative – of communication interventions in VHR districts.

## **Surveillance**

### **AFP surveillance**

Surveillance for Acute Flaccid Paralysis (AFP) is the gold standard for detecting cases of poliomyelitis. Environmental surveillance adds to the sensitivity and detection of wild poliovirus.

The AFP surveillance system in Afghanistan generally meets global standards. Findings of an external review of the AFP surveillance system in Afghanistan, conducted during the second quarter of 2015, confirmed that AFP quality remains strong and exceeds global standards in most areas. However, a

number of smaller problems and issues were identified affecting surveillance sensitivity mainly at the provincial level and below.

A number of measures were taken to strengthen the AFP surveillance system, especially in hard-to-reach and security-compromised areas. Also, active AFP case searches have been conducted frequently in areas where AFP surveillance is suspected to be weak. Active AFP case search has also been introduced as one of the tasks for vaccinators to undertake during SIAs and for transit teams to implement as they conduct ongoing vaccination.

The next external surveillance review is planned to be conducted from 19th to 27th June 2016 and the recommendations will guide further improvements in the system.

The following are key interventions planned for strengthening AFP surveillance in 2016-17:

- Review and expansion of reporting network: The reporting network will be reviewed and expanded on a need basis. Emphasis will be placed on including the health care service providers catering to high risk population groups, insecure areas, high risk areas and districts with low NPAFP rate. Health facility contact analysis of all AFP cases, particularly inadequate cases will be done and used for expanding the reporting network.
- Surveillance data will be analyzed in a disaggregated manner down to the district level and also by security status to identify gaps for taking corrective actions.
- Active surveillance visits will be further strengthened with closer supervision and tracking from regional and National level.
- Polio workers will continue to look for suspected AFPs during SIAs; this will be further strengthened in the vaccinator trainings.

#### **Environmental surveillance:**

As of now Afghanistan is doing environmental surveillance at 14 sites in 5 provinces of Nangarhar (3) Kunar (1), Kandahar (3), Helmand (4) and Kabul (3).

In 2015, a survey was conducted for looking into possibility of expansion of environmental sampling sites. The programme will explore the possibility of expanding environmental surveillance sites to the areas surveyed without compromising on the quality at the existing sites.

#### **National Certification Committee**

The NCC is composed of independent experts, following the TORs adopted by the Eastern Mediterranean Regional Polio Certification Commission (RCC/ EMR). The NCC meets twice a year to review the overall polio situation, to assess the status of requirements for the certification process and to prepare for the eventual presentation of national polio-free documentation to the Regional Certification Commission (RCC).

The NCC will continue to undertake field visits as per the RCC protocol, prepare and submit the Afghanistan Annual Progress Report on Certification to the RCC, and participate in and present the report during the annual meetings of the RCC.

#### **Response to any new polio case**

A National Rapid Response Team (NRRRT) exists and it conducts detailed case and epidemiological investigations whenever a polio case is confirmed. This team consists of representatives from MoPH,

WHO, UNICEF, CDC and BMGF with expertise on epidemiological investigations and management of outbreak response activities.

The NRRT reports to National EOC and is expected to:

- Conduct the detailed investigation of any new polio case within 72 hours of notification by the lab and produce a narrative report within 3 days of completing the investigation.
- In coordination with the National EOC, support provincial/regional team in planning for any case response
- Provide feedback to National EOC on additional support required.

Every new polio case will be responded to according to the following approach:

- Detailed epidemiological and case investigation
- 3 SIAs after date of onset covering at least 500,000 children in the surrounding area
  - First campaign within 2 weeks
  - Preferably one of the three campaigns to be conducted with IPV, if the area is high risk and has not received IPV-OPV opportunity in 2015-2016.
  - Target age to depend on epidemiology.
  - National level monitors to support and monitor pre-intra-post campaign phase of all response SIAs.

National EOC will produce a report of outbreak response after completion of 3 SIA campaigns after the last case in area.

### Response to detection of poliovirus type 2

In line with the global guideline, detection of any poliovirus type 2-wild, vaccine derived, or even Sabin (4 months post switch) will be notified as required under IHR (2005).

In response to detection of any type 2 polio virus, the following actions will be taken:

- Investigation and risk assessment
  - Enhancing surveillance in all the concerned areas,
  - Conducting rapid field investigation
  - Conducting risk assessment as per the global SOP. The nature of the virus (e.g. WPV, VDPV, or Sabin) and strength of evidence of circulation (e.g. confirmed, probable, or possible) will determine the potential risk of further poliovirus type 2 transmission. Unlike type 1 or 3 isolates, for type 2 isolates, the transmission classification (not typology) determines response.
  - Conducting an additional investigation to determine whether tOPV (or mOPV2) are still being utilized or the potential of a containment breach.
- Response:
  - Preparations for a vaccination response will begin upon receiving initial sequencing results and not wait for a complete epidemiologic investigation or final classification of an isolate.

- An initial vaccination response using mOPV2 (from a global stockpile), targeting 500,000 children under 5 years of age, will be implemented within 14 days of receiving the initial sequencing results.
- Depending on the further classification of the virus and transmission risk analysis, additional SIAs will be conducted targeting a minimum of 2 million children approximately every 2-3 weeks.
- One of the SIAs will use IPV-mOPV2 in the outbreak area and IPV alone for an expanded high risk sub-population.

For conducting the response vaccination as described above, Afghanistan will apply to WHO to access mOPV2 and IPV from the global stockpile.

## **Cross border coordination**

As highlighted above, Afghanistan and Pakistan form one common reservoir. The programme will continue to strengthen cross border coordination with the Pakistan team at all levels. As agreed by the country teams of both the countries, the following activities will be carried out:

- Weekly communication between the identified cross border focal points of Afghanistan and Pakistan national EOCs;
- biannual face to face meeting and VCs of the national EOCs
- Monthly meetings of concerned provincial and regional teams from both countries;
- SIA dates will be synchronized and any change in dates of SIAs will be communicated;
- Cross-notification of AFP cases will be further streamlined to ensure timely communication and detailed investigations of all WPV cases will be shared;
- Communication interventions of the cross border transit points will be uniform and there will be regular sharing of media/communication plans to ensure consistent messaging;
- Timely information sharing on high risk population movements, including nomads, displaced populations, new immigrations and returnees;

## Evaluation

Looking at the critical stage of programme and to ensure that progress is being made against the NEAP, Programme performance will be evaluated using different methods as highlighted below:

- Operational evaluation:
  - Internal evaluation of the progress in NEAP 2016-17 will be conducted in December 2016 (mid-term) and June 2017 (end-term). This evaluation will be done by involving national/international experts and key stakeholders. The results of mid-term review will help in mid-course correction and end-term evaluation will guide the development of next NEAP.
  - Surveillance review will be conducted in June 2017 to assess the ability of system to detect transmission.
- Evaluating population immunity:
  - Indirect evaluation through assessing vaccination status of NPAFP cases
  - Direct evaluation through serological survey will be done in Q1 2017.

## **Routine immunization strengthening**

Efforts to strengthen routine immunization will sustain the gains achieved by regular supplementary immunization activities through to certification. It is important to highlight that the prioritized very high risk districts (HRDs) for polio also report low RI coverage and have high numbers of un-immunized or under-immunized children. Continued emphasis in 2016/17 will be to reduce the numbers of un/under immunized children in the prioritized VHR districts through the regular engagement of the polio infrastructure by undertaking the following:

### **Operations**

The terms of reference of all polio field workers will be reviewed to ensure up to 20% of their time is earmarked to supporting RI activities and in particular support for:

- Planning of RI sessions;
- Monitoring of fixed and outreach sessions; and
- Training of health workers.

Staff will be oriented and trained on their responsibilities by the end of Q3 2016 and performance indicators set and measured.

### **Mobilization**

- Focus will be on ensuring that during all relevant meetings with key stakeholders at community level information on RI and the scheduled dates of outreach sessions are highlighted.
- Identification of the low RI coverage areas during household visits and missed children tracking by FLWs to find areas where RI coverage is low and report to district /provincial teams.
- Newborn mobilization for RI: Given the role of the ICN will be expanded beyond polio SIAs, focus will also be placed on tracking newborns by the mobilizers. Parents and family members of all newborns to be given a message of RI vaccines and details of the EPI fixed centers, vaccinator contacts and dates of outreach.

## Transition plan

Although Afghanistan still remains polio-endemic and is prioritizing the implementation of activities to achieve objective number 1 of the Global Endgame Plan, it is important for the country to start planning for the transition of polio assets beyond certification. Enabling the transition of polio assets to support other basic public health functions, wherever possible, will be a priority. It is important that a plan is put in place to guide the transition of polio staff and infrastructure, into the country's health system, with governmental or other sources of funding.

MOPH, with GPEI support, will take the lead in developing these plans, engaging donors and other key stakeholders in the process. "Transition Planning Guidelines" will be used in development of these plans with support from the 'Transition Management Group'.

Key actions to be taken to achieve this are:

- **Structure:** Appoint a 'transition' oversight committee, chaired by a senior Government representative, before September 2016 to oversee the planning. This body would include participants from implementing partners, donors and other key stakeholders in the health sector.
- **Management:** Identify a focal person within the N-EOC to manage the transition plan development and ensure that there is a work plan by Q1 2017.
- **Asset Mapping and stakeholder workshop:** With the support of the PEI Implementing partners, ensure that asset mapping is conducted and a transition planning workshop held in Q4.
- **Follow-up:** Ensure that a draft plan is developed and shared with partners and donors for inputs by Q2 2017.