Islamic Republic of Afghanistan

National EPI and PEI Programs

Complementary Accountability framework PEI/EPI and NGO's

Mutual Support Activities

With thanks to those who developed.
Approved. EOC to follow.

Oct 2018

Background: Polio eradication as a global public health emergency remains at the core of priorities for the government of Islamic Republic of Afghanistan, the Ministry of Public Health and its partners. Indeed, this is a responsibility for every single Afghan citizen irrespective of any affiliations. A strong EPI is necessary to sustain the progress so far made in limiting the wild polio virus transmission in the country. On the other hand, the PEI programme in Afghanistan has wide range of resources that can be deployed to support EPI. Thus, the PEI/EPI close coordination, collaboration and joint efforts is an essential element to frame result-oriented outcomes and mutually enhanced programs. The PEI program field staff are required to provide support to the RI through spending of at least 20% of their time.

The strengthened routine EPI is indeed, the sustainable mechanism not only to prevent other vaccine preventable diseases but also to keep the country polio free after polio virus eradication in Afghanistan. In similar order, the RI program which is mainly managed by NGOs can provide support in different ways to PEI efforts including IEC and social mobilization activities, monitoring and supervision, access negotiation, HR as front-line workers by use of CHWs network and so forth.

The initial intention was to develop this accountability framework for PEI support to RI but the immense needs makes it efficient to accommodate as much as possible to support other programmatic priorities.

Rationale: Polio Eradication and End Game Strategic Plan 2013-2018 and NEAP 2018 for Afghanistan indicate the PEI support to EPI should be streamlined which is not sufficiently defined. On the other hand, RI implementation requires more assertive follow up to ensure statements are translated into actions at the field level. In Afghanistan, both PEI and EPI programs are needing the support from each other which requires more focused and result oriented management and follow up. RI still needs further breakdown to ensure a successful RI program and similarly PEI support requires further details to ensure RI receive appropriate support from PEI.

To this end, this document not only highlights the responsibilities of PEI but also the EPI and NGOs which are considered to be the key stakeholders.

The accountability framework will ensure program effectiveness through follow up of key actions required for ensuring optimal mutual collaboration between PEI and EPI programs. In order to be more assertive at different layers of program management, the accountability framework will be used as a basis for taking informed disciplinary actions or motivating those who perform beyond their best ability.

This accountability framework will complement the accountability framework currently used for SIAs management at different stages and could be revised after the lessons learned from its implementation.

Accountability Framework development process:

The framework is drafted by NGO coordinator and discussed in designated task force consisted of the members from EOC, CDC, EPI, GCMU, WHO and UNICEF. It is further discussed and agreed with NGOs and legal basis in relation to contractual

bindings of NGOs have been considered. The framework is ultimately approved by H.E. Public Health Minister.

Objective of the Accountability Framework:

The objective of the AC as an assertive measure is to ensure holistic implementation of PEI, EPI and NGOs programmatic priorities in a collaborative manner to reach the national objectives of polio eradication as well as strengthening routine immunization services.

Implementation arrangements:

The information provided through monitoring reports, data analysis, surveys, staff appraisals, assessments and field visits will be used as the basis for application of this AC. Decisions can be made objectively at the field, provincial, regional and national levels by program management as well as other responsible officers at the EOC, Partners, NGO and MOPH.

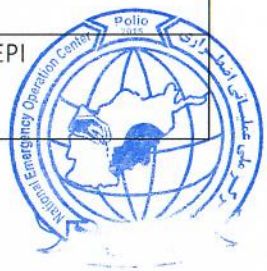
The **disciplinary actions** will entail verbal counselling, written warning, and termination of staff on individual or group basis within PEI, EPI or NGO. However, decision for applying a particular step will be justified based on the size of neglect. In addition, the process may involve development and implementation of improvement plans especially at program management levels at PEI, EPI or NGO levels. For NGO implementers, in required circumstances, this may also result into termination of NGO contracts based on the terms and conditions of the contracts which will follow the stages of communicating the concerns, development of improvement plans, warning letters and finally termination of the contract.

This accountability framework should also be applied as a tool **to justify rewarding** of the staff and the teams who perform beyond expectations. The rewards will include appreciation letters signed by different levels, identification of heroes, promotion or monetary reward. The rewarding type will be decided by the authorized officers of each PEI/EPI and NGOs management as per their HR guidelines.

GCMU in coordination with NGO coordinator will remain the prime source of communication with NGOs. Minor concerns will be communicated by GCMU while major concerns and recommendations will be jointly made by the task team. Decisions that require approval of H.E. Minister of Public will be communicated through appropriate channels to MoPH leadership for approval and will be back communicated to the concerned programs.

EI/EPI/NGO Accountability Framework

Area/Component	Level	Activity/Expectation	Indicator/Target	Means of verification	Responsible
Management & Coordination	National	PEI Coordination meetings with BPHS NGOs	NEOC holds monthly meeting with NGOs	Minutes	NEOC/GCMU
Management & Coordination	Regional/ Provincial	NGO attends regional EOC/REMT/PEMT meetings	NGOs attend 100 % of EOC/REMT/PEMT meetings	Minutes	EOC/REMT/PEMT
Management & Coordination	Regional/ Provincial	NGO attends regional/provincial post-campaign review meeting (two weeks after each campaign)	NGOs attend post campaign review meeting	Minutes	NGO/Regional EOC
Management & Coordination	Provincial	NGO attends provincial pre-campaign coordination meeting (based on prov. Plans)	NGO attends prov. pre-campaign coordination meeting	Minutes	BPHS NGOs /PEMT
Management & Coordination	Provincial	Salary of NGO EPI staff and vaccinators are timely paid	NGO EPI staff receives salary on monthly basis	Payroll	GCMU/BPHS NGO
Management & Coordination	District	NGO attends district level coordination meeting in focus districts two weeks prior to campaign	NGO officer/head of HF attends district coordination meeting	Reports	BPHS NGOs /PEMT
Planning	District	NGOs develop and share micro-plans based on national guidelines with the REOC/REMT or PEMT/PCU and PHD of the respective province and National EOC	NGO annual micro plan is available at all levels of PEI program	Copy of plan	BPHS NGOs
Planning	District/P rovincial	NGO develops micro plan on annual basis, however, to address emerging needs such as inflow of refugees will be updated as per need. The process should be supported by PEI staff.	NGO micro plan covers the entire province	Copy of plan	BPHS NGOs
Planning	Regional/ Provincial	EOC/REMT/PEMT reviews NGO micro plan and provides written feedback to NGO	Regular feedback at planning stages initiated between programs	Copy of PEI feedback	REMT/PEMT
Planning	National	EPI department shares the updated guidelines for micro planning annually	NGOs access updated national microplanning guidelines	Letters/emails of circulation	EPI
		EPI conducts TOTs for micro planning to NGOs on annual basis and provide technical support to the process	NGO officers have the knowledge to properly guide micro planning	Post TOT test score sheet	EPI



Area/Component	Level	Activity/Expectation	Indicator/Target	Means of verification	Responsible
Service delivery	District/HF level	NGO will conduct outreach sessions based on plan and share monthly reports of outreach sessions held and coverage by numbers and percentage through HMIS channels	NGO outreach sessions are held regularly as per approved plans	Reports/monitoring visits	BPHS NGOs
Service delivery	District/HF level	NGO will conduct mobile sessions based on plan and share monthly reports of mobile sessions held and coverage by numbers and percentage through HMIS channels	NGO mobile sessions are held regularly as per approved plans	Reports/Monitoring visits	BPHS NGOs
Service delivery	District/HF	NGO will ensure all HFs provide immunization services including upgraded PHCs and MHTs as per HF session plan, and share results on sessions held and coverage in numbers and percentages through HMIS channels	All HF including upgraded PHCs and Mobile teams provide immunization services	Reports/Monitoring visits	BPHS NGOs
Service delivery	District/HF	NGO will target immediately the areas where AFP is associated with zero dose polio through any appropriate strategy within one month and report back to EOC	Areas with zero dose polio AFP cases covered within one month after receiving the report from EOC	Reports/Monitoring visits	BPHS NGOs
SIAs	District/HF	NGO will share updated list of CHWs/CHS per village/HF to PEI every six months	NGO updated list of CHWs/CHS available at EOCs	Copy of the list	BPHS NGOs
SIAs	District/HF	PEI teams will hire CHWs of NGO in SIAs during each NID/sNID	CHWs actively involved in campaigns implementation	Copy of the FLWs/Reports	DEMT, PPO/DPO, DHO, DCO (based on district management structure)
Training	District/HF	NGO will provide the need for the initial training of new vaccinators to National EPI every six months	EPI has the updated need assessment for the training of vaccinators at country level	Related database	BPHS NGOs
Training	National	EPI department will develop the training plan and train new vaccinators as per NGO needs	New vaccinators are timely supplied to the NGOs	Database/Reports	EPI/UNICEF/WHO
Training	Provincial	NGO will introduce the candidates for initial EPI training with main focus on female based on	At least 90% of graduated vaccinators are deployed at the field	Records/Monitoring visits	EPI/BPHS NGOs

Area/Component	Level	Activity/Expectation	Indicator/Target	Means of verification	Responsible
		national criteria and will have the responsibility to deploy them after graduation			
Training	National	EPI department will establish and maintain an updated database of trained vaccinators across the country	Resources are efficiently utilized for the training of new vaccinators	Updated database	EPI
Training	Provincial	NGO will provide at least one refresher training per year for all vaccinators	Vaccinator received at least one refresher training per year	Reports/Monitoring visits	BPHS NGOs
Training	National	EPI department will provide TOT for NGO officers at least once per year to support refresher trainings of vaccinators at field level	NGO officers have the knowledge to properly conduct refresher trainings	Post TOT test score sheet	EPI
Training	Nat, Reg.	PEI will train polio field staff on key aspects of routine immunization	PEI staff have the knowledge of RI	Reports/Monitoring visits	EPI
Training	National	EPI department will share updated refresher training tools and guidelines to NGOs every six months	NGO access updated refresher training guidelines and tools	Letters/emails of circulation	EPI
Monitoring and evaluation	District	NGO two officers/CHWs/CHS/Health committees will participate in monitoring of campaigns	Monitoring of campaigns supported by NGOs	Reports	BPHS NGOs /REMT/PEMT
Monitoring and evaluation	HF	NGOs will supervise immunization services of each HF	Each HF RI is supervised by NGO officer at least each 45 days	Reports/Visit book of HF	BPHS NGOs
Monitoring and evaluation	District	PEI staff will develop a supervision plan of RI sessions /HFs and provide written feedback to PEMT and NGO	At least 25% of Sessions/HFs per month is supervised by PEI staff	Reports	PPO/PCO/PEMT
Monitoring and evaluation	Provincial	NGO will hire sufficient number of supervisors as per national EPI guidelines	100% of HF has designated EPI supervisor	Reports/HR records	BPHS NGOs
Monitoring and evaluation	National	EPI department will share updated supervisory tools to NGOs	NGO access updated RI supervisory tools	Letter/email of circulation	EPI
Monitoring and evaluation	HF	NGOs will ensure the quality of routine immunization reporting is optimal	At least 90% consistency and accuracy exist in NGO routine reports	Reports/monitoring visits	BPHS NGOs
Monitoring and evaluation	HF	Each HF will have monthly updated RI monitoring chart	Data is used for decision making at HF	Monitoring visits	Vaccinator

Area/Component	Level	Activity/Expectation	Indicator/Target	Means of verification	Responsible
Social Mobilization	National	EPI department will share IEC materials or samples to NGOs	NGOs receive updated IEC materials at least once per year	Reports/Monitoring visits	EPI
Social Mobilization	District	NGO will supply IEC material to all HFs on quarterly basis	All HFs are equipped with updated IEC materials	Report/Monitoring visits	BPHS NGOs
Social Mobilization	HF	PEI social mobilizers (SM) will develop register of each child for following up their routine immunization in ICN districts (if no bans exist)	PEI SMs traces each child for immunization in ICN districts for both Polio and routine	Report/Monitoring visits	SM/DCO/PCO
Social Mobilization	HF	PEI SMs and FLWs refer the unimmunized children for routine to the nearest HF or outreach/mobile sites	>80% of children who need routine vaccines are referred to nearest HF	Reports/Monitoring visits	SM/DCO/Cluster supervisor and volunteer
Social Mobilization	HF	PEI social mobilizers and FLWs will communicate key messages related to routine vaccines to families	Target families are encouraged to RI during each campaign	Report/Monitoring visits	SM/DCO
Social Mobilization	HF	SMs in areas where ICN exists will regularly sign their attendance sheet in nearest HF	HF is receiving continuous support from SMs	Attendance sheet	SM/DCO/PCO
Vaccine/cold chain	Provincial	NGOs to prepare the updated inventory of cold chain equipment available/needed and submit it to their National Offices for procurement or provision from National EPI at least annually	NGOs cold chain need is regularly assessed and updated within NGO	Updated inventory	BPHS NGOs
Vaccine/cold chain	National	National offices of BPHS partners should verify, compile and submit the list of cold chain requirements to National EPI/VCCM Committee for validation	National cold chain need is regularly assessed and updated	EPI database	BPHS NGOs
Vaccine/cold chain	National	National EPI/VCCM Committee to address confirmed gaps at least on an annual cycle	>95% of NGO HFs are equipped with required cold chain equipment	Inventory/Monitoring visits	National EPI
Vaccine/cold chain	Provincial	NGOs to prepare plans for regular vaccine supply to HFs	Vaccine supply plans exists at NGO provincial office	Copy of plans /Monitoring visits	BPHS NGOs
Vaccine/cold chain	Provincial	NGOs to ensure uninterrupted vaccine supply to HFs	100% of HFs are supplied with required vaccine needs	Reports/Monitoring visits	BPHS NGOs

Area/Component	Level	Activity/Expectation	Indicator/Target	Means of verification	Responsible
Vaccine/cold chain	All	BPHS NGOS to have a clear plan for Effective vaccine management at all levels	100% of vaccines at HF meets VVM requirements based on national guidelines	Reports/Monitoring visits	BPHS NGOs
Vaccine/cold chain	All	BPHS partners should ensure proper cold chain maintenance and minor repair at all facilities	100% of cold chain equipment is in functional condition at HF	Reports/Monitoring visits	BPHS NGOs
Vaccine/cold chain	National	BPHS partners to have a plan for their relevant staff on adequate training in cold chain and vaccine management	100% of relevant staff have received trainings on vaccine management and cold chain at least once a year	Reports/Monitoring visits	National EPI/BPHS NGOs
Actions on MoPH monitoring findings	Provincial	NGOs will take timely actions on the gaps identified and report on the progress made against MoPH/GCMU/EOC/EPI field visits every month	NGOs take timely actions to address performance gaps	Reports/Monitoring visits	BPHS NGOs /GCMU/EOC/EPI
Reporting	Provincial (High risk provin.)	NGOs will provide a summary report of their contribution to polio campaigns as well as their findings after each NID and sNID to NGO coordinator.	NGO reports are available after each campaign	Reports	BPHS NGOs
Reporting	Provincial	NGOs will report on PEI contribution to RI every quarter on the number of referrals made, status of community mobilization by PEI to RI, defaulter tracing, contributions to micro planning and monitoring within two weeks after completion of each quarter	Support to RI through PEI is further streamlined	Reports	BPHS NGOs

Accountability framework

Components	Level	Activity	Expectation/Target	Responsible person/Organization
Management & coordination	National	National EOC coordination meetings	Weekly meeting	Director, National EOC
Management & coordination	National	National post-campaign review meeting	Two weeks after each campaign	Director, National EOC
Management & coordination	National	Review of NEAP task tracker	Monthly meeting	Director, National EOC
Management & coordination	National	Cross-border coordination meeting	Quarterly meeting	Director, National EOC
Management & coordination	National	Pre-campaign dashboard review	Two weeks, one week, three days and one day prior to the campaign start date	Director, National EOC; National EOC data team
Management & coordination	National	Deployment and briefing of national supervisors for SIAs	Two weeks prior to the campaign date	Operations Lead, National EOC
Management & coordination	National	National Polio High Council meeting	Quarterly meeting	Presidential Focal Point and team
Management & coordination	National	Coordination meeting with BPHS and NGOs	Monthly meeting	Polio Focal Person, MoPH
Management & coordination	Regional	Regional EOC meetings	At least two meetings each week	Manager Regional EOC; facilitated by partners
Management & coordination	Regional	Regional post-campaign review meeting	Two weeks after each campaign	Manager, Regional EOC; facilitated by partners
Management & coordination	Regional	Pre-campaign dashboard review	Two weeks, one week, three days and one day prior to the campaign start date	Manager, Regional EOC; facilitated by partners
Management & coordination	Regional	Deployment and briefing of regional supervisors for SIAs	Two weeks prior to the campaign date	Manager, Regional EOC; facilitated by partners
Management & coordination	Regional	Cross-border coordination meeting / weekly teleconference	Weekly teleconference	Manager, Regional EOC; facilitated by partners
Management & coordination	Provincial	Provincial post-campaign review meeting	Two weeks after each campaign	PEMT, facilitated by partners, supported by regional teams
Management & coordination	Provincial	Provincial campaign coordination & advocacy meeting	Two weeks prior to the campaign date	PEMT, facilitated by partners, supported by regional teams
Management & coordination	Provincial	Pre-campaign dashboard review	Two weeks, one week, three days and one day prior to the campaign start date	PEMT, facilitated by partners, supported by regional teams
Management & coordination	National	Outbreak investigation of each confirmed WPV/VDPV	Detailed epidemiological investigation of each event occurs within 10 days of the event	National Rapid Response Team
SIA - Microplanning	Regional	Validation and revision of microplans in all priority districts	All prioritized districts have updated microplans two weeks prior to the campaign date	WHO, with partners

Accountability framework

Components	Level	Activity	Expectation/Target	Responsible person/Organization
SIA - Microplanning	Regional	Validation of district profiles and plans after each campaign	Two weeks prior to the campaign date	Regional EOC, supported by partners
SIA - Microplanning	District	Preparing, validating and revising detailed field microplans	All prioritized districts have updated microplans two weeks prior to the campaign date	DPO, DCO, DC, Cluster Supervisors, BPHS implementers
SIA - Microplanning	District	District profile and plan updated after each campaign	Updated two weeks prior to the campaign date	DPO, DCO, DC, Cluster Supervisors, BPHS implementers
SIA - Microplanning	District	Teams selected according to the national guidelines	At least one female local vaccinator; status review one week prior to the campaign	District Coordinators
SIA - Social Mobilization	National	IEC materials distributed ahead of every campaign	Two weeks prior to the campaign date	UNICEF, supported by MoPH and WHO
SIA - Social Mobilization	National	Monitor media tonality; manage positive messaging through print/electronic media	Monthly media monitoring report circulated amongst stakeholders	UNICEF, supported by MOPH and WHO
SIA - Social Mobilization	National	Meeting of National Islamic Ulema Group (NIUG) to ensure coordination with key religious influencers	Quarterly meeting	NIUG Focal Person
SIA - Social Mobilization	National	Generate social data analysis guiding communication strategy	By end 2016	UNICEF
SIA - Social Mobilization	Regional	Dissemination of IEC material to Provinces/Districts	Ten days prior to the campaign date	UNICEF, supported by Regional EOC
SIA - Social Mobilization	Regional	Tracking refusals and missed children after each campaign	Data/reason analysis presented during post-campaign review meeting	UNICEF, supported by Regional EOC
SIA - Social Mobilization	District	Social mobilization plan incorporated into district specific plan	Two weeks prior to the campaign date	UNICEF, supported by district team
SIA - Social Mobilization	District	Follow up of missed children through Social Mobilizers	80% missed children recovered by mobilizers after each campaign	UNICEF
SIA - Trainings	Regional	TOT for provincial staff	TOT of provincial staff twice every year	WHO, with partners
SIA - Trainings	District	Master trainers conduct training for frontline workers	Training of 90% FLWs conducted at least 2 days prior to campaign	District Coordinator, supported by partners
SIA - Trainings	Regional	Monitoring of training quality	At least 90% of training sessions in prioritized areas monitored by regional and provincial teams	Regional EOC, PEMT and partners
SIA - Vaccine/cold chain	National	Vaccine and logistics made available at regional level	10 days prior to campaign	UNICEF, WHO, National EPI
SIA - Vaccine/cold chain	Regional	Vaccine and logistics made available at provincial level	4 days prior to campaign	REMT, supported by partners
SIA - Vaccine/cold chain	Regional	Vaccine and logistics made available at district level	2 days prior to campaign	PEMT, supported by partners

Accountability framework

Components	Level	Activity	Expectation/Target	Responsible person/Organization
SIA - Vaccine/cold chain	Regional	Weekly vaccine stock inventory and reporting	Weekly	REMT
SIA - Vaccine/cold chain	Provincial	Weekly vaccine stock inventory and reporting	Weekly	PEMT
SIA - Vaccine/cold chain	All	Effective vaccine management	No vaccine found beyond stage 2 at any level	All stakeholders
SIA - Monitoring	All	Compilation of pre-campaign dashboard	Two weeks, one week, three days and one day prior to the campaign start date	National EOC data team
SIA - Monitoring	Regional	Compilation of pre-campaign dashboard	Two weeks, one week, three days and one day prior to the campaign start date	Regional EOC data team
SIA - Monitoring	Provincial	Compilation of pre-campaign dashboard	Two weeks, one week, three days and one day prior to the campaign start date	PEMT/PPCU
SIA - Monitoring	Provincial	Compilation of pre-campaign dashboard	Two weeks, one week, three days and one day prior to the campaign start date	District Coordinator, supported by DPO and DCO
SIA - Monitoring	National	Compilation of intra-campaign monitoring data	Provide ICM data to the programme within 24 hours of each campaign day at the national level	Data Team
SIA - Monitoring	National	Compile PCA data and share with National EOC and partners	PCA data available for programme review and interventions within 10 days after campaign	WHO
SIA - Monitoring	National	Compile administrative coverage data and share with National EOC and partners	Administrative coverage data available within 10 days after campaign	National EPI
SIA - Monitoring	Regional	Validation of PCA and LQAS	10% of surveyors will be cross-checked by provincial polio officers/provincial communication officers during monitoring activities. In addition, 10% of completed forms will be validated in the field for correctness.	Regional WHO and UNICEF field teams
SIA - Monitoring	Regional	Conducting field investigation of rejected LQAS lots, providing report to National level	Reason analysis of rejected LQAS lots conducted within 2 days of the initial survey	Manager, Regional EOC
SIA - Payments	Provincial	Submission of financial documents of implementation	Within 7 days of completion of campaign	PEMTs through RMT
SIA - Payments	District	Payments to FLWs completed	Before the start of next campaign	WHO
Performance indicators	All	Cardinal surveillance indicators maintained above globally recommended targets	In 100% regions, 100% provinces, >90% districts	WHO
Performance indicators	All	Involvement of CHWs in vaccination teams	>20% CHW increase in engagement of CHWs compared to 2015/16 baseline	GSMU and BPHS

Accountability framework

Components	Level	Activity	Expectation/Target	Responsible person/Organization
Performance indicators	All	High quality campaigns	Where PCA/LQAs fails more than 3 times, a detailed investigation to be undertaken by a national team; sanctions to be taken based on the results of the investigation	National EOC
Performance indicators	All	High quality campaigns	<5% missed children (PCA); if >3 missed children found in more than 1 supervisory area the coordinator will be sanctioned; if >3 missed children found in a supervisory area the team supervisor will be sanctioned for the performance of their teams;	All stakeholders
Transparency	All	High quality & transparent data/information	Removal of any team member who falsifies information/data	All stakeholders
Transparency	All	Apropriate Utilization of Resources	Zero Tolerance for misuse of resources. If identified, immediate removal and possible punitve actions	All Stakeholders

Risk Categorization of Districts 2019

Region	Province	District	DCODE	Priority of districts 2019
South	Helmand	Nad-e-Ali	3203	FD
South	Helmand	Nahr-e-Saraj	3202	FD
South	Helmand	Nawzad	3207	FD
South	Helmand	Lashkargah	3201	FD
South	Helmand	Musaqalah	3206	FD
South	Helmand	Nawa-e-Barakzaiy	3204	FD
South	Helmand	Sangin	3205	FD
South	Helmand	Reg	3212	FD
South	Helmand	Kajaki	3210	FD
South	Kandahar	Kandahar	3301	FD
South	Kandahar	Shahwalikot	3306	FD
South	Kandahar	Zheray	3303	FD
South	Kandahar	Maywand	3308	FD
South	Kandahar	Spinboldak	3311	FD
South	Kandahar	Panjwayi	3304	FD
South	Daykundi	Gizab	2205	HRD
Southeast	Ghazni	Giro	1111	HRD
West	Ghor	Taywarah	2106	HRD
South	Helmand	Washer	3208	HRD
South	Helmand	Baghran	3211	HRD
South	Helmand	Garmser	3209	HRD
Southeast	Khost	Mandozayi	2605	HRD
Southeast	Khost	Musakhel	2603	HRD
Southeast	Khost	Terezayi	2608	HRD
East	Kunar	Barkunar	1311	HRD
East	Kunar	Chawkay	1308	HRD
East	Kunar	Narang	1303	HRD
East	Kunar	Khaskunar	1309	HRD
East	Kunar	Dangam	1310	HRD
East	Kunar	Nari	1315	HRD
East	Kunar	Asadabad	1301	HRD
East	Laghman	Alingar	704	HRD
East	Nangarhar	Surkhrod	603	HRD
East	Nangarhar	Kama	607	HRD
East	Nangarhar	Pachieragam	612	HRD
East	Nangarhar	Dehbala	613	HRD
East	Nangarhar	Kot	614	HRD
South	Nimroz	Khashrod	3405	HRD
East	Nuristan	Kamdesh	1407	HRD
East	Nuristan	Poruns	1401	HRD
East	Nuristan	Barg-e- Matal	1408	HRD
Southeast	Paktia	Chamkani	1210	HRD
Southeast	Paktia	Zadran	1206	HRD
South	Urozgan	Shahid-e-Hassas	2303	HRD

Risk Categorization of Districts 2019

Region	Province	District	DCODE	Priority of districts 2019
South	Urozgan	Chora	2302	HRD
South	Zabul	Arghandab	2402	HRD
South	Zabul	Mizan	2403	HRD
South	Zabul	Daychopan	2408	HRD
South	Zabul	Tarnak Wa Jaldak	2404	HRD
South	Zabul	Shahjoy	2406	HRD
South	Zabul	Atghar	2409	HRD
South	Zabul	Nawbahar	2411	HRD
Central	Kabul	Kabul	101	VHRD
East	Kunar	Watapur	1302	VHRD
East	Kunar	Shigal Wa sheltan	1306	VHRD
East	Kunar	Chapadara	1313	VHRD
East	Kunar	Marawara	1305	VHRD
East	Kunar	Dara-e-Pech	1307	VHRD
East	Nangarhar	Achin	617	VHRD
East	Nangarhar	Batikot	615	VHRD
East	Nangarhar	Lalpur	620	VHRD
East	Nangarhar	Muhmand Dara	619	VHRD
East	Nangarhar	Behsud	602	VHRD
East	Nangarhar	Shinwar	618	VHRD
East	Kunar	Ghaziabad	1312	VHRD
East	Nangarhar	Sherzad	611	VHRD
South	Kandahar	Reg	3309	VHRD
South	Kandahar	Shorabak	3310	VHRD
South	Kandahar	Miyanshin	3313	VHRD
South	Kandahar	Ghorak	3315	VHRD
South	Kandahar	Arghandab	3302	VHRD
South	Kandahar	Khakrez	3307	VHRD
South	Kandahar	Daman	3305	VHRD
South	Kandahar	Arghestan	3312	VHRD
South	Kandahar	Nesh	3314	VHRD
South	Nimroz	Zaranj	3401	VHRD
South	Urozgan	Dehrawud	2304	VHRD
South	Urozgan	Tirinkot	2301	VHRD
South	Zabul	Qalat	2401	VHRD
East	Nangarhar	Jalalabad	601	VHRD
Southeast	Paktika	Bermel	2515	VHRD
West	Farah	Bakwa	3102	VHRD
West	Farah	Balabuluk	3103	VHRD
West	Farah	Khak-e-Safed	3104	VHRD
West	Farah	Gulestan	3109	VHRD
West	Herat	Shindand	3015	VHRD

Risk Categorization of Districts 2019

Focus districts

Region	Province	District
South	Helmand	Nad-e-Ali
South	Helmand	Nahr-e-Saraj
South	Helmand	Nawzad
South	Helmand	Lashkargah
South	Helmand	Musaqalah
South	Helmand	Nawa-e-Barakzaiy
South	Helmand	Sangin
South	Helmand	Reg
South	Helmand	Kajaki
South	Kandahar	Kandahar
South	Kandahar	Shahwalikot
South	Kandahar	Zheray
South	Kandahar	Maywand
South	Kandahar	Spinboldak
South	Kandahar	Panjwayi

Very High Risk Districts

Region	Province	District
Central	Kabul	Kabul
East	Kunar	Watapur
East	Kunar	Shigal Wa sheltan
East	Kunar	Chapadara
East	Kunar	Marawara
East	Kunar	Dara-e-Pech
East	Nangarhar	Achin
East	Nangarhar	Batikot
East	Nangarhar	Lalpur
East	Nangarhar	Muhmand Dara
East	Nangarhar	Behsud
East	Nangarhar	Shinwar
East	Kunar	Ghaziabad
East	Nangarhar	Sherzad
South	Kandahar	Reg
South	Kandahar	Shorabak
South	Kandahar	Miyanshin
South	Kandahar	Ghorak
South	Kandahar	Arghandab
South	Kandahar	Khakrez
South	Kandahar	Daman
South	Kandahar	Arghestan
South	Kandahar	Nesh
South	Nimroz	Zaranj
South	Urozgan	Dehrawud
South	Urozgan	Tirinkot
South	Zabul	Qalat
East	Nangarhar	Jalalabad
Southeast	Paktika	Bermel
West	Farah	Bakwa
West	Farah	Balabuluk
West	Farah	Khak-e-Safed
West	Farah	Gulestan
West	Herat	Shindand

High Risk Districts

Region	Province	District
East	Kunar	Barkunar
East	Kunar	Chawkay
East	Kunar	Narang
East	Kunar	Khaskunar
East	Kunar	Dangam
East	Kunar	Nari
East	Kunar	Asadabad
East	Laghman	Alingar
East	Nangarhar	Surkhrod
East	Nangarhar	Kama
East	Nangarhar	Pachieragam
East	Nangarhar	Dehbala
East	Nangarhar	Kot
East	Nuristan	Kamdesh
East	Nuristan	Poruns
East	Nuristan	Barg-e- Matal
South	Daykundi	Gizab
South	Helmand	Washer
South	Helmand	Baghran
South	Helmand	Garmser
South	Nimroz	Khashrod
South	Urozgan	Shahid-e-Hassas
South	Urozgan	Chora
South	Zabul	Arghandab
South	Zabul	Mizan
South	Zabul	Daychopan
South	Zabul	Tarnak Wa Jaldak
South	Zabul	Shahjoy
South	Zabul	Atghar
South	Zabul	Nawbahar
Southeast	Ghazni	Giro
Southeast	Khost	Mandozayi
Southeast	Khost	Musakhel
Southeast	Khost	Terezayi
Southeast	Paktia	Chamkani
Southeast	Paktia	Zadran
West	Ghor	Taywarah

Risk Categorization of Districts 2017-2019

Region	Province	District	DCODE	Priority of districts 2017	Priority of districts 2018	Priority of districts 2019
Northeast	Badakhshan	Fayzabad	1501	No HR	No HR	**No HR**
Northeast	Badakhshan	Yaftal-e-Sufla	1502	No HR	No HR	**No HR**
Northeast	Badakhshan	Argo	1503	No HR	No HR	**No HR**
Northeast	Badakhshan	Arghanjkhwa	1504	No HR	No HR	**No HR**
Northeast	Badakhshan	Kohestan	1505	No HR	No HR	**No HR**
Northeast	Badakhshan	Raghestan	1506	No HR	No HR	**No HR**
Northeast	Badakhshan	Yawan	1507	No HR	No HR	**No HR**
Northeast	Badakhshan	Shahr-e-Buzorg	1508	No HR	No HR	**No HR**
Northeast	Badakhshan	Teshkan	1509	No HR	No HR	**No HR**
Northeast	Badakhshan	Darayem	1510	No HR	No HR	**No HR**
Northeast	Badakhshan	Khash	1511	No HR	No HR	**No HR**
Northeast	Badakhshan	Baharak	1512	No HR	No HR	**No HR**
Northeast	Badakhshan	Shuhada	1513	No HR	No HR	**No HR**
Northeast	Badakhshan	Shighnan	1514	No HR	No HR	**No HR**
Northeast	Badakhshan	Darwaz-e-Balla	1515	No HR	No HR	**No HR**
Northeast	Badakhshan	Kofab	1516	No HR	No HR	**No HR**
Northeast	Badakhshan	Khwahan	1517	No HR	No HR	**No HR**
Northeast	Badakhshan	Keshem	1518	No HR	No HR	**No HR**
Northeast	Badakhshan	Tagab	1519	No HR	No HR	**No HR**
Northeast	Badakhshan	Yamgan	1520	No HR	No HR	**No HR**
Northeast	Badakhshan	Jorm	1521	No HR	No HR	**No HR**
Northeast	Badakhshan	Warduj	1522	No HR	No HR	**No HR**
Northeast	Badakhshan	Eshkmesh	1523	No HR	No HR	**No HR**
Northeast	Badakhshan	Darwaz	1524	No HR	No HR	**No HR**
Northeast	Badakhshan	Shaki	1525	No HR	No HR	**No HR**
Northeast	Badakhshan	Koran wa Monjan	1526	No HR	No HR	**No HR**
Northeast	Badakhshan	Zebak	1527	No HR	No HR	**No HR**
Northeast	Badakhshan	Wakhan	1528	No HR	No HR	**No HR**
West	Badghis	Muqur	2902	**HRD**	**HRD**	**No HR**
West	Badghis	Qala-e-Naw	2901	No HR	No HR	**No HR**
West	Badghis	Abkamari	2903	No HR	No HR	**No HR**
West	Badghis	Qadis	2904	No HR	No HR	**No HR**
West	Badghis	Jawand	2905	No HR	No HR	**No HR**
West	Badghis	Balamurghab	2906	No HR	No HR	**No HR**
Northeast	Baghlan	Baghlan-e-Jadid	902	**HRD**	**HRD**	**No HR**
Northeast	Baghlan	Pul-e- khumri	901	No HR	No HR	**No HR**
Northeast	Baghlan	Dahana-e-Ghori	903	No HR	No HR	**No HR**
Northeast	Baghlan	Doshi	904	No HR	No HR	**No HR**
Northeast	Baghlan	Nahrin	905	No HR	No HR	**No HR**
Northeast	Baghlan	Tala Wa barfak	906	No HR	No HR	**No HR**
Northeast	Baghlan	Khenjan	907	No HR	No HR	**No HR**

Risk Categorization of Districts 2017-2019

Region	Province	District	DCODE	Priority of districts 2017	Priority of districts 2018	Priority of districts 2019
Northeast	Baghlan	Andarab	908	No HR	No HR	**No HR**
Northeast	Baghlan	Khwajahejran	909	No HR	No HR	**No HR**
Northeast	Baghlan	Burka	910	No HR	No HR	**No HR**
Northeast	Baghlan	Pul-e-Hesar	911	No HR	No HR	**No HR**
Northeast	Baghlan	Dehsalah	912	No HR	No HR	**No HR**
Northeast	Baghlan	Guzargah-e- Nur	914	No HR	No HR	**No HR**
Northeast	Baghlan	Fereng Wa Gharu	915	No HR	No HR	**No HR**
Northeast	Baghlan	Khost Wa Fereng	913	**HRD**	**HRD**	**No HR**
North	Balkh	Mazar-e-Sharif	1801	No HR	No HR	**No HR**
North	Balkh	Nahr-e- Shahi	1802	No HR	No HR	**No HR**
North	Balkh	Shortepa	1803	No HR	No HR	**No HR**
North	Balkh	Dawlatabad	1804	No HR	No HR	**No HR**
North	Balkh	Balkh	1805	No HR	No HR	**No HR**
North	Balkh	Dehdadi	1806	No HR	No HR	**No HR**
North	Balkh	Charkent	1807	No HR	No HR	**No HR**
North	Balkh	Marmul	1808	No HR	No HR	**No HR**
North	Balkh	Khulm	1809	No HR	No HR	**No HR**
North	Balkh	Kaldar	1810	No HR	No HR	**No HR**
North	Balkh	Sharak-e-Hayratan	1811	No HR	No HR	**No HR**
North	Balkh	Charbulak	1812	No HR	No HR	**No HR**
North	Balkh	Chemtal	1813	No HR	No HR	**No HR**
North	Balkh	Sholgareh	1814	No HR	No HR	**No HR**
North	Balkh	Keshendeh	1815	No HR	No HR	**No HR**
North	Balkh	Zari	1816	No HR	No HR	**No HR**
Central	Bamyan	Bamyan	1001	No HR	No HR	**No HR**
Central	Bamyan	Sayghan	1002	No HR	No HR	**No HR**
Central	Bamyan	Yakawlang	1003	No HR	No HR	**No HR**
Central	Bamyan	Panjab	1004	No HR	No HR	**No HR**
Central	Bamyan	Shibar	1005	No HR	No HR	**No HR**
Central	Bamyan	Kahmard	1006	No HR	No HR	**No HR**
Central	Bamyan	Waras	1007	No HR	No HR	**No HR**
Central	Daykundi	Nili	2201	No HR	No HR	**No HR**
Central	Daykundi	Ashtarlay	2202	No HR	No HR	**No HR**
Central	Daykundi	Khadir	2203	No HR	No HR	**No HR**
Central	Daykundi	kiti	2204	No HR	No HR	**No HR**
Central	Daykundi	Shahrestan	2206	No HR	No HR	**No HR**
Central	Daykundi	Sang-e-Takht	2207	No HR	No HR	**No HR**
Central	Daykundi	Kajran	2208	No HR	No HR	**No HR**
Central	Daykundi	Miramor	2209	No HR	No HR	**No HR**
South	Daykundi	Gizab	2205	**HRD**	**HRD**	**HRD**
West	Farah	Farah	3101	No HR	No HR	**No HR**

Risk Categorization of Districts 2017-2019

Region	Province	District	DCODE	Priority of districts 2017	Priority of districts 2018	Priority of districts 2019
West	Farah	Pushtrod	3105	No HR	No HR	**No HR**
West	Farah	Qala-e-Kah	3106	No HR	No HR	**No HR**
West	Farah	Shibkoh	3107	No HR	No HR	**No HR**
West	Farah	Lash-e-Juwayn	3108	No HR	No HR	**No HR**
West	Farah	Purchaman	3110	No HR	No HR	**No HR**
West	Farah	Anardara	3111	No HR	No HR	**No HR**
West	Farah	Bakwa	3102	**VHRD**	**VHRD**	**VHRD**
West	Farah	Balabuluk	3103	**VHRD**	**VHRD**	**VHRD**
West	Farah	Khak-e-Safed	3104	**VHRD**	**VHRD**	**VHRD**
West	Farah	Gulestan	3109	**VHRD**	**VHRD**	**VHRD**
North	Faryab	Ghormach	2907	**HRD**	**HRD**	**No HR**
North	Faryab	Almar	2805	**HRD**	**HRD**	**No HR**
North	Faryab	Maymana	2801	No HR	No HR	**No HR**
North	Faryab	Khwajasabzposh	2802	No HR	No HR	**No HR**
North	Faryab	Pashtunkot	2803	No HR	No HR	**No HR**
North	Faryab	Shirintagab	2804	No HR	No HR	**No HR**
North	Faryab	Kohestan	2807	No HR	No HR	**No HR**
North	Faryab	Garziwan	2808	No HR	No HR	**No HR**
North	Faryab	Bilcheragh	2809	No HR	No HR	**No HR**
North	Faryab	Dawlatabad	2810	No HR	No HR	**No HR**
North	Faryab	Andkhoy	2811	No HR	No HR	**No HR**
North	Faryab	Qaramqol	2812	No HR	No HR	**No HR**
North	Faryab	Khan-e-Char Bagh	2813	No HR	No HR	**No HR**
North	Faryab	Qorghan	2814	No HR	No HR	**No HR**
North	Faryab	Qaysar	2806	**VHRD**	**VHRD**	**No HR**
Southeast	Ghazni	Ghazni	1101	No HR	No HR	**No HR**
Southeast	Ghazni	Khwajaumari	1102	No HR	No HR	**No HR**
Southeast	Ghazni	Walimuhammad-e- Shahid	1103	No HR	No HR	**No HR**
Southeast	Ghazni	Waghaz	1104	No HR	No HR	**No HR**
Southeast	Ghazni	Andar	1105	No HR	No HR	**No HR**
Southeast	Ghazni	Dehyak	1106	No HR	No HR	**No HR**
Southeast	Ghazni	Zanakhan	1107	No HR	No HR	**No HR**
Southeast	Ghazni	Rashidan	1108	No HR	No HR	**No HR**
Southeast	Ghazni	Jaghatu	1109	No HR	No HR	**No HR**
Southeast	Ghazni	Qarabagh	1110	No HR	No HR	**No HR**
Southeast	Ghazni	Nawur	1112	No HR	No HR	**No HR**
Southeast	Ghazni	Jaghuri	1113	No HR	No HR	**No HR**
Southeast	Ghazni	Muqur	1114	No HR	No HR	**No HR**
Southeast	Ghazni	Abband	1115	No HR	No HR	**No HR**
Southeast	Ghazni	Ajrestan	1116	No HR	No HR	**No HR**
Southeast	Ghazni	Malestan	1117	No HR	No HR	**No HR**

Risk Categorization of Districts 2017-2019

Region	Province	District	DCODE	Priority of districts 2017	Priority of districts 2018	Priority of districts 2019
Southeast	Ghazni	Gelan	1118	No HR	No HR	**No HR**
Southeast	Ghazni	Nawa	1119	No HR	No HR	**No HR**
Southeast	Ghazni	Giro	1111	**HRD**	**HRD**	**HRD**
Central	Ghor	Lal Wa Sarjangal	2108	**HRD**	**HRD**	**No HR**
West	Ghor	Chaghcharan	2101	No HR	No HR	**No HR**
West	Ghor	Charsadra	2102	No HR	No HR	**No HR**
West	Ghor	DoLayna	2103	No HR	No HR	**No HR**
West	Ghor	Dawlatyar	2104	No HR	No HR	**No HR**
West	Ghor	Shahrak	2105	No HR	No HR	**No HR**
West	Ghor	Pasaband	2107	No HR	No HR	**No HR**
West	Ghor	Tolak	2109	No HR	No HR	**No HR**
West	Ghor	Saghar	2110	No HR	No HR	**No HR**
West	Ghor	Taywarah	2106	**HRD**	**HRD**	**HRD**
South	Helmand	Nad-e-Ali	3203	**VHRD**	**FD**	**FD**
South	Helmand	Nahr-e-Saraj	3202	**VHRD**	**FD**	**FD**
South	Helmand	Nawzad	3207	**VHRD**	**FD**	**FD**
South	Helmand	Lashkargah	3201	**VHRD**	**FD**	**FD**
South	Helmand	Musaqalah	3206	**VHRD**	**FD**	**FD**
South	Helmand	Nawa-e-Barakzaiy	3204	**VHRD**	**FD**	**FD**
South	Helmand	Sangin	3205	**VHRD**	**FD**	**FD**
South	Helmand	Reg	3212	**VHRD**	**FD**	**FD**
South	Helmand	Kajaki	3210	**VHRD**	**FD**	**FD**
South	Helmand	Deh-e-shu	3213	No HR	No HR	**No HR**
South	Helmand	Washer	3208	**HRD**	**HRD**	**HRD**
South	Helmand	Baghran	3211	**HRD**	**HRD**	**HRD**
South	Helmand	Garmser	3209	**HRD**	**HRD**	**HRD**
West	Herat	Herat	3001	No HR	No HR	**No HR**
West	Herat	Injil	3002	No HR	No HR	**No HR**
West	Herat	Kushk	3003	No HR	No HR	**No HR**
West	Herat	Zindajan	3004	No HR	No HR	**No HR**
West	Herat	Guzara	3005	No HR	No HR	**No HR**
West	Herat	Pashtunzarghun	3006	No HR	No HR	**No HR**
West	Herat	Karukh	3007	No HR	No HR	**No HR**
West	Herat	Gulran	3008	No HR	No HR	**No HR**
West	Herat	Ghoryan	3009	No HR	No HR	**No HR**
West	Herat	Adraskan	3010	No HR	No HR	**No HR**
West	Herat	Farsi	3011	No HR	No HR	**No HR**
West	Herat	Obe	3012	No HR	No HR	**No HR**
West	Herat	Kushk-e-Kohna	3013	No HR	No HR	**No HR**
West	Herat	Kohsan	3014	No HR	No HR	**No HR**
West	Herat	Chisht-e-Sharif	3016	No HR	No HR	**No HR**

Risk Categorization of Districts 2017-2019

Region	Province	District	DCODE	Priority of districts 2017	Priority of districts 2018	Priority of districts 2019
West	Herat	Shindand	3015	VHRD	VHRD	VHRD
North	Jawzjan	Shiberghan	2701	No HR	No HR	No HR
North	Jawzjan	Mingajik	2702	No HR	No HR	No HR
North	Jawzjan	Khwajadukoh	2703	No HR	No HR	No HR
North	Jawzjan	Qushtepa	2704	No HR	No HR	No HR
North	Jawzjan	Fayzabad	2705	No HR	No HR	No HR
North	Jawzjan	Khanaqa	2706	No HR	No HR	No HR
North	Jawzjan	Aqcha	2707	No HR	No HR	No HR
North	Jawzjan	Mardyan	2708	No HR	No HR	No HR
North	Jawzjan	Qarqin	2709	No HR	No HR	No HR
North	Jawzjan	Khamyab	2710	No HR	No HR	No HR
North	Jawzjan	Darzab	2711	No HR	No HR	No HR
Central	Kabul	Dehsabz	102	No HR	No HR	No HR
Central	Kabul	Shakardara	103	No HR	No HR	No HR
Central	Kabul	Paghman	104	No HR	No HR	No HR
Central	Kabul	Chaharasyab	105	No HR	No HR	No HR
Central	Kabul	Musayi	106	No HR	No HR	No HR
Central	Kabul	Bagrami	107	No HR	No HR	No HR
Central	Kabul	Qarabagh	108	No HR	No HR	No HR
Central	Kabul	Kalakan	109	No HR	No HR	No HR
Central	Kabul	Mirbachakot	110	No HR	No HR	No HR
Central	Kabul	Guldara	111	No HR	No HR	No HR
Central	Kabul	Khak-e- Jabbar	112	No HR	No HR	No HR
Central	Kabul	Surobi	113	No HR	No HR	No HR
Central	Kabul	Estalef	114	No HR	No HR	No HR
Central	Kabul	Farza	115	No HR	No HR	No HR
Central	Kabul	Kabul	101	VHRD	VHRD	VHRD
South	Kandahar	Kandahar	3301	VHRD	FD	FD
South	Kandahar	Shahwalikot	3306	VHRD	FD	FD
South	Kandahar	Zheray	3303	VHRD	FD	FD
South	Kandahar	Maywand	3308	VHRD	FD	FD
South	Kandahar	Spinboldak	3311	VHRD	FD	FD
South	Kandahar	Panjwayi	3304	VHRD	FD	FD
South	Kandahar	Maruf	3316	No HR	No HR	No HR
South	Kandahar	Reg	3309	VHRD	VHRD	VHRD
South	Kandahar	Shorabak	3310	VHRD	VHRD	VHRD
South	Kandahar	Miyanshin	3313	VHRD	VHRD	VHRD
South	Kandahar	Ghorak	3315	VHRD	VHRD	VHRD
South	Kandahar	Arghandab	3302	VHRD	VHRD	VHRD
South	Kandahar	Khakrez	3307	VHRD	VHRD	VHRD
South	Kandahar	Daman	3305	VHRD	VHRD	VHRD

Risk Categorization of Districts 2017-2019

Region	Province	District	DCODE	Priority of districts 2017	Priority of districts 2018	Priority of districts 2019
South	Kandahar	Arghestan	3312	VHRD	VHRD	VHRD
South	Kandahar	Nesh	3314	VHRD	VHRD	VHRD
Central	Kapisa	Mahmud-e- Raqi	201	HRD	HRD	No HR
Central	Kapisa	Nejrab	202	HRD	HRD	No HR
Central	Kapisa	Kohband	203	No HR	No HR	No HR
Central	Kapisa	Hisa-e- Duwum-e- Kohestan	204	No HR	No HR	No HR
Central	Kapisa	Tagab	205	No HR	No HR	No HR
Central	Kapisa	Alasay	206	No HR	No HR	No HR
Central	Kapisa	Hisa-e- Awal-e- Kohestan	207	No HR	No HR	No HR
Southeast	Khost	Mandozayi	2605	HRD	HRD	HRD
Southeast	Khost	Musakhel	2603	HRD	HRD	HRD
Southeast	Khost	Terezayi	2608	HRD	HRD	HRD
Southeast	Khost	Khost(Matun)	2601	No HR	No HR	No HR
Southeast	Khost	Sabari	2602	No HR	No HR	No HR
Southeast	Khost	Nadirshahkot	2604	No HR	No HR	No HR
Southeast	Khost	Tani	2606	No HR	No HR	No HR
Southeast	Khost	Gurbuz	2607	No HR	HRD	No HR
Southeast	Khost	Qalandar	2609	No HR	No HR	No HR
Southeast	Khost	Shamal	2610	No HR	No HR	No HR
Southeast	Khost	Spera	2611	No HR	HRD	No HR
Southeast	Khost	Bak	2612	No HR	No HR	No HR
Southeast	Khost	Jajimaydan	2613	No HR	No HR	No HR
East	Kunar	Barkunar	1311	HRD	HRD	HRD
East	Kunar	Chawkay	1308	No HR	No HR	HRD
East	Kunar	Narang	1303	HRD	HRD	HRD
East	Kunar	Khaskunar	1309	HRD	HRD	HRD
East	Kunar	Dangam	1310	HRD	HRD	HRD
East	Kunar	Nari	1315	HRD	HRD	HRD
East	Kunar	Asadabad	1301	HRD	HRD	HRD
East	Kunar	Sarkani	1304	No HR	No HR	No HR
East	Kunar	Nurgal	1314	No HR	No HR	No HR
East	Kunar	Watapur	1302	VHRD	VHRD	VHRD
East	Kunar	Shigal Wa sheltan	1306	VHRD	VHRD	VHRD
East	Kunar	Chapadara	1313	VHRD	VHRD	VHRD
East	Kunar	Marawara	1305	VHRD	VHRD	VHRD
East	Kunar	Dara-e-Pech	1307	VHRD	VHRD	VHRD
East	Kunar	Ghaziabad	1312	HRD	HRD	VHRD
Northeast	Kunduz	Dasht-e-Archi	1707	VHRD	VHRD	No HR
Northeast	Kunduz	Emamsaheb	1702	HRD	HRD	No HR
Northeast	Kunduz	Aliabad	1705	HRD	HRD	No HR
Northeast	Kunduz	Kunduz	1701	HRD	HRD	No HR

Risk Categorization of Districts 2017-2019

Region	Province	District	DCODE	Priority of districts 2017	Priority of districts 2018	Priority of districts 2019
Northeast	Kunduz	Chardarah	1704	HRD	HRD	No HR
Northeast	Kunduz	Qala-e-Zal	1703	No HR	HRD	No HR
Northeast	Kunduz	Khanabad	1706	No HR	HRD	No HR
East	Laghman	Alingar	704	HRD	HRD	HRD
East	Laghman	Mehtarlam	701	No HR	No HR	No HR
East	Laghman	Alishang	702	No HR	No HR	No HR
East	Laghman	Qarghayi	703	No HR	No HR	No HR
East	Laghman	Dawlatshah	705	No HR	No HR	No HR
Central	Logar	Pul-e- Alam	501	No HR	No HR	No HR
Central	Logar	Khoshi	502	No HR	No HR	No HR
Central	Logar	Mohammadagha	503	No HR	No HR	No HR
Central	Logar	Barakibarak	504	No HR	No HR	No HR
Central	Logar	Charkh	505	No HR	No HR	No HR
Central	Logar	Kharwar	506	No HR	No HR	No HR
Central	Logar	Azra	507	No HR	No HR	No HR
East	Nangarhar	Surkhrod	603	HRD	HRD	HRD
East	Nangarhar	Kama	607	No HR	No HR	HRD
East	Nangarhar	Pachieragam	612	No HR	No HR	HRD
East	Nangarhar	Dehbala	613	HRD	HRD	HRD
East	Nangarhar	Kot	614	HRD	HRD	HRD
East	Nangarhar	Achin	617	VHRD	VHRD	VHRD
East	Nangarhar	Batikot	615	VHRD	VHRD	VHRD
East	Nangarhar	Khogyani	604	No HR	No HR	No HR
East	Nangarhar	Chaparhar	605	No HR	No HR	No HR
East	Nangarhar	Rodat	606	No HR	No HR	No HR
East	Nangarhar	Kuzkunar	608	No HR	No HR	No HR
East	Nangarhar	Dara-e-Nur	609	No HR	No HR	No HR
East	Nangarhar	Hesarak	610	No HR	No HR	No HR
East	Nangarhar	Goshta	616	No HR	No HR	No HR
East	Nangarhar	Nazyan	621	No HR	No HR	No HR
East	Nangarhar	Durbaba	622	No HR	No HR	No HR
East	Nangarhar	Lalpur	620	VHRD	VHRD	VHRD
East	Nangarhar	Muhmand Dara	619	VHRD	VHRD	VHRD
East	Nangarhar	Behsud	602	VHRD	VHRD	VHRD
East	Nangarhar	Shinwar	618	VHRD	VHRD	VHRD
East	Nangarhar	Sherzad	611	VHRD	VHRD	VHRD
East	Nangarhar	Jalalabad	601	VHRD	VHRD	VHRD
South	Nimroz	Khashrod	3405	HRD	HRD	HRD
South	Nimroz	Kang	3402	No HR	No HR	No HR
South	Nimroz	Charburjak	3403	No HR	No HR	No HR
South	Nimroz	Chakhansur	3404	No HR	No HR	No HR

Risk Categorization of Districts 2017-2019

Region	Province	District	DCODE	Priority of districts 2017	Priority of districts 2018	Priority of districts 2019
South	Nimroz	Zaranj	3401	VHRD	VHRD	VHRD
East	Nuristan	Kamdesh	1407	HRD	HRD	HRD
East	Nuristan	Poruns	1401	No HR	No HR	HRD
East	Nuristan	Barg-e- Matal	1408	HRD	HRD	HRD
East	Nuristan	Mandol	1402	No HR	No HR	No HR
East	Nuristan	Duab	1403	No HR	No HR	No HR
East	Nuristan	Nurgeram	1404	No HR	No HR	No HR
East	Nuristan	Wama	1405	No HR	No HR	No HR
East	Nuristan	Waygal	1406	No HR	No HR	No HR
Southeast	Paktia	Chamkani	1210	HRD	HRD	HRD
Southeast	Paktia	Zadran	1206	HRD	HRD	HRD
Southeast	Paktia	Gardez	1201	No HR	No HR	No HR
Southeast	Paktia	Sayedkaram	1202	No HR	No HR	No HR
Southeast	Paktia	Ahmadaba	1203	No HR	No HR	No HR
Southeast	Paktia	Zurmat	1204	No HR	No HR	No HR
Southeast	Paktia	Shawak	1205	No HR	No HR	No HR
Southeast	Paktia	Lija Ahmad Khel	1207	No HR	No HR	No HR
Southeast	Paktia	Alikhel (Jaji)	1208	No HR	No HR	No HR
Southeast	Paktia	Janikhel	1209	No HR	No HR	No HR
Southeast	Paktia	Dand wa Patan	1211	No HR	No HR	No HR
Southeast	Paktika	Sharan	2501	No HR	No HR	No HR
Southeast	Paktika	Matakhan	2502	No HR	No HR	No HR
Southeast	Paktika	Yosufkhel	2503	No HR	No HR	No HR
Southeast	Paktika	Sarrawzah(Sarhawzah)	2504	No HR	No HR	No HR
Southeast	Paktika	Zarghunshahr	2505	No HR	No HR	No HR
Southeast	Paktika	Yahyakhel	2506	No HR	No HR	No HR
Southeast	Paktika	Omna	2507	No HR	No HR	No HR
Southeast	Paktika	Gomal	2508	No HR	No HR	No HR
Southeast	Paktika	Sarobi	2509	No HR	No HR	No HR
Southeast	Paktika	Urgun	2510	No HR	No HR	No HR
Southeast	Paktika	Naka	2511	No HR	No HR	No HR
Southeast	Paktika	Janikhel	2512	No HR	No HR	No HR
Southeast	Paktika	Wazakhah	2513	No HR	No HR	No HR
Southeast	Paktika	Wormamay	2514	No HR	No HR	No HR
Southeast	Paktika	Gyan	2516	No HR	HRD	No HR
Southeast	Paktika	Ziruk	2517	No HR	No HR	No HR
Southeast	Paktika	Dila	2518	No HR	No HR	No HR
Southeast	Paktika	Turwo (Tarwe)	2519	No HR	No HR	No HR
Southeast	Paktika	Bermel	2515	VHRD	VHRD	VHRD
Central	Panjshir	Bazarak	801	No HR	No HR	No HR
Central	Panjshir	Shutul	802	No HR	No HR	No HR

Risk Categorization of Districts 2017-2019

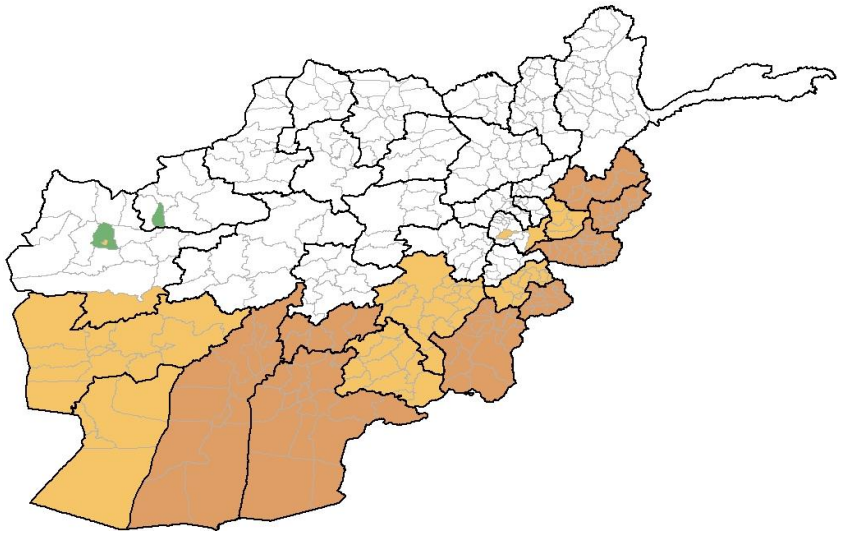
Region	Province	District	DCODE	Priority of districts 2017	Priority of districts 2018	Priority of districts 2019
Central	Panjshir	Rukha	803	No HR	No HR	**No HR**
Central	Panjshir	Dara	804	No HR	No HR	**No HR**
Central	Panjshir	Khenj (Hes-e- Awal)	805	No HR	No HR	**No HR**
Central	Panjshir	Onaba(Anawa)	806	No HR	No HR	**No HR**
Central	Panjshir	Paryan	807	No HR	No HR	**No HR**
Central	Parwan	Charikar	301	**HRD**	**HRD**	**No HR**
Central	Parwan	Jabalussaraj	302	No HR	No HR	**No HR**
Central	Parwan	Shinwari	303	No HR	No HR	**No HR**
Central	Parwan	Bagram	304	No HR	No HR	**No HR**
Central	Parwan	Saydkhel	305	No HR	No HR	**No HR**
Central	Parwan	Salang	306	No HR	No HR	**No HR**
Central	Parwan	Ghorband	307	No HR	No HR	**No HR**
Central	Parwan	Koh-e- Safi	308	No HR	No HR	**No HR**
Central	Parwan	Shekhali	309	No HR	No HR	**No HR**
Central	Parwan	Surkh-e- Parsa	310	No HR	No HR	**No HR**
North	Samangan	Aybak	1901	No HR	No HR	**No HR**
North	Samangan	Hazrat-e- Sultan	1902	No HR	No HR	**No HR**
North	Samangan	Feroznakhchir	1903	No HR	No HR	**No HR**
North	Samangan	Dara-e- Suf-e- Payin	1904	No HR	No HR	**No HR**
North	Samangan	Dara-e Suf-e-Bala	1905	No HR	No HR	**No HR**
North	Samangan	Khuram Wa Sarbagh	1906	No HR	No HR	**No HR**
North	Samangan	Ruy-e-Duab	1907	No HR	No HR	**No HR**
North	Sar e Pul	Sar-e-Pul	2001	No HR	No HR	**No HR**
North	Sar e Pul	Sayad	2002	No HR	No HR	**No HR**
North	Sar e Pul	Kohestanat	2003	No HR	No HR	**No HR**
North	Sar e Pul	Sozmaqala	2004	No HR	No HR	**No HR**
North	Sar e Pul	Gosfandi	2005	No HR	No HR	**No HR**
North	Sar e Pul	Balkhab	2006	No HR	No HR	**No HR**
North	Sar e Pul	Sancharak(sangchark)	2007	No HR	No HR	**No HR**
Northeast	Takhar	Taloqan	1601	No HR	No HR	**No HR**
Northeast	Takhar	Hazarsumuch	1602	No HR	No HR	**No HR**
Northeast	Takhar	Baharak	1603	No HR	No HR	**No HR**
Northeast	Takhar	Bangi	1604	No HR	No HR	**No HR**
Northeast	Takhar	Chal	1605	No HR	No HR	**No HR**
Northeast	Takhar	Namakab	1606	No HR	No HR	**No HR**
Northeast	Takhar	Farkhar	1607	No HR	No HR	**No HR**
Northeast	Takhar	Kalafgan	1608	No HR	No HR	**No HR**
Northeast	Takhar	Rostaq	1609	No HR	No HR	**No HR**
Northeast	Takhar	Chahab	1610	No HR	No HR	**No HR**
Northeast	Takhar	Yangi Qala	1611	No HR	No HR	**No HR**
Northeast	Takhar	Khwajabahawuddin	1612	No HR	No HR	**No HR**

Risk Categorization of Districts 2017-2019

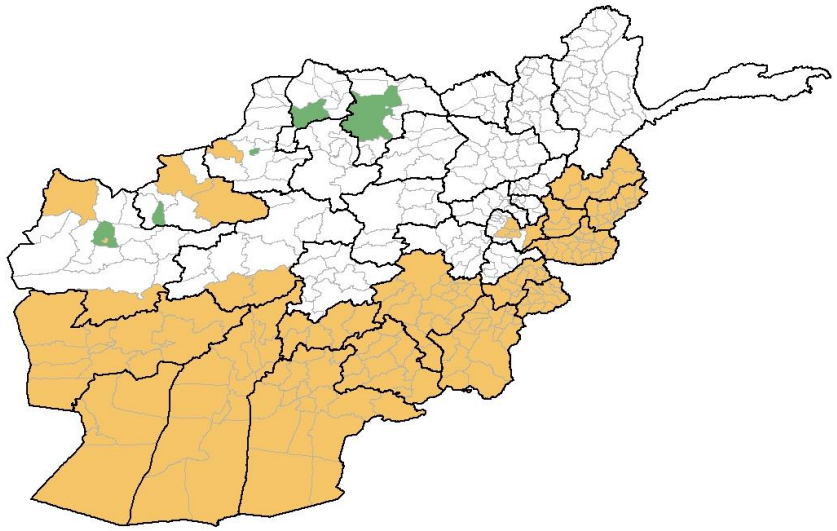
Region	Province	District	DCODE	Priority of districts 2017	Priority of districts 2018	Priority of districts 2019
Northeast	Takhar	Dasht-e- Qala	1613	No HR	No HR	**No HR**
Northeast	Takhar	Khwajaghar	1614	No HR	No HR	**No HR**
Northeast	Takhar	Eshkashem	1615	No HR	No HR	**No HR**
Northeast	Takhar	Warsaj	1616	No HR	No HR	**No HR**
Northeast	Takhar	Darqad	1617	No HR	No HR	**No HR**
South	Urozgan	Shahid-e-Hassas	2303	**HRD**	**HRD**	**HRD**
South	Urozgan	Chora	2302	**HRD**	**HRD**	**HRD**
South	Urozgan	Khasuruzgan	2305	No HR	No HR	**No HR**
South	Urozgan	Dehrawud	2304	**VHRD**	**VHRD**	**VHRD**
South	Urozgan	Tirinkot	2301	**VHRD**	**VHRD**	**VHRD**
Central	Wardak	Maydanshahr	401	No HR	No HR	**No HR**
Central	Wardak	Jalrez	402	No HR	No HR	**No HR**
Central	Wardak	Nerkh	403	No HR	No HR	**No HR**
Central	Wardak	Hesa-e- Awal-e- Behsud	404	No HR	No HR	**No HR**
Central	Wardak	Daymirdad	405	No HR	No HR	**No HR**
Central	Wardak	Chak	406	No HR	No HR	**No HR**
Central	Wardak	Saydabad	407	No HR	No HR	**No HR**
Central	Wardak	Markaz-e-Behsud	408	No HR	No HR	**No HR**
Central	Wardak	Jaghatu	409	No HR	No HR	**No HR**
South	Zabul	Arghandab	2402	**HRD**	**HRD**	**HRD**
South	Zabul	Mizan	2403	**HRD**	**HRD**	**HRD**
South	Zabul	Daychopan	2408	**HRD**	**HRD**	**HRD**
South	Zabul	Tarnak Wa Jaldak	2404	**HRD**	**HRD**	**HRD**
South	Zabul	Shahjoy	2406	**HRD**	**HRD**	**HRD**
South	Zabul	Atghar	2409	**HRD**	**HRD**	**HRD**
South	Zabul	Nawbahar	2411	**HRD**	**HRD**	**HRD**
South	Zabul	Shinkay	2405	**HRD**	**HRD**	**No HR**
South	Zabul	Qalat	2401	**VHRD**	**VHRD**	**VHRD**
South	Zabul	Kakar	2407	No HR	No HR	**No HR**
South	Zabul	Shomulzay	2410	No HR	No HR	**No HR**

SIA calendar 2019 (Jan-Jun)

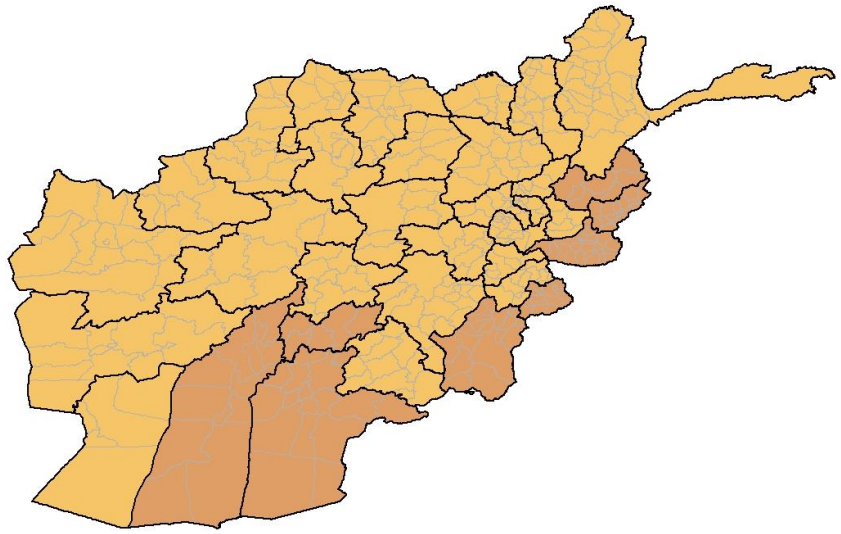
21-25 January 2019



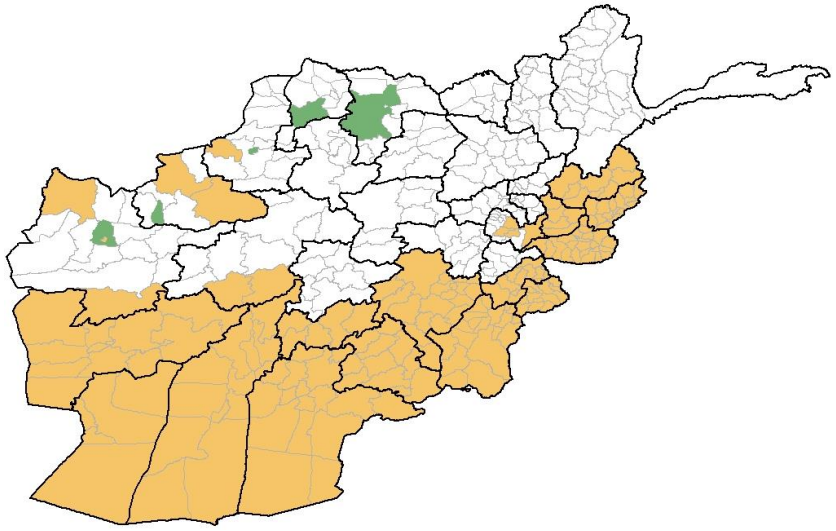
18-22 February 2019



25-29 March 2019



22-26 April 2019



17-21 June 2019

Full district targeted – mOPV1

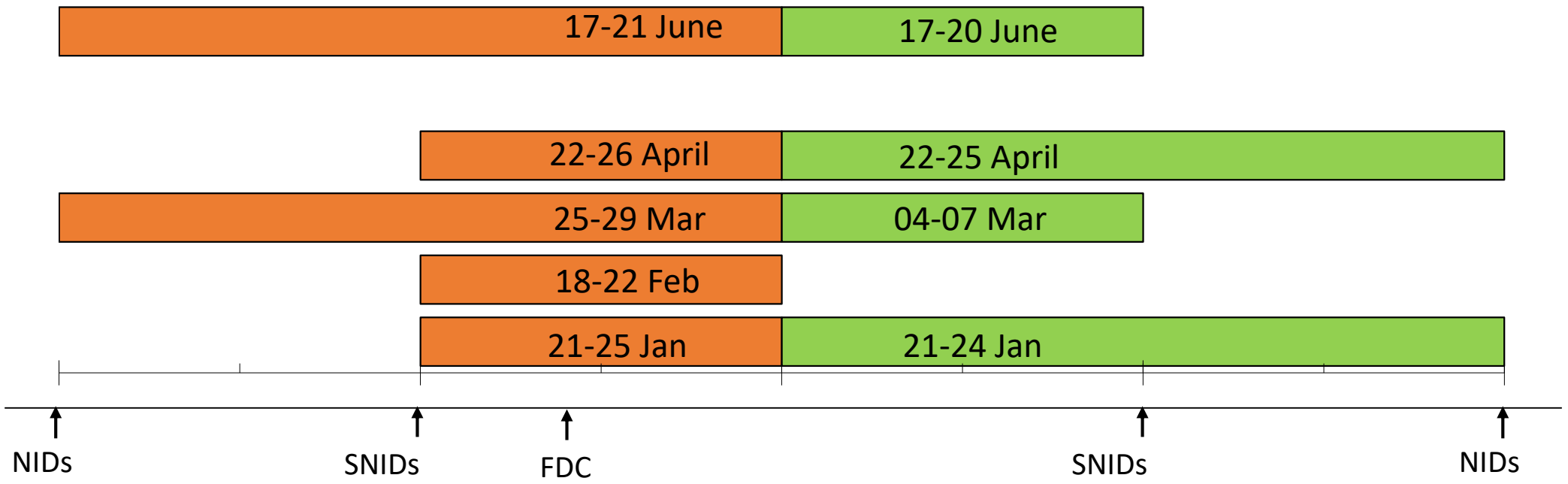
Full district targeted - bOPV

Partial district targeted (IDP/HRMP) - bOPV

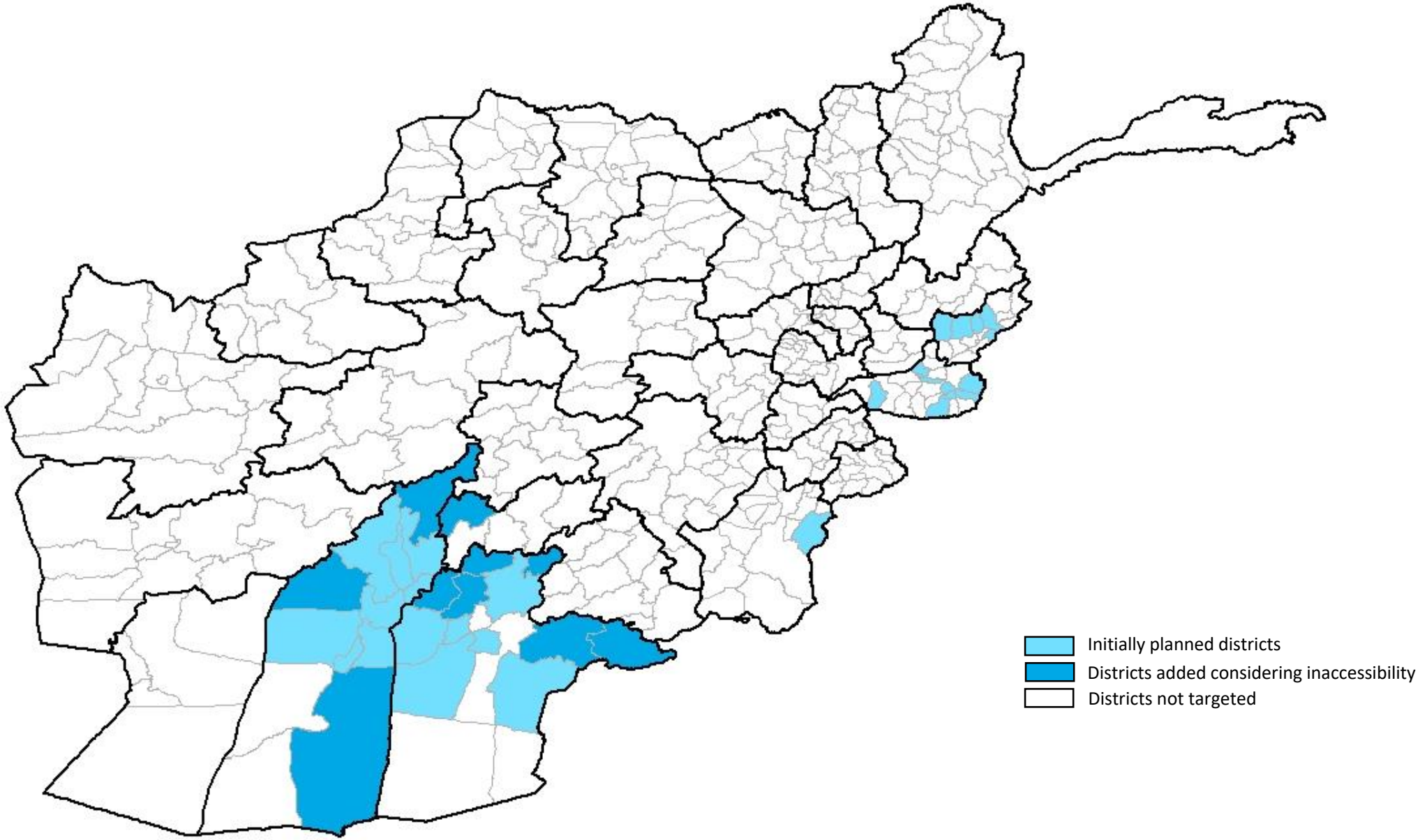
SIA schedule AFG & PAK, Jan to June 2019

AFGHANISTAN

PAKISTAN



SIA Schedule for 2019 (IPV)



Afghanistan Polio Eradication

Communication Action Plan
2019

Contents

Overview

The purpose of this document is to summarize the polio communications strategic response for 2019. This document is for internal/partners use and is intended as a reference for communications staff working on polio communication.

Mission

Support the NEAP goal of stopping transmission of wild poliovirus in the Southern & Eastern regions of the country, with no further spread to polio-free areas.

Vision and Goals

The purpose of this communications action plan is to ensure the vision that the Communication Work Group communicates effectively with one voice to help create a polio-free Afghanistan by achieving the following goals:

- **Increase knowledge** to support positive vaccination decisions
- **Improve polio communication coordination** to increase efficiency and effectiveness of efforts
- **Increase community trust** in polio vaccine and program
- **Reduce missed children** (including by not limited to refusals)

Figure 1: CWG Vision and Goals

Background

In 2017, Afghanistan had a total 14 confirmed wild polio vises cases. The number of cases increased in 2018 with a total of 21 cases. While Afghanistan has done a good job reducing the areas with polio, the South and Eastern regions continue to have ongoing transmission.

These regions remain challenges due to insecurity, access problems and, cross-border movement. Additionally, misperceptions about the vaccine persist. Due to these issues, the Southern and Eastern districts contribute to the highest numbers of refusals and absences in the country.

The Southern region districts form a common epidemiological corridor known as the 'Southern Corridor' together with districts of Baluchistan Province in Pakistan. The southern corridor has frequent and consistent movement. This has led to high numbers of children marked as 'absent' when vaccination teams visit their homes. Apart from the southern corridor, the wild polio virus continues to circulate in localized geographical areas in the east, which is another priority for communication initiatives.

Building on Successes

Vaccine acceptance has increased. For example, caregivers' intent to vaccinate *increased* from 77% in 2015 to 89% in 2017. Additionally, belief in destructive polio-related rumours *decreased* from 42% in 2015 to 16% in 2017.[1]

[1] 2015 and 2017 Harvard Polling Knowledge, Attitudes and Practices study. New data will be available 2Q19.

Absent children have decreased. Missed children reduced from 6.8% in 2016 to 4.2% in 2017 and 3.14% in 2018. Specifically, for very high-risk districts which have the Immunization Communication Network (ICN), missed children reduced from 7.6% to 3.01% during that same period.

Refusals remain low. The overall percentage of children missed due to refusal reduced from 0.3% in 2016 down to 0.27% in 2017 but increased again in 2018 to 0.43%; while in ICN districts it reduced from 0.44% 2016 to 0.36% in 2017 but increased again in 2018 to 0.44%.[2]

Of important note, "catch up" activities and non-campaign vaccination vaccinates many children missed due to absence or refusal. On average, 70% of the children missed as absent, and 30% children missed as refusals were vaccinated by social mobilizers in between campaigns, and therefore not captured in the above campaign data.

However, there are chronic pockets of refusals and these areas need to be a focus for communication efforts (see Figures 2 and 3 below).

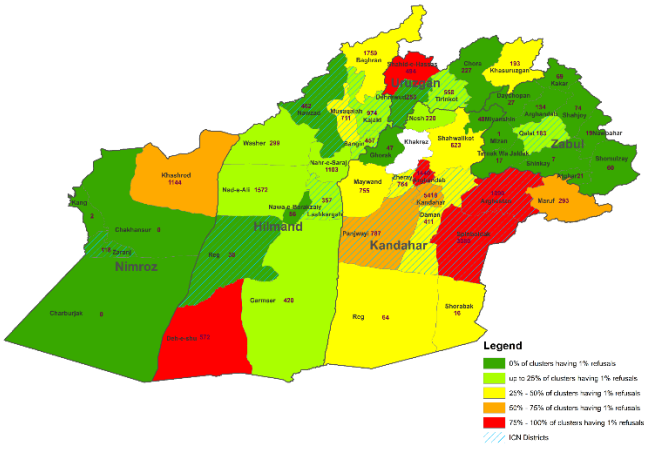


Figure 2: Southern Region Refusals (Source: Admin data May 2018)

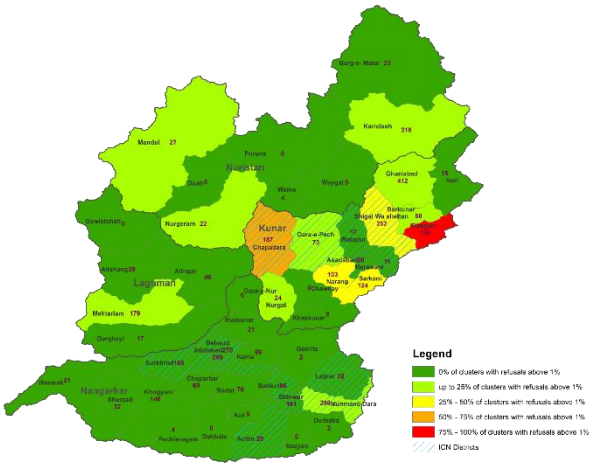


Figure 3: Eastern Region Refusals (Source: Admin data May 2018)

Continuing challenges

The program has done a very good job improving coverage and quality but there is still work to be done.

Inaccessibility in the South. Since May 2018, the program has been banned from conducting house-to-house campaigns in many areas of the Southern Region (see figure 3). In the months since the ban, almost 1 million children each campaign are unprotected from polio in a region where polio has the highest transmission in Afghanistan. ***Communication must work with operations and other groups to ensure appropriate communication about activities designed to reach these children (PPT, etc.) while ensuring communication strategies provide a consistent narrative at the environmental level about the importance of house-to-house campaigns.***

[2] 2018 PCM data, WHO.

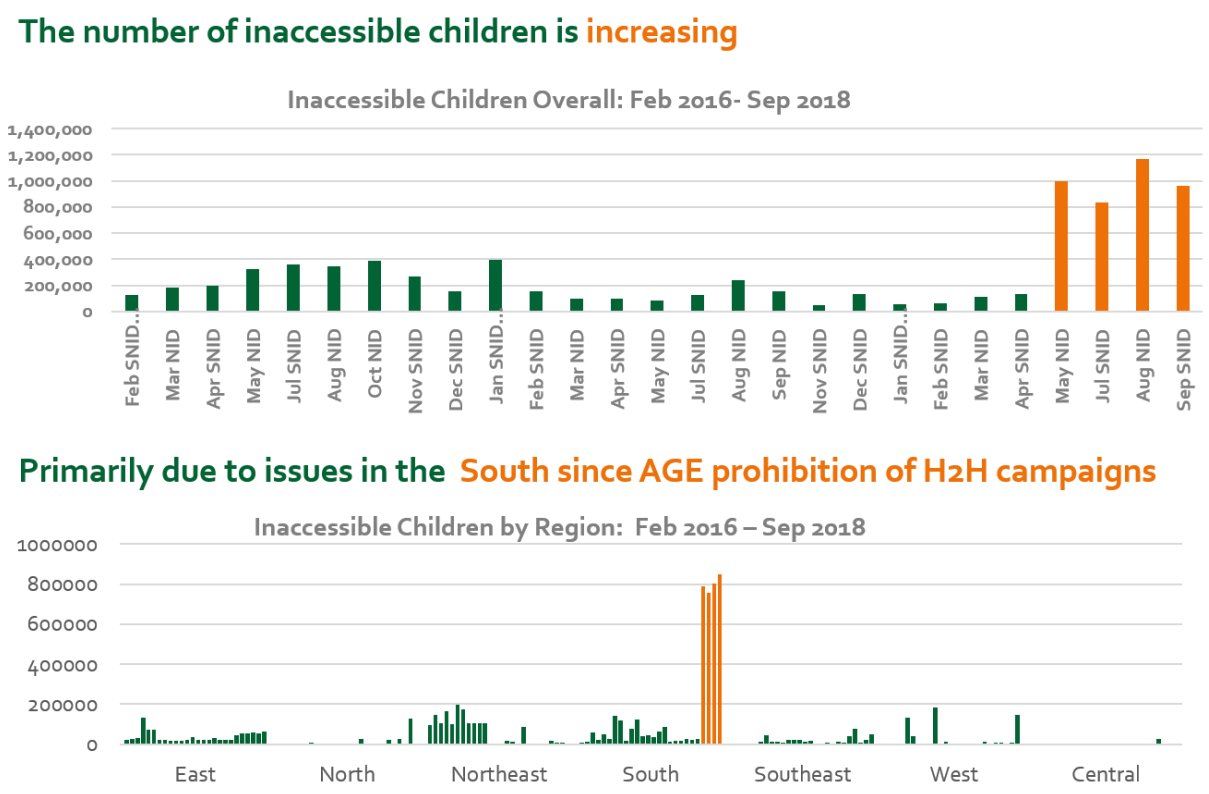


Figure 3: Increase in Inaccessible children

Continuing transmission in the Southern and Eastern Regions. While most regions of Afghanistan have stopped polio transmission, the Southern and Eastern regions continue to have cases. ***Targeted strategies were developed last year and need to be more strategically implemented this year reach the cluster level, particularly in high risk areas like Shahwalikot. The Technical Advisory Group has emphasized a need to focus on Kandahar.***

Large pockets of missed children. Missed children continues to be an issue, particularly in high-risk areas. In Kandahar, for example the percentage of missed children is on the rise. While these issues are isolated to specific pockets, the issue is significant. In three Kandahar districts, more than 50 percent of the clusters are missing more than 5 % of the children. Two major reasons of missed children are refusal and absent children. Root cause analysis needs to be conducted at the cluster level to understand the core issues related to absences and refusals specific to each high-risk cluster. ***Evidence-based strategies, tailored for context, need to employed and documented/reported on for specifically identified clusters.***

High-risk mobile populations continue to be difficult to reach. Mobile populations have been traditionally underserved by the Polio program, and by every other health service, in both Afghanistan and Pakistan. The work of the Cross-Border Task Team (CBTT) and communication approaches for High-Risk Mobile Populations (HRMP), adapted for the Northern and Southern Corridors through specifically tailored strategies, will be important for reaching these populations. Regional Emergency Operations Centers and regional-based team members will drive the content of adapted/adaptable approaches based on the needs and evidence in their regions. ***In conjunction with other partners, operations and communication teams will use HRMP data to increase vaccine acceptance in under-served populations.***

Misinformation, rumours, and trust issues regarding the vaccine and programme continue to be powerful detractors to vaccination. Perceptions and attitudes regarding polio vaccination are improving, however more effort is needed to address misinformation/rumours and public concerns contributing to missed children and pockets of persistent chronic refusals, especially focused in the south and east. Regional Emergency Operations Centers (REOCs) will regularly update the national-level communication working group to ensure that district and cluster level data related to persistent misinformation and rumours can inform communication activities and content. ***Crisis communication protocols with identified focal points will be the primary mechanism for ensuring that both proactive and reactive (when necessary) interventions are implemented on a timely and consistent basis.***

Fatigue and low feeling of community ownerships impacts engagement at the local level. Polio campaigns are frequent and extremely visible, and it is not well understood in the community why the focus and frequency are necessary. Additionally, there are trust issues with the programme that impact perception. Communication strategies will be adapted and updated over time to ensure that as community perceptions change, the Polio program's content changes apace. "Polio+ communication approaches" will be increasingly adopted to ensure that Frontline social mobilizers regularly share additional child-health related information, of perceived interest and use to caregivers. Increasing the perceived value of the information shared via radio, in advocacy meetings and at the doorstep may not reduce caregiver's feelings of "fatigue" towards repeated vaccination campaigns, but it may increase the perceived value of each "knock at the door," and thus facilitate with access to under-immunized children. ***Regular engagement by FLWs with caregivers will ensure that the perceptions and needs of community members are regularly identified and documented, so they can be addressed when possible, via health information or more resource-intensive "Polio +" activities.***

Perceptions and Motivations

- **Perception:** With the success of the polio program over the decades cases have waned to an extremely low number. The success has a negative side where polio is not always seen as a serious threat. Additionally, misconceptions about polio vaccines persist, such as that the vaccine is not halal. Additional perception considerations include:
    - Distrust of polio programme including FLW who are providing services
    - Disinterest in programme given other needs and priorities / diseases with higher burden
    - Distrust of polio campaigns, of concern are the lack of understanding of:
        - Need for repeated campaigns, particularly at the doorstep in an environment which can be insecure and lack of other services being offered
        - Why focus on polio when there are so many other competing issues
        - Why focus on Afghanistan ("if polio vax is so good why don't US/England/Etc. do it?")
    - Some families who don't want to vaccinate their children but feel pressured to do so are likely to:
        - undervalue the vaccine;
        - resent the pressure to get vaccinated;
        - assume that any illness their children get is a side-effect of the vaccine;
        - experience that illness as more severe than it would otherwise seem;
        - demand more in the way of treatment; and
        - blame the authorities for pushing them to get vaccinated.

- **Motivation:** There are important motivation considerations that we have learned to be true for polio vaccination. The biggest considerations are risk perceptions, perceptions of personal susceptibility and strength of trusted source recommendation.
    - **Risk Perception:** Because there is low morbidity polio may also not be seen as a serious threat.
    - **Personal Susceptibility:** Because the epidemiology of polio is not well understood by the public, there is a low understanding of the amount of disease circulating vs the visible singular case. Therefore, perception of personal susceptibility can be very low.
    - **Trusted Source Recommendation:** Strong recommendation by a trusted source or key influencer is a key factor in vaccination.

NEAP Objectives

The 2019 National Emergency Action Plan (NEAP) for Polio Eradication identified eight objectives for 2019. This strategy's efforts should be informed by and align with the following 2019 objectives:

1. To stop ongoing transmission in South and East region
2. To achieve and maintain high population immunity in the rest of VHRDs and HRDs, ensuring no secondary cases following possible importation.
3. To achieve and maintain high population immunity among HRMPs
4. To rapidly and effectively respond to any importation of WPV1 and/or emergence of VDPV2 into polio free areas of Afghanistan
5. To reduce proportion of missed children to less than 5% in all polio high risk areas by improving quality of SIAs
6. To improve vaccine acceptance contributing to a reduction in refusals
7. To gain and maintain access through flexible approaches
8. To maintain high levels of surveillance quality across the country with surveillance quality indicators meeting the global standards in all provinces

NEAP 2019 Goal

To stop transmission of wild poliovirus in the Southern & Eastern regions of the country, with no further spread to polio-free areas.

TAG and External Review Recommendations

The TAG (Jan '19) identified six key areas to prioritize in the next six months (see figure 4), including implementing a one team approach, addressing all missed children (not just refusals), a return to treating polio eradication as an emergency program, and a focus on Kandahar to stop transmission there in the next six months.

Figure 4: TAG Focus Areas

Several months prior to the TAG, an External Communication Review was conducted by UNICEF with participation from all partners and a number of outside organizations. The review identified six major areas for focus. The CWG mapped these areas, and specific recommendations, to the TAG focus areas to ensure a coordinated approach to addressing the recommendations of both the TAG and the External Review (see figure 5).

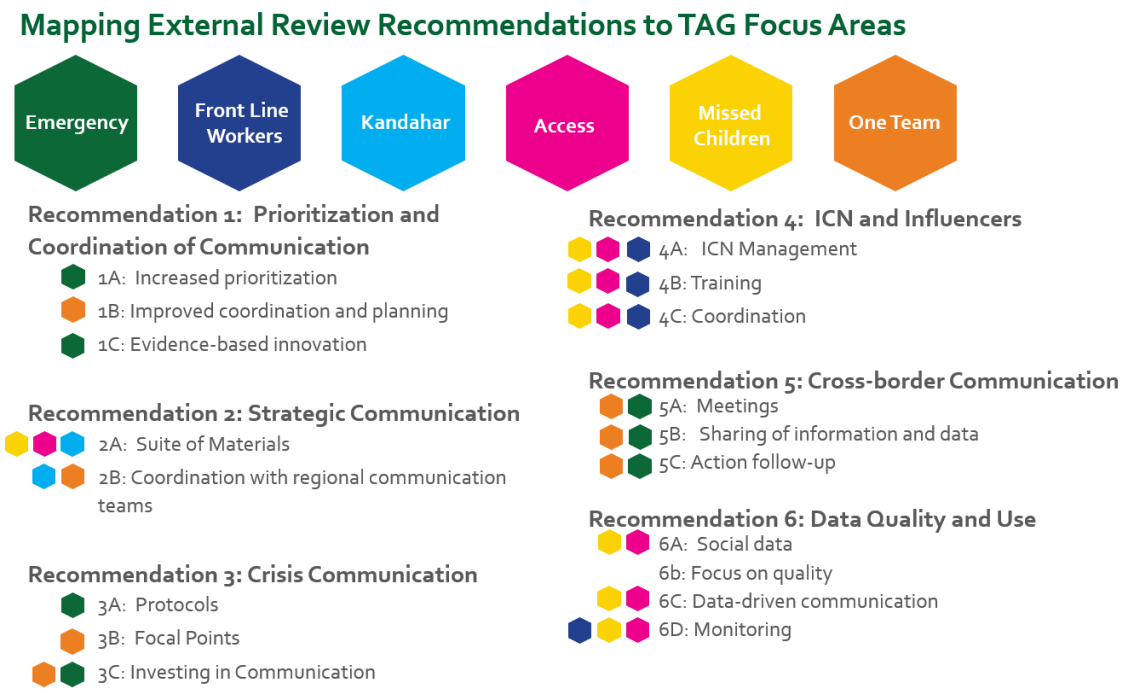


Figure 5: External Review and TAG Recommendations

Action Plan Synopsis / Key Components

The action plan is developed to support the 2019 NEAP priorities and objectives, the Jan 2019 TAG recommendations, the Nov 2018 External Review recommendations, and priorities identified by the field (particularly the South and East).a Key components include:

- **Consistent Messaging & Activities:** Effective communication efforts must use consistent messaging. Part of this action plan will be to update / develop core messages that are consistently used across ***all activities*** including internally (external communication, social mobilization, field level operations, etc.) and externally (partners, influencers, etc.).[3] Standardized guidance and tools, and if/when necessary training, will be provided to National and Regional communication team members to ensure coherence and consistency of messaging and other communication activities.
- **Tailor-ability:** Per the NEAP plan and TAG recommendations, this action plan provides a framework that is the foundation for communication activities with the ability to tailor based on audience and situation with a focus on IPC and limited materials for high priority regions.
- **Community Engagement:** All communication activities will be designed to include opportunities for the public to be involved, provide feedback, and ideally develop a strengthened sense of ownership in the program and the health and protection of their children.

[3] There is ample evidence that consistent core messaging is critical to programmatic success. In order to leverage the benefits of evidence-based, tested messages a core message bank will be updated/revised for use by all parties.

- **Coordination**: The action plan identifies ways to coordinate, and where possible integrate, efforts between communication and operations teams, between National and Regional teams, and between Polio and complementary programs (health, routine immunization, etc.)
- **Priorities:** While national level, overarching polio communication must continue to maintain progress across Afghanistan, this communication action plan focuses on several issues and regions:
    - **Issues:**
        - Missed Children: Refusal / Absence
        - HRMP
        - Misinformation / Rumors /mistrust
        - Community Engagement / Ownership
        - Fatigue / Waning Interest in Polio
    - **Regions:**
        - Border areas / Northern and Southern Corridors
        - Southern and Eastern Regions

Polio Program Communication Principles

The communication principles are based on a standard project management loop, tailored for communication. It is a three-part framework: develop for efficiency, localize for effectiveness, and strategize for impact.

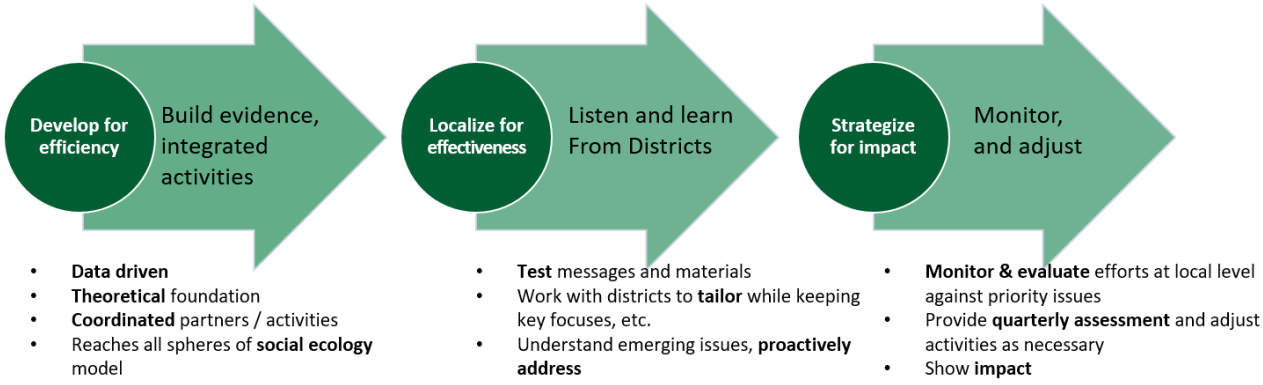
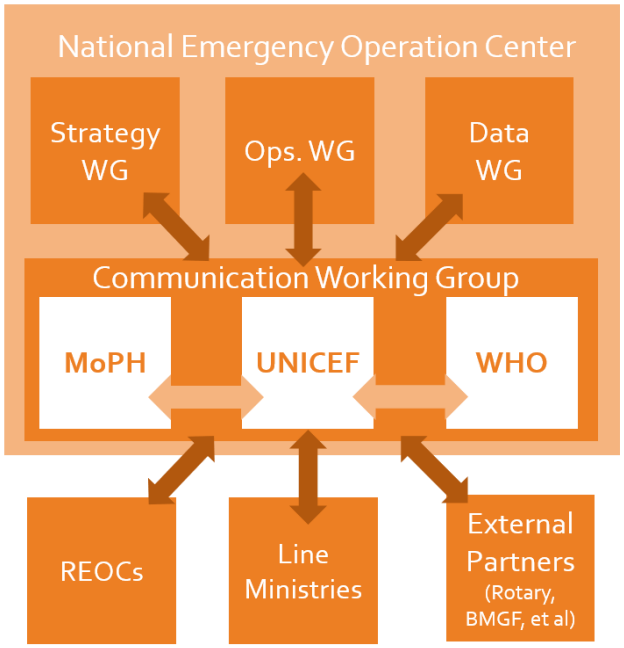


Figure 6: Polio Communication Framework

Vertical and Horizontal Coordination

Per both the TAG and External Review recommendations, special attention as been paid to developing a coordination "one team" approach to the communication work (as outlined in Figure 8). Activities will include more inclusive review and approval processes, regular meeting between NEOC and REOC communication teams, and improved integration across working groups at the NECO.

Developing a One Team Approach based on improved collaboration & coordination



- Monthly Communication Update
- Regular presentation to Strategy WG
- Invites to Ops and Data to present to CWG

- Weekly Mtgs. – last week of month is an all day work session
- Materials / Activities development and review SOP
- Collaboration development process

- Quarterly NEOC-REOC Video Conference
- REOC driven activities
- REOC review process
- Monthly Email Report on Activities

Figure 7: One Team Approach for Integration

Goals & Objectives

The CWG identified the following goals for 2019 in support of the NEAP:

Additionally, the CWG identified 13 focus areas:

Based on the above, the 2019 communication objectives are:

Goal 1: Increase knowledge to support positive vaccination decisions	
Objective 1.1: At least 90% of caregivers are aware of the polio vaccination campaign prior to the start of the campaign	Means of verification/measurement: 1.1: Post-campaign monitoring, LQAs (?)
Goal 2: Improve polio communication coordination to increase efficiency and effectiveness of efforts	
Objective 2.1: Communication working group meetings are held at least three times per month Objective 2.2: Coordination calls between NEOC and REOC are held at least two times per month	Means of verification/measurement: 2.1: Meeting minutes 2.2: Meeting minutes
Goal 3: Increase community trust in polio vaccine and program	
Objective 3.1: Community influential persons (CIPS) are deployed during each campaign, with contributions to the reduction of missed children shared with national level M & E task team within 10 days of end-of-campaign	Means of verification/measurement 3.1: Data dashboard* **CIP data will be included in the dashboard once the regional data collection forms are harmonized – process is underway (Feb. 2019).*
Goal 4: Reduce missed children (including by not limited to refusals)	
Objective 4.1: Immunization Communication Network (ICN) will identify absent children for revisit and coordinate with operations teams and/or vaccinate directly to reduce the absolute number of under-immunized children (Target: Less than 5% missed children) Objective 4.2: ICN + CIPs (including swift teams), will persuade refusal parents to accept vaccination to reduce the absolute number of under-immunized children for reasons of family refusal (Target: Less than 5% missed children)	Means of verification/measurement: 4.1: Post-campaign monitoring, LQAs, ICN catch-up data, CIP+ refusal card data 4.2: Post-campaign monitoring, LQAs, ICN catch-up data, CIP+ refusal card data

Target Audiences

Effective audience segmentation uses a strategic approach based on the Social Ecological Model (Bronfenbrenner, 1977) to coordinate consistent, credible, and understandable messages that are tailored to the information needs of the segment. The audience segments for this Action Plan were developed to reach three types of audience (decision makers, opinion formers, and wider influencers) across the social ecology.

Figure 7 shows the audience segments and where they fall across the social ecology to assist with tailored messaging, materials, and activities. Audience segments are divided into three broad categories:

- **Decision Makers:** Those responsible for determining issues such as community access or household acceptance of vaccine.
- **Opinion Formers:** Those who provide valued insights into decision making.
- **Wider Influencers:** Those individuals who are broadly admired and who opinions are valued by both opinion formers and decision makers.

Figure 8: Social Ecology Influencers & Decision Makers

Audience Grid

Social Ecology Sphere	Segment	Barriers / Issues	Desired Behavior	Information / Tools Needed to Model Desired Behavior	Key Channels
Individual: risk of polio, benefits of IZ	**Parents / Caregivers** Decision Makers	Repeated vaccination Misinformation Trust in FLWs	Vaccinate children every time Vax is offered	• Know influencers support • Misinformation addressed respectfully/appropriately • Empowered dialogue @ PoV	Media, FLWs, Interpersonal, Community, and Organization (particularly HCWs) spheres.
Interpersonal: Misinformation, rumors, protecting children	**Family / Friends / Community Elders** Opinion Formers	Repeated vaccination Misinformation Trust in FLWs	Encourage vaccination of all children	• Know influencers support • Misinformation addressed respectfully/appropriately	Media, FLWs, Influencers, Community sphere
	Tribal Leaders Decision Formers	Public Perception Misinformation	Provide access to communities for IZ	• Accurate understandable info on polio risk, vax benefits • Info to make Vax champion and SME in community	
Community: ↑ understand. of polio and IZ, Af. position to end.	**Religious Leaders** Decision Makers	Public Perception Misinformation Religious Issues	Vocalize parents should vaccinate	• Accurate understandable info on polio risk, vax benefits • Info to make Vax champion and SME in community	Media, Influencers, Policy sphere.
	ICN / FLWs Opinion Formers	Public Perception Misinformation HH / Decision Maker access	Provide respectful support & info to vaccinate	• Strong understanding of polio and vax • Strong interpersonal comm skills • Ability to effectively tailor messages	

Social Ecology Sphere	Segment	Barriers / Issues	Desired Behavior	Information / Tools Needed to Model Desired Behavior	Key Channels
Organizational: source of accurate info, trusted champions	**Doctors** Opinion Formers	Better understanding of polio & vax if snr. doc, lower vax specific understanding if local doc; Repeated vaccination	Provide strong recommendation to vaccinate	• Strong understanding of polio and vax • Info to make Vax champion and SME	Media, Influencers, Policy sphere.
	Media Opinion Formers	Better understanding of polio & vax Lack of strong journalism skills	Provide accurate info about polio, IZ and campaigns	• Strong understanding of polio and vax • Improved journalism skills	
	Professors Opinion Formers	Lack of understanding re polio & vax	Provide understandable technical info re polio and IZ	• Strong understanding of polio and vax • Info to make Vax champion and SME	
Policy /Enabling Support polio IZ efforts	**Religious Scholars** Decision Makers	Better engagement with IAG ↑ understand. of Halal vax production	Vocalize parents should vaccinate	• Strong understanding of polio and vax • Info to be Vax champion/SME	Other policy sphere experts and respected leaders.
	Gov't Decision Makers	Competing priorities	Provide access to communities for IZ	Increased coordination with communication activities	
	Advisors Wider Influencers	Better understanding of polio & vax	Vocalize support of IZ, champions	• Strong understanding of polio and vax • Info to make Vax champion and SME	
	Celebrities Wider Influencers	Better understanding of polio & vax	Vocalize support of IZ, champions.	• Strong understanding of polio and vax • Info to be vax champion/SME	

Appendices

At-A-Glance Planning: Vaccine Campaign Communication (including missed children tracking)

Guiding Principles:	• Continual strengthening of frontline communicators (including vaccinators) though training materials distribution and use, supportive supervision and monitoring • Adaptations and improvements for activities and materials (including training materials) to be driven by routinely collected data and special studies		
Program Activities			
Q1	**Q2**	**Q3**	**Q4**
• Pre-campaign data analysis and planning • Pre-campaign social mobilization • Interpersonal communication training of front-line workers (WHO, with ICN input) • Refusal resolution (Vaccinators, ICN, Community Influential People (CIP), Refusal resolution committee members, Swift teams. • Reporting on missed (absent and refusal) to operations teams for revisit and catch up	• [Same as Q1] • Refresher trainings (as needed)	• [Same as Q1] • + Regional planning and coordination meeting (lessons learned, needs to be addressed) a • Refresher trainings (as needed)	• [Same as Q1] • Refresher trainings (as needed)
Key Dates for Online Planning			
• **18-22 Feb:** SNID • **25-29 Mar:** NID	• **22-25 Apr:** SNID • **17-20 Jun:** NID		• **24 Oct:** WPD • **TBD Dec:** Awards

At-A-Glance Planning: Advocacy for social mobilization via influencers (Religious and traditional leaders, doctors, educators)

Guiding Principles:	• Focus on **key influencers at local and regional levels** • Use relationship principles to build strong, trusted, valuable networks • Apply integrated strategy to ensure not eroding good will of influencers		
Program Activities			
Q1	**Q2**	**Q3**	**Q4**
Religious Leaders: • ID most important RLs in key areas (both refusing and supporting) • Dev coordinated approach to 1) ensure continued support and 2) convert refusers into advocates • Ulama support planning •	**Religious Leaders:** • Regional Workshops (South and East) • Engagement Opportunities: pre-campaign press, blog articles, video interviews, etc.	**Religious Leaders:** • Engagement Opportunities: pre-campaign press, blog articles, video interviews, etc.	**Religious Leaders:** • Regional Workshops (South and East) • Engagement Opportunities: pre-campaign press, blog articles, video interviews, etc. •
Medical Doctors: • Regional Workshops (South and East)	**Medical Doctors:** • Engagement Opportunities: pre-campaign press, blog articles, video interviews, etc.	**Medical Doctors:** • Regional Workshops (South and East) • Engagement Opportunities: pre-campaign press, blog articles, video interviews, etc.	**Medical Doctors:** • Engagement Opportunities: pre-campaign press, blog articles, video interviews, etc.
Community Stakeholder: • Briefings and advocacy meetings* with local leaders and institutions (Education, associations, other traditional leaders)	**Community Stakeholder:** • Briefings and advocacy meetings* with local leaders and institutions (Education, associations, other traditional leaders)	**Community Stakeholder:** • Briefings and advocacy meetings* with local leaders and institutions (Education, associations, other traditional leaders)	**Community Stakeholder:** • Briefings and advocacy meetings* with local leaders and institutions (Education, associations, other traditional leaders) •
*Briefings to provide information for new stakeholders and advocacy meetings to motivate and coordinate existing partners.			
Key Dates for Online Planning			
• **18-22 Feb:** SNID • **25-29 Mar:** NID	• **22-25 Apr:** SNID • **17-20 Jun:** NID		• **24 Oct:** WPD • **TBD Dec:** Awards

At-A-Glance Planning: Polio+ communication activities (integrated communication)

Guiding Principles:	• Leverage polio assets to contribute to broader child health outcomes • Integration of health communication tools, message and activities within polio activities to the extent possible (where we have human resources and access)		
Program Activities			
Q1	**Q2**	**Q3**	**Q4**
• Including polio+ content in routine social mobilization (ICN activities) • Explanation and use of referral cards at household level to encourage uptake of services (where they exist and are safely accessible) • Monitoring of routine immunization outreach sessions with data aggregation and sharing via Open Data Kit (ODK) system • Periodic support for routine immunization activities (social mobilization and/or monitoring during measles campaigns or other vaccination campaigns)	• [Same as Q1]	• [Same as Q1] • + Regional planning and coordination meeting (lessons learned, needs to be addressed) – Same meeting as described in campaign vaccination activities	• [Same as Q1]
Key Dates for Online Planning			
• **18-22 Feb:** SNID • **25-29 Mar:** NID	• **22-25 Apr:** SNID • **17-20 Jun:** NID		• **24 Oct:** WPD • **TBD Dec:** Awards

At-A-Glance Planning: Strategic communication activities

Program Activities			
Q1	Q2	Q3	Q4
• Finalize Branding / Dev Guidelines / Templates • Crisis Comm Strategy and Tools	• Key message grid based on data • Testing / validation of key messages • Training on Branding and Templates • Crisis Comm and Spokesperson Training (Nat'l, Priority Regions)		•
Key Dates for Online Planning			
• **18-22 Feb:** SNID • **25-29 Mar:** NID	• **22-25 Apr:** SNID • **17-20 Jun:** NID		• **24 Oct:** WPD • **TBD Dec:** Awards

At-A-Glance Planning: Advocacy [Web, social media and partner engagement] [From: KG: I suggest we fuse this section with the "partnership engagement" section – I think it's better to not be "channel-based" here but rather activity/audience based}

Guiding Principles:	• Focus on **priority issues**: reasons for absences (incl. refusals), inaccessibility, combating misinformation, increasing understanding of polio/polio vax, campaign awareness, increase of female workers • Amplify messages/voices through online influencer engagement • Identify opportunities for increased engagement • Share positive media stories to increase credibility through diverse voices		
Program Activities			
Q1	**Q2**	**Q3**	**Q4**
Website: • Draft content • Dev. Visuals • Contract for coding • ID / Build Blog Bank	**Website:** • Finalize development of website • QC / Launch Site • Start Weekly Blog • Eval: estab. web metrics baseline	**Website:** • Minimum of 4 external key blogs from influencers	**Website:** • TBD
Social Media: • Begin daily posting on FB • Create Instagram and Twitter Accounts • Begin daily posting on Instagram • Dev./Imp. Online engagement for campaigns	**Social Media:** • Continue daily FB and Instagram posts, at least 1/week twitter posts • Research/select social media scheduling tool • Develop/sched. Social media 45 days in adv. • Develop holidays/ special days calendar for online acknowledgement • Dev./Imp. Online engagement for campaigns	**Social Media:** • Continue daily FB and Instagram posts, at least 1/week twitter posts • Successfully engaged 3 top AFG online influencers to be regular polio vax advocates online	**Social Media:** • Continue daily FB and Instagram posts, at least 1/week twitter posts • Dev/Imp World Polio (WPD) Day Online activities as part of larger effort
Online Influencers:	**Online Influencers:** • Identify key AFG online influencers, prioritize engagement • Develop relationship with 3 online influencers	**Online Influencers:** • Maintain existing ~3 online influencer relationships • Develop relationship with ~5 additional online influencers	**Online Influencers:** • Maintain relationship with existing influencers • Identify opportunities for additional online influencer support • Engage influencers in WPD efforts
Key Dates for Online Planning			
• **18-22 Feb:** SNID • **25-29 Mar:** NID	• **22-25 Apr:** SNID • **17-20 Jun:** NID		• **24 Oct:** WPD • **TBD Dec:** Awards

At-A-Glance Planning: Materials Development (multi-media, mass media and print)

Guiding Principles:	• Focus on **priority issues**: reasons for absences (incl. refusals), inaccessibility, combating misinformation, increasing understanding of polio/polio vax, campaign awareness • Use key messages, visual communication • Tailor (language, branded/unbranded, region integration) • Coordinate with Web/Social to ensure all materials are available online.		
Program Activities			
Q1	**Q2**	**Q3**	**Q4**
Print Materials: • ID core concepts for illustration • Dev Bank of core illustrations • Health Facility Posters Suite (~3 topics TBD) • Doctors Booklet • Billboards TOR	**Print Materials:** • Finalize core illustrations • School Posters (~3 topics TBD) • Religious Leaders Booklet • Propaganda flyer plan / develop ~2 flyers • Dev of new billboards	**Print Materials:** • TBD	**Print Materials:** • TBD
Photography/Video: • President's Inaccess. • Southern Corridor • Region Photo Coord./Imp. • Produce 1 1-minute videos (ArtLords)	**Photography/Video:** • Region Photo Complete • Produce 4 1-minute videos (ArtLords) • Propaganda video plan / Dev 1 propaganda video • Produce 50% of animated videos • 1+ survivor video	**Photography/Video:** • Produce 4 1-minute videos (ArtLords) • Dev 1 propaganda video • Finish animated video production • 1+ survivor video	**Photography/Video:** • Dev 1 propaganda video • 1+ survivor video
IEC Materials: • New Flyers: Mar-Jun	**IEC Materials:** • New Flyers: Q3 • New Banners for Q3-Q4	**IEC Materials:** • New Flyers: Q4 • Audit/Assess Existing Materials	**IEC Materials:** • Regional consultations for development or adaptation of materials for 2020 • Plan for 2020 IEC materials • Dev IEC materials for 1Q20
Other Materials: • Finalize 9 New PSAs • Finalize stencil/mural concepts / begin production	**Other Materials:** • Master PPT Deck • Plan Bank of PSAs • Continue stencil/mural production • Design Transport Adverts / Print / Post • Begin Polio song	**Other Materials:** • Finish mural / stencil production • Finish Transport Advert printing/posting • Finalize polio song	**Other Materials:** • TBD
Key Dates for Online Planning			
• **18-22 Feb:** SNID • **25-29 Mar:** NID	• **22-25 Apr:** SNID • **17-20 Jun:** NID		• **24 Oct:** WPD • **TBD Dec:** Awards

At-A-Glance Planning: Advocacy via partnership engagement

Guiding Principles:	• Focus on **key influencers** and **priority regions** • Use partnership development best practices • Focus on value for partners to build loyalty		
Program Activities			
Q1	**Q2**	**Q3**	**Q4**
Line Ministries: • Dev partnership training/sched mtgs. • Provide Q1 finalized videos • Explore add'l opps such as video talks, roundtables / plan	**Line Ministries:** • Provide Q2 finalized videos	**Line Ministries:** • Provide Q3 finalized videos	**Line Ministries:** • Provide Q4 finalized videos
Associations: • Medical Council • ID other potential partnerships	**Associations:** • Dev partnership with: • Midwifery Council	**Associations:** • TBD	**Associations:** • TBD
Donors: • Coordinate list of donors with # tags • Produce at least 2 social media "shout outs" per donor • Plan donor focused blogs for Q2-Q4 (at least 1 per donor)	**Donors:** • 2+ social media shouts outs per donor • 1+ blog articles per donor	**Donors:** • 2+ social media shouts outs per donor • 1+ blog articles per donor	**Donors:** • 2+ social media shouts outs per donor • 1+ blog articles per donor
NGOs/CBOs: • ID iNGOs coordination • ID Nat'l NGO coord. • ID Regional CBO coord.	**NGOs/CBOs:** • TBD	**NGOs/CBOs:** • TBD	**NGOs/CBOs:** • TBD
Private-Public: • ID 5 potential private AFG corporations for partnership	**Private-Public:** • Engage/Formalize partnership with 1 corporation	**Private-Public:** • Engage/Formalize partnership with 1 corporation	**Private-Public:** • Engage/Formalize partnership with 1 corporation
REOC: • Quarterly Video Conf. • ID Priorities from So / East / Plan for development / imp. • ID cap dev / support for So / East / Plan for field visits	**REOC:** • Quarterly Video Conf. • ~1 field for each So/East for cap dev	**REOC:** • Quarterly Video Conf. • ~1 field for each So/East for cap dev	**REOC:** • Quarterly Video Conf. • ~1 field for each So/East for cap dev • ID needs/priorities for 2020
Key Dates for Online Planning			
• **18-22 Feb:** SNID • **25-29 Mar:** NID	• **22-25 Apr:** SNID • **17-20 Jun:** NID		• **24 Oct:** WPD • **TBD Dec:** Awards

At-A-Glance Planning: Media Engagement

Guiding Principles:	• Focus on **priority issues**: reasons for absences (incl. refusals), inaccessibility, combating misinformation, increasing understanding of polio/polio vax, campaign awareness • Develop supportive relationship with media		
Program Activities			
Q1	**Q2**	**Q3**	**Q4**
Reporters/News Outlets: • Dev bank of story ideas • Reporter Master List • Begin Reporter Training / TOR	**Reporters/News Outlets:** • Begin Monthly eNews email • Quarterly Reporters Lunch (1 @ Nat'l, 1 South, 1 East) • Finalize training, conduct TOT with vendor / implement training	**Reporters/News Outlets:** • Monthly eNews email • Quarterly Reporters Lunch (1 @ Nat'l, 1 South, 1 East) • Continue training	**Reporters/News Outlets:** • Monthly eNews email • Quarterly Reporters Lunch (1 @ Nat'l, 1 South, 1 East) • Continue training
EduTainment: • BBC • PACT • TOR for add'l Edutainment • ID metrics and eval.	**EduTainment:** • BBC • PACT • Begin add'l Edutainment	**EduTainment:** • TBD	**EduTainment:** • TBD
Other: • ID vendor for radio mapping	**Other:** Conduct radio mapping	**Other:** Tailor media buys based on mapping	**Other:** TBD
Key Dates for Online Planning			
• **18-22 Feb:** SNID • **25-29 Mar:** NID	• **22-25 Apr:** SNID • **17-20 Jun:** NID		• **24 Oct:** WPD • **TBD Dec:** Awards

SIA minimum standards

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

Islamic Republic of Afghanistan

30 oct 2018

Ministry of Public Health

National EOC

Memorandum of Understanding

For

INVOLVEMENT OF BPHS NGOs IN POLIO PROGRAM AND PEI SUPPORT TO RI

Validity:	From the date signed until end of Dec 2018
Drafted by:	NGO Coordinator - Emergency Operation Center (EOC)
Agreed by:	National EOC, BPHS implementing NGOs and GCMU

Background: Extensive efforts have been placed to eradicate polio in Afghanistan by national and international partners. Despite all good work, deteriorating effects of insecurity coupled by other problems such as refusals, quality of campaigns and room to strengthen coordination, has resulted into increased cases in 2018. As of 30th Sep 2018, there are 15 positive WPV1 cases in 5 provinces of Kandahar, Nangarhar, Kunar, Uruzgan and Helmand. In addition, there are 40 positive environmental samples in 6 provinces.

Among the current arrangements, the role of BPHS implementers and PEI support to Routine Immunization (RI) has been limitedly defined. The BPHS NGOs roles had been framed in an MoU (Aug 2016-Sep 2018), however, the lessons learned indicate the need for practical interventions and activities rather than laying general statements. In addition, PEI support to RI has been mainly focusing on Monitoring of RI by PEI staff though the NEAP 2018 states that the PEI staff should spend 20% of their time to support RI. The other potential areas where PEI can support RI such as referrals, community mobilization, defaulter tracing and so forth either not sufficiently focused or followed up through existing systems. In light with this, efforts have been made to make this MoU more practical and also keep a balance of NGO support to Polio eradication as well as PEI support to RI in line with the principles of objective two "strengthening routine immunization" of Polio Eradication and End Game Strategic Plan 2013-2018.

Introduction: This MoU defines key roles and responsibilities of Polio Eradication Initiative (PEI) team support for routine immunization as well as the key role of Basic Package of Health Services (BPHS) implementer NGOs in planning, implementation and monitoring of polio campaigns. The MoU is agreed by National EOC, Grants and Contracts Management Unit (GCMU) and BPHS implementing NGOs of the 5 polio high risk provinces.

Objective: The objective of this MoU is to contribute to reaching the national goals of polio eradication and strengthened routine immunization in high risk provinces of Afghanistan through:

1. Streamlining the NGOs involvement in Polio eradication efforts and;
2. Determining the areas where PEI teams could contribute towards RI strengthening.

Geographic coverage: The current MoU will be implemented in 5 high risk provinces of Kandahar, Helmand, Farah, Nengarhar and Kunar. Lessons learned from implementation of this MoU could be generalized across all 34 provinces of the country after the interruption of polio virus circulation in these five high risk provinces.

I. Responsibilities of the parties:

A: Roles and responsibilities of BPHS Implementing NGOs of five high risk provinces

1. NGOs will participate in in regional/provincial coordination meetings bi weekly or as per provincial plan and will be considered as a key contributor to decision making.
2. NGOs will be involved in in district planning and coordination during each Polio SIA primarily through their management officers or heads of clinics where such officers are not available at district level.
3. NGO will share the list of active CHWs by Health Facility including list of all its catchment villages to regional/provincial EOC/PETM within two weeks of signing of this MoU.
4. NGO will assign at least two supervisors to monitor the pre and intra-campaign stages in inaccessible areas where national monitors are not able to visit. The main focus in pre-campaign phase would be to monitor the selection of staff including FLWs, Monitors, Supervisor and Coordinators; monitor the trainings, monitor pre-campaign communication efforts such as advocacy meetings with community influencers and updating process of micro plans. For monitoring the intra-campaign process, the NGOs will use national monitoring checklist currently used by NEOC.
5. NGO will allocate two vehicles during pre and intra-campaign phases of the remaining two SIAs in Nov and Dec 2018 and ad hoc polio SIAs to be used for the monitoring by the NGO itself.
6. NGO where applicable will provide support to access negotiation with AGEs to address inaccessibility. NGOs will explore channels as per their convenience and where applicable in a coordinated manner with regional/provincial EOC/PEMT.
7. NGOs will assign the CHSs (Community Health Supervisors) of each HF to monitor the pre and intra-campaign stages through CHW teams and health committees. CHS will guide and compile the reports of CHWs and Health Committees. If required, the Head of HF should help the CHS in compilation of the report. The reports will be sent to the provincial EPI officer of NGO and will be integrated into the NGO post campaign report. The CHWs and health

committee members during pre-campaign stage will monitor 3 key issues: 1. whether the FLWs, Supervisors and social mobilizers are local; 2. monitor the trainings; and 3. monitor if villages are visited by polio teams.

8. NGOs will orient the Heads of Health Committee of each health facility on polio and immunization with special focus on the potential role they could play (subject to additional financial and technical support provided by EOC).
9. NGOs will actively reach R/PEMTs three weeks prior to the next campaign date to get IEC materials related to polio and post them on the appropriate areas in health facilities and communities through the network of CHWs, CHS and Health Committees. Posting of the IEC materials at community level should take place at least 2 or 3 days prior to actual campaign.
10. NGOs will instruct the HFs to include the subject of Polio vaccine and its importance in the schedule of their Health Education sessions as a regular subject.
11. NGOs will provide support the cold chain of Polio SIAs through filing the gaps of Ice packs availability if any in the areas where solar ice pack freezer is provided through Gavi-HSS funds.
12. NGO will target immediately the areas where AFP is reported as "zero dose polio" through mobile strategy or any other appropriate strategy on monthly basis and report back to EOC in the NGO Post campaign report.
13. NGO will instruct their HFs to screen the fingers of children <5yrs coming to HFs and accordingly administer OPV or IPV based on specific campaign requirement until three days after campaign.
14. NGOs will extend their support similarly to other SIAs such as measles SIA with main focus on upcoming second phase of Measles campaign in Nov.
15. NGOs will provide a summary report of their contribution to polio campaigns as well as their findings after each NID and sNID to NGO coordinator. The report will also include the support they received from PEI teams after the last campaign.

B. Roles and responsibilities of PEI staff to strengthen Routine Immunization:

1. PEI staff such as FLWs, SMs, and supervisors will refer the unimmunized children during campaigns to the nearest HFs of BPHS NGO using the standard referral sheet.
2. PEI staff such as DPOs, DCOs, PPOs and PCOs will contribute to the micro plan of NGO at district and provincial level. In case they have observations on the quality of NGO micro plan they should provide written feedback on the accuracy and quality of NGO micro-plans with copy to subnational EOCs/PEMTs as well as NGO coordinator at National EOC.
3. PEI staff such as FLWs, SMs and supervisors will provide health education messages for the use of routine immunization to communities.

4. PEI staff will monitor the RI activities including fixed, outreach and mobile activities and provide written feedback to NGOs.
5. SMs where the ICN is active sign their attendance sheet at the HFs of BPHS NGO and will support defaulter tracing to reduce drop-out rates for RI antigens through active search and referral to HFs.
6. PEI staff should support expansion of Community Based Health Care (CBHC) program through identifying areas (villages) without CHW and informing the NGOs to train CHWs in those areas.
7. PEI staff will invite regularly the BPHS implementing NGO officers or heads of clinics at community level in different Polio planning and coordination meetings.

C: Roles and Responsibilities of National and Regional EOCs and PCUs.

1. National EOC is responsible to communicate and clarify content of this MoU with all regional EOCs and Provincial Coordination Units (PCUs) and follow up implementation of this MoU at all levels.
2. Regional EOCs and PCUs are responsible and accountable to regularly invite NGOs in each regional, provincial and district level polio planning and coordination meetings and give them a voting right for decisions.
3. Regional EOCs and PCUs should ensure that all district level plans are developed in coordination with BPHS implementer NGOs for supporting and monitoring of RI at health facility level.
4. In the selection of frontline workers, REOCs and PCUs should prioritize active and local CHWs and CHSs from the list provided by the NGOs representative.
5. REOCs and PCUs should give special priority to local female CHWs/CHSs in selection process.
6. In cases where CHW or CHS is not willing to take part in campaign or perform poorly, the R/Provincial EOC has no responsibility to use CHWs/CHS.

D. Roles and responsibilities of GCMU

1. The GCMU rep. will attend national level meetings with NGOs related to implementation of this MoU and take corrective actions where applicable.
2. GCMU where applicable will follow up the implementation of actions agreed between EPI and related NGOs in line with contractual obligations during the GCMU contract compliance field missions.
3. The GCMU will keep regular communication with NGO coordinator in relation to the implementation of this MoU including sharing the visit reports of GCMU staff in the concerned five high risk provinces.

II: Governance of this MoU:

The NGO coordinator at National EOC will oversee the implementation status of this MoU jointly with GCMU, PEI-EPI task team (including EPI, WHO, Unicef and CDC) and BPHS implementing NGOs of the concerned provinces after each Polio SIA. Based on applicability,

improvement plans will be made and followed up. At provincial level, the implementation status of this MoU will be assessed by provincial PEI, EPI and BPHS implementing NGO teams.

III: Revision timelines:
The MoU is valid from the date of signing until end of Dec 2018. In Jan 2019, the MoU will be revised and signed with BPHS implementing NGOs based on the lessons learned from the two rounds of SIAs in Nov and Dec 2018.

IV: Copies:
The original copies of this MoU will be six set in three languages of Pashto, Dari and English. One original set will remain at EOC and one will be kept by each of the 5 NGOs. The other stakeholder will receive the non-original signed copies officially.

CHA NGO Rep.
Name: Dr. Jahed Nabil
Title: Health program manager

BARAN NGO Rep.
Name:
Title:

AADA NGO Rep.
Name: Dr. Yasami
Title: Acting General Director

AMI NGO Rep.
Name: Dr. Izzatullah
Title: Dep. Medical Coordinator

BRAC NGO Rep.
Name: MOHAMMAD ASLAM
Title: CR

National EPI Manager

NGO Coordinator

EOC Director

GCMU Director

Routine Immunization Intensification Framework

Two-Year Plan

National Expanded Program on Immunization

ABBREVIATIONS

AFP	Acute Flaccid Paralysis
AHS	Afghanistan Health Survey
ANC	Antenatal Care
BPHS	Basic Package of Health Services
CHW	Community Health Worker
CMYP	Comprehensive Multi Year Plan
EPHS	Essential Package of Hospital Services
FHH	Family Health House
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GCMU	Grant and Contract Management Unit
HPD	Health Promotion Department
HSS	Health System Strengthening
ICN	Immunization Communication Network
IIP	Immunization in Practice
MLM	Mid-Level Management
MOPH	Ministry of Public Health
MoU	Memorandum of Understanding
NEPI	National Expanded Program on Immunization
NGO	Non-Governmental Organization
OPV	Oral Polio Vaccine
PEC	Provincial EPI Committee
PEI	Polio Eradication Initiative
PEMT	Provincial EPI Management Team
PHP	Private Health Care Provider
REC	Reach Every Child/Community
REMT	Regional EPI Management Team
RI	Routine Immunization
RIIF	Routine Immunization Improvement Framework
SEHAT	System Enhancement for Health Action in Transition
SIA	Supplemental Immunization Activities
TT	Tetanus Toxoid
WHO	World Health Organization
WPV	Wild Poliovirus
UNICEF	United Nations Children's Fund

BACKGROUND & RATIONALE:

1. Immunization is one of the core components of the preventive functions of the MoPH integrated in the BPHS and EPHS. The new BPHS contract under Sehatmandi Project are performance based, where the Service Providers are accountable based on their performance and a third party evaluation will ascertain their reports; their payment will be done based on the performance reports after certification of third party monitors.

2. With all efforts, still Afghanistan is one of the two countries in the world with existing polio virus transmission and has the highest number of polio cases in the world. Outbreak of vaccine preventable diseases in Afghanistan (21 cases of polio, and 176 outbreaks of measles in 2018) indicates that the situation requires considerable attention. Additionally, finding zero dose of Polio vaccination among AFP cases indicates a serious alarm that there are plenty of children unimmunized and are susceptible to polio and other vaccine preventable diseases in the community.

3. Evidence from surveys and reports suggest that immunization services and coverage in the country is sub-optimal, with coverage very little progress over the last 3 years. The national coverage is 50% for fully immunized and 61% for Penta 3 (AHS 2018). This coverage has been stagnated over the last few years, indicating little or no progress at immunization services. Moreover, the national average masks huge disparity within and between regions and provinces. The provinces in the southern, south eastern and eastern regions having lower coverages compared to those in the northern, northeastern and western regions. For example, Penta 3 coverage for Urozgan is only 3% compared with 89% for Bamyan. There are also variations in the immunization coverage between urban and rural areas. The poor immunization coverage has been contributing to outbreaks of vaccine preventable diseases including measles and wild poliovirus.

4. The difference between coverage of Penta 1 and Penta 3; TT1 and TT2+ as well as the differences between administrative coverage data and household surveys indicates that the quality of EPI services in the country has been suffering from lack of proper attention. The PEMT staff TOR and the role of Service Providers are not defined very clearly and management of EPI services at all levels require a focused review and revision.

5. The BPHS Service Providers have decreased their management costs considerably during the recent Sehatmandi bidding process, due to the changes in the contracting mechanisms. This indicates that they also decreased their focus in managing EPI services and focused more on the 11 key indicators which their payments are linked with. This fact requires that we have to pay more attention to improve the capacity of PEMT in supervision, monitoring and support of the service providers.

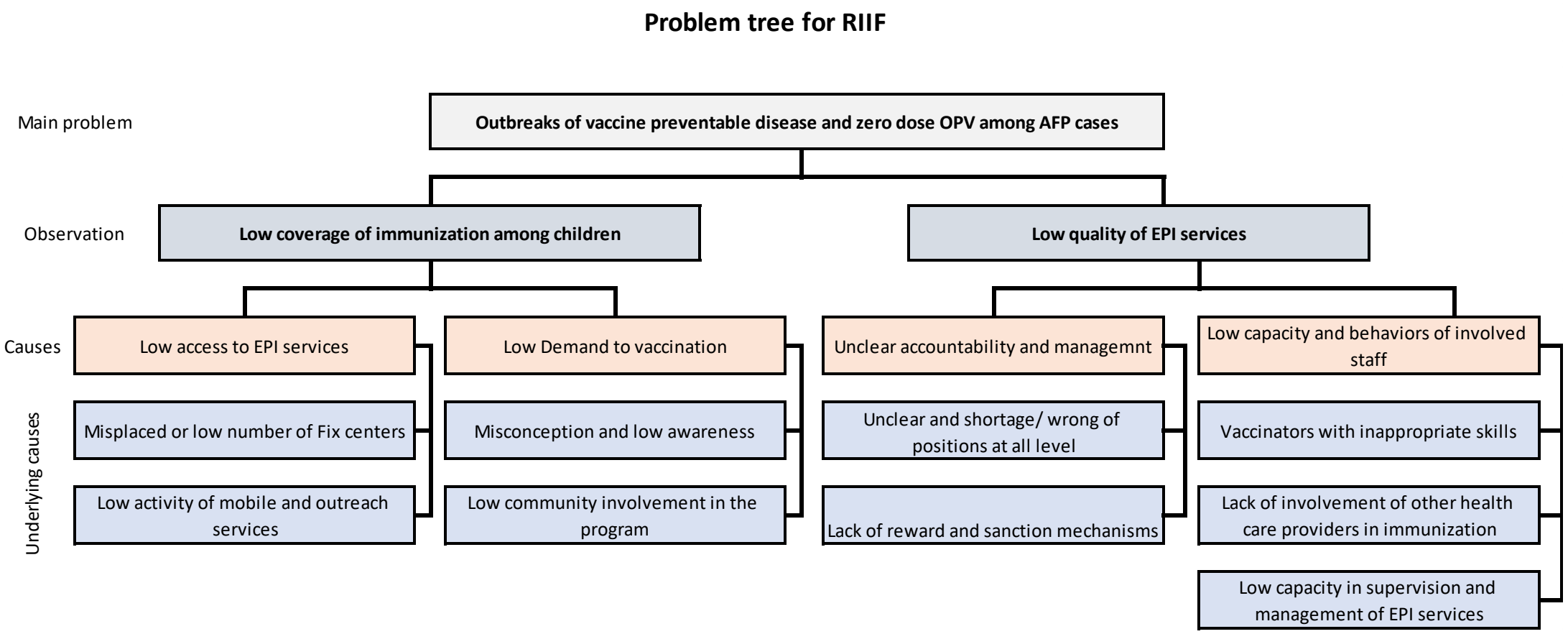
6. Decades of conflict, low access to immunization services, low education level of majority of population, particularly women, rumors and propaganda regarding adverse effects of immunization; insufficient commitment of health workers and Service Providers; and sociocultural/religious norms are the main bottlenecks and barriers to immunization of children and women in the country. There are key bottlenecks to achieving higher coverage on both supply (access) and demand (utilization) sides. The main reasons for low access include Inequity in distribution of HF (White areas), Issues of urban and rural RI strategies, (no outreach in cities and poor implementation of strategy), no shift working mechanisms (vaccinators works for limited hours until 1 pm especially in urban areas) , Poor community engagement in the selection of sites (Influencers interruption), Presence of difference types of Anti-governmental Elements (AGE) (supportive -non supportive), Insufficient number of trained staff which affect access to health services, Geographical barriers and scatter population and IDPs (Internal Displaced People/returnees refugees.

7. The leadership of MOPH is highly concerned by the polio and routine immunization situation in the country. The leadership advised National EPI to come up with a practical plan and framework to breakdown the stagnant situations and improve the coverage. NEPI assigned a technical team to review the situation and come up with a plan to improve immunization coverage as a matter of urgency, within the context of the Comprehensive Multi-Year Plan (CMYP) and BPHS service delivery in the forthcoming two years. The team conducted a comprehensive analysis of existing problems and came up with this proposal to intensify routine immunization services across the country, with a focus on high risk provinces with outbreaks of Polio and Measles. Figure 1, below explains the summary of problem analysis regarding the Routine Immunization and the base for this Intensification Framework.

8. Priority provinces for implementation of RIIF:

The main goal of the plan is to strengthen routine immunization services in all provinces of the country and ultimately increase immunization coverage in Afghanistan. The provinces are prioritized based on their Penta-3 coverage from the AHS 2018 report. The first priority provinces are those with less than 50 % coverage for Penta 3 or being endemic/high risk for polio; the second priority provinces are with Penta 3 coverage between 50-70%; and the third priority provinces are those provinces that have more than 70% Penta 3 coverage. The main focus of the plan (RIIF) will be on the first priority provinces including Urozgan, Zabul, Helmand, Paktika, Kandahar, Paktia, Jawzjan, Khost, Badghis, Nuristan, Ghor, Nangahar, Kunar and Farah. In addition to the priority provinces, routine immunization will be improved in urban settings through the urban immunization program.

Figure 1: Problem Analysis



8. DESCRIPTION OF RIIF

Based on the problem analysis, the team developed the result framework to overcome the problem.

GOAL of RIIF:

To reduce morbidity and mortality due to vaccine preventable diseases among the target population through improvement of the routine immunization coverage in the country.

OBJECTIVES:

1. To increase Penta-3 & TT2+ coverage
2. To improve quality of Routine Immunization System

INTERMEDIATE RESULTS and IMEDIATE RESULTS (Outputs):

1.1 Access Increased

1.1.1 Number of fix centers increased
1.1.2 Number of Outreach activities increased
1.1.3 Urban immunization program strengthened

1.2 Demand Increased

1.2.1 Behavior change communication improved
1.2.2 Community engaged effectively

2.1 Accountability and management improved

2.1.1 ToR and Structure of EPI at all levels revised
2.1.2 SPs Rewarded, sanctioned through Performance Management
2.1.3 EPI staff Rewarded, sanctioned

2.2 Capacity increased among Care providers

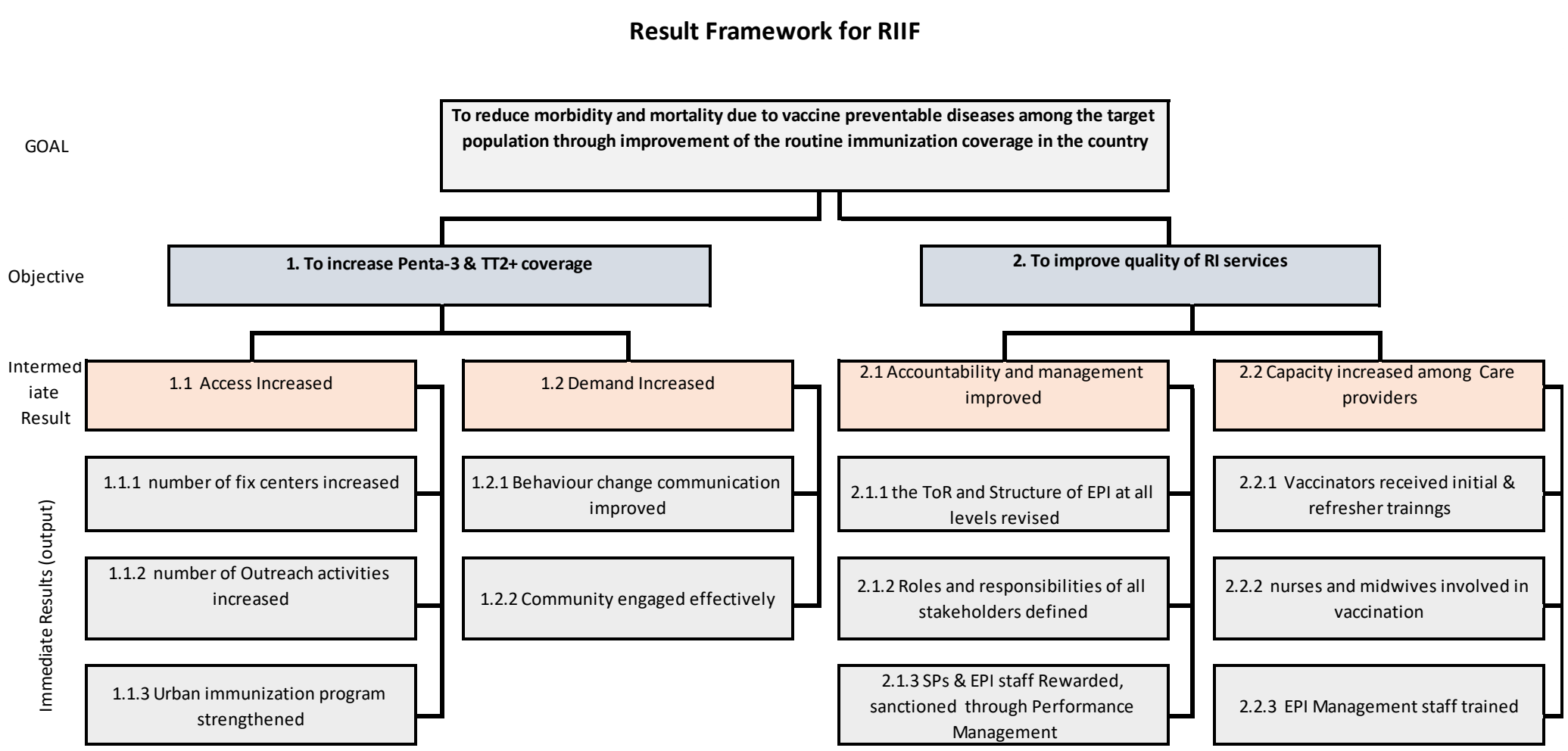
2.2.1 Vaccinators received initial training
2.2.2 nurses and midwives involved in vaccination
2.2.3 EPI Management staff trained

Figure 2, explains the result framework for the RIIF.

To link logically the result framework with the activities and explain the monitoring framework of the proposal, the Logical Framework (Table 1), implementation process matrix (Table 2), Work plan (Table 3), and Indicators Reference Sheet (Table 4) have been developed as below.

The budget for implementation of RIIF has been calculated and the detail budget is included (Table 5).

Figure 2: Result Framework



Logical Framework for RIIF

Objectives/ Results	**Indicators**	**Baseline**	**Targets**	**Reporting Timeline**	**Data source**	**Assumptions**
GOAL: To reduce morbidity and mortality due to vaccine preventable diseases among the target population through improvement of the routine immunization coverage in the country	*Number of vaccine preventable disease outbreak*	*21 WPV 176 Measles outbreaks*	*Zero Polio Cases*	*Annual*	*Surveillance system*	*The overall socio-political and security situation of the country remain stable*
Objective 1. To increase Penta-3 & TT2+ coverage	*Coverage of penta 3 and TT2+*	61% 40%	86% 65%	*Annual*	*Household Survey*	*No interruption in the Service Delivery mechanisms*
Intermediate Result 1.1 Access Increased	Coverage of penta 1	76%	100%	Bi-annual	*Household Survey*	No other socio-cultural or natural disaster occur
Output 1.1.1 number of fix centers increased	Number of vaccination fix center	2210	2500	Bi-annual	HMIS	fund availability
Output 1.1.2 number of Outreach activities increased	Number of outreach teams	1520	2210	Bi-annual	HMIS	fund availability
Output 1.1.3 Urban immunization program strengthened	Number of EPI facilities	470*	470*	Bi-annual	HMIS	fund availability
Intermediate Result 1.2 Demand Increased	Percentage of clients attend HFs for vaccination	76%	100%	Bi-annual	Household Survey	No other socio-cultural disruption exist

Output 1.2.1 Behavior change communication improved	Perception of care givers from EPI staff in household survey	57%	80%	Annual	Household Survey	
Output 1.2.2 Community engagement strengthened	Number of community communication campaigns	0	600	Annual	Household Survey	
Objective 2. To improve quality of RI services	Difference between Penta 1 and Penta 3 coverage	15	10	*Bi-annual*	Household Survey	Third party monitor verify HMIS report
Intermediate Result 2.1 accountability and management improved	Number of review meetings of SPs performance	0	1	Quarterly	Performance Management Report	
Output 2.1.1 ToR and Structure of EPI at all levels revised	Number of EPI positions with revised TOR	0	100%	Once	EPI Unit Report	The revision of TOR and Structure approved
Output 2.1.2 Roles and responsibilities of all stakeholders defined	Number of SOP defining different roles and responsibilities	0	1	Once	EPI Unit Report	Collaboration of stakeholders
Output 2.1.3 SPs Rewarded, sanctioned through Performance Management	Number of SPs received reward or sanction during the last six month	0	2	Bi-annual	EPI Unit Report	No political influences
Intermediate Result 2.2 Capacity increased among Care providers	Average percentage of knowledge/Practice score improved from baseline	NA	5%	Annual	EPI capacity assessment database	
Output 2.2.1 Vaccinators received initial and refresher training	Number of vaccinators received training during the last six months	0	50%	Bi-annual	EPI Unit Report	vaccinators allowed to attend the training

Output 2.2.2 Nurses and midwives involved in vaccination	Number of nurses and midwives trained on vaccination	0	50%	Bi-annual	REMT and PEMT Report	collaboration of Service Providers
Output 2.2.3 EPI Management staff trained	Number of EPI management team received training	0	100%	Bi-annual	EPI Unit Report	

*-outreach services will be added to all cities that is the reason the number of fixed center in the cities remain the same.

Table 2: Implementation Process Matrix

Activities	Tasks/Methodology	Deliverables	Quantity	Estimated cost	Total cost	Risks/ Assumptions
Activities for Output 1.1.1 number of fix centers increased						
Activity 1.1.1.1 Upgrading/establishment of sub-health centers to EPI fixed centers	Providing cold chain, hiring and training of vaccinators, provision of vaccines in coordination with IPs	*HMIS report from the upgraded SHCs*	*290*	*9600*	*2784000*	
Activity 1.1.1.2 engagement of private health providers in the delivery of routine immunization services	Identification, negotiation, signing MoU, providing cold chain, vaccine, training and supervision	HMIS report from upgraded private centers	500	9600	*4800000*	
Activity 1.1.1.3 Engagement of family health houses	Providing cold chain, hiring and training of vaccinators, provision of vaccines in coordination with IPs	HMIS report on engagement of family health houses in EPI	185	9600	*1776000*	
Activity 1.1.1.4 Establishing EPI facilities for IDPs and Returnee settlements	Coordination with Returnees Health Project and other stakeholders	HMIS report from IDPs EPI facilities	58	9600	*556800*	Activation of Returnee project
Activities for Output 1.1.2 number of outreach activities increased						
Activity 1.1.2.1 Improving microplanning exercise	Mapping at district level, coordination with all stakeholders, finalizing the plan	District level micro-level available in PEMT	34	30000	1020000	

Activity 1.1.2.2 Increasing outreach teams	Identification of uncovered areas, appointing outreach teams, providing cold chain	Outreach facilities are available in under covered area	500	4800	2400000	
Activities for Output 1.1.3 Urban immunization program strengthened						
Activity 1.1.3.1 Assessing the coverage, activities, resources and clients in the cities	Assessment of clients, resources and coverage in the field	EPI assessment report on clients, coverage and resources	2500	50	125000	
Activity 1.1.3.2 Developing SOPs for better patient flow to avoid missed opportunity	Development, printing and distribution of SOPs to HFs	SOPs are available at all levels	2500	50	125000	
Activity 1.1.3.3 Providing additional resources to implement the SOP for EPHS and urban immunization	Mobilization and allocation of resources for SOP implementation and lunching of Urban immunization	EPI assessment Report on SOPs implementation in the field	500	9600	4800000	
Activity 1.1.3.4 Establishing outreach teams in urban areas	Recruitment of vaccinators for outreach teams, provision means of transportation peridm	Outreach services are available urban settings	500	4800	2400000	
Activities for Output 1.2.1 Behavior change communication improved						
Activity 1.2.1.1 Finalizing and operationalizing communication strategy	Assignment of technical team to finalized and distribute EPI communication strategy	Finalized SOPs	2500	500	1250000	

Activity 1.2.1.2 Engaging ICN and CHWs in routine immunization	Mobilization of CHWs and ICN in under covered areas, involving them in EPI and provision of incentives	CHWs and ICNs are part of the program	2500	600	1500000	
Activity 1.2.1.3 inter-personal and group communication by vaccinators	Immunization status of all eligible clients visiting HFs is checked by vaccinators	Immunizations status of all clients assessed	2500	200	500000	
Activities for Output 1.2.2 Community engagement strengthened						
Activity 1.2.2.1 Engaging community health committees (Shuras)	Community Health Shura have regular meetings with EPI staff at HFs	Meeting minutes with Health Shura	2500	200	500000	
Activity 1.2.2.2 Branding EPI program	Design Logo for EPI and increase awareness of community via effective communication means	EPI logo available in all HFs and public awareness increased	2500	150	375000	
Activity 1.2.2.3 Strengthen Health Promotion Department (HPD) involvement into EPI communication	HPD participates in all coordination meetings	Enhanced coordination between EPI and HPD	0	0	0	
Activities for Output 2.1.1 ToR and Structure of EPI at all levels revised						
Activity 2.1.1.1 Establishing REMT in 7 regions	Announcement of vacancies, hiring of staff and development of TORs for 7 REMTs	REMTs established in 7 region	7	483600	3385200	

Activity 2.1.1.2 Revising TOR of PEMT	A technical committee reviews TORs of PEMTs	Revised TORs	0	0	0	
Activity 2.1.1.3 Restructuring PEMT	Supervisors added based on need	Supervisor added & TORs revised	143	4800	686400	
Activity 2.1.1.4 Restructuring National EPI department	All position in NEPI re-announced and staff are hired with revised TORs	Revised organogram	1	0	0	
Activity 2.1.1.5 Revising National EPI department TOR	Technical team assigned to revised TORs	Revised TORs	1	0	0	
Activities for Output 2.1.2 Roles and responsibilities of all stakeholders defined						
Activity 2.1.2.1 Developing EPI services SOP	A technical committee in consultation with partners develop SOPs for EPI services	SOPs are available at all levels	2500	2	5000	
Activity 2.1.2.2 Implementing EPI services SOP	Performances taking place according to SOPs	EPI reports on SOPs implementation	2500	50	125000	
Activities for Output 2.1.3 SPs Rewarded, sanctioned through Performance Management						
Activity 2.1.3.1 Supervising BPHS/EPHS facilities	Continues supervisions are taking place from BPHS and EPHS by national staff	Number of Supervision conducted	2500	100	250000	
Activity 2.1.3.2 Participating in the quarterly and bi-annual performance management review meetings	Material and schedule for the meeting are in place and meetings are conducted on time	Meeting minutes	136	300	40800	

Activities for Output 2.2.1 Vaccinators received initial & refresher training						
Activity 2.2.1.1 Conducting training need assessment	Need assessment for capacity building taken place at all levels	Assessment report	0	0	0	
Activity 2.2.1.2 Conducting initial training	All newly recruited vaccinators are trained before joining the job	Training report	1000	500	500000	
Activities for Output 2.2.2 Nurses and midwives involved in vaccination						
Activity 2.2.2.1 Conducting training need assessment	Need assessment for capacity building taken place at all levels	Assessment report	34	0	0	
Activity 2.2.2.2 Developing training guidelines	IIP and MLM are used to develop training guidelines in close coordination with partners and services providers	Guidelines are available	2500	20	50000	
Activity 2.2.2.3 Conducting initial training for nurses and midwives	All CHW, midwives and nurses involved in the program are trained	Training reports	2500	150	375000	
Activities for Output 2.2.3 EPI Management staff trained						
Activity 2.2.3.2 Refresher trainings for PEMT, REMT and NEPI	All vaccinators, supervisors and data officers, PETM REMT and NEPI staff receive refresher trainings bi-annually	Training reports	4500	150	675000	

Activity 2.2.3.3 Quarterly review meetings at the PEMT level	Review material, schedule are in place and quarterly reviews are conducted by PEMTs	Review Reports	136	300	40800	
Total						31045000

Table 3: Work plan (Gant chart)																										
Activities	**Timeline (months)**																								**Deliverable**	**Remarks**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**		
Activities for Output 1.1.1 number of fix centers increased																										
Activity 1.1.1.1 Upgrading/establishment of sub-health centers to EPI fixed centers																										
Activity 1.1.1.2 engagement of private health providers in the delivery of routine immunization services																										

Activity 1.1.1.3 Engagement of family health houses																									
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Activity 2.1.2.1 Supervising BPHS/EPHS																									
Activity 2.1.2.2 Participating in the quarterly and bi-annual performance management review meetings																									
Activities for Output 2.1.3 EPI staff Rewarded, sanctioned																									

Activity 2.1.3.1 Developing a SOP for EPI staff activities and reward/ sanction mechanisms																									
Activity 2.1.3.2 Appraisal of EPI staff from top to down biannually																									
Activities for Output 2.2.1 Vaccinators received initial training																									
Activity 2.2.1.1 Conducting training need assessment																									
Activity 2.2.1.2 Conducting initial training																									
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Activities for Output 2.2.3 EPI Management staff trained																									
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Activity 2.2.3.2 Refresher trainings for PEMT, REMT and NEMT																									
Activity 2.2.3.3 Quarterly review meetings at the PEMT level																									

METHODOLOGY/ APPROACH

Activity 1.1.1.1 Upgrading/establishment of sub-health centers to EPI fixed centers:

Upgrading of sub-health centers to EPI fixed centers: MOPH pursued upgrading of sub-centers through provision of EPI fixed centers vaccination services under the GAVI HSS funding and within SEHAT program. However, a total of 469 sub- health centers still don't provide RI services. Sub-health centers could be upgraded as follows:

- Assess the needs of the sub health centers depending on the number of served population (number of vaccinators needed or available midwife to take on the vaccinator's function, cold chain requirement, vaccines and recording/reporting tools);
- Train and recruit additional vaccinator(s) or midwife;
- Provision of cold chain equipment, vaccines and dry supplies, registration, recording, and reporting tools;
- Training and supportive supervision.

Activity 1.1.1.2 engagement of private health providers in the delivery of routine immunization services:

Engagement of private health providers: The private sector is widely distributed throughout the country. Its current involvement in RI varies from province to province. For example, one out of 130 Private Health Care Provider (PHPs) in Uruzgan province provide EPI services. Therefore, PHPs further engagement can rapidly expand access to the EPI services especially in white and underserved areas. In order to further engage private sector in routine immunization the following activities will be carried out:

- Private sector engagement focal point will be assigned at national and provincial levels;
- Reinforce implementation of the MOPH policy for mandatory inclusion of immunization service into the private hospitals and clinics as appropriate;
- Map out existing private health providers and identify their needs for establishment of fixed EPI centers (vaccinators, cold chain, recording/reporting) with focus on under-served and white areas;
- Build capacity of private health providers on planning and implementation of immunization services;

- ❖ Provide resources to the private hospitals including salary of vaccinators' cold chain equipment, recording/reporting tools;
- ❖ The engagement of PHPs should be further formalized through MoUs outlining mutual responsibilities of MOPH/NEPI and providers;
- ❖ Establish robust supervision and monitoring system with mechanism for actions to address poor performance and compliance with NEPI standards.

Activity 1.1.1.3 Engagement of family health houses:

Engagement of Family Health Houses (FHHs) into provision of the EPI services: FHH is a new intervention to improve access of child bearing aged women to pre-natal, intra-natal, and post-natal care in rural settings of few provinces in the country. It is run by a midwife. The MOPH has intention to expand the services to other provinces in the future. Engagement of the FHHs could also contribute to the rapid extension of the EPI services in the rural communities. It can serve as site for outreach or fixed session, depending on the number of births given in the facility. The advantages are that midwife is aware of the target population of infants, women, and others. It has been reported that many of midwifes used to serve as vaccinators in some health facilities.

Activity 1.1.1.4 Establishing EPI facilities for IDPs and Returnee settlements:

Internal Displacement Population (IDP) are a huge mass and the most venerable people in this country. And they need health services including vaccines more than other people. The MOPH therefore, designed a project under General Directorate of Diseases Control and Prevention to provide a package of health services to this special population. EPI services will be provided to this population with lunching of the project.

Activity 1.1.2.1 Improving microplanning exercise:

Microplanning is one of the tools that health workers use to ensure that immunization services reach every community. Microplanning is used to identify priority communities, to address barriers, and to develop work plans with solutions. Currently the NEPI designed these activities in close coordination with services providers and partners in Kandahar province. This activity will be extended to other provinces once work in Kandahar.

- ❖ The micro-plans will be prepared at the Health Facility (HF) level by ensuring the involvement of head of HF, vaccinators, CHWs/CHSs and community representatives. The

process of development of micro-plans at health facilities will be supervised by the District Facilitators that would be identified and assigned by REMT/PEMT.

- ❖ The data of EPI and PEI micro-plan will be reviewed to ensure complete congruence between the two plans. It will be ensured that no geographical areas and/or population subgroup identified in one plan is missed in the other plan.
- ❖ Based upon the feedback of the Health facility staff, CHWs and community representatives, the villages will be combined to form clusters and the type of session (fixed, outreach and mobile) will be decided.
- ❖ The micro plans will be developed based on needs and not based on resources available with the districts/health facilities. Once the micro plans are developed, additional resources will be identified and put in place is completed.

Activity 1.1.2.2 Increasing outreach teams:

Outreach and mobile services will be strengthened, with a focus on the white and under-served areas following quality microplanning process and review of availability and effectiveness of the existing outreach and mobile services. Currently cities do not have outreach activities and we plan to lunch outreach in cities and outreach needs to be conducted by two vaccinators instead of one.

Activity 1.1.3.1 Assessing the coverage, activities, resources and clients in the cities:

Many cities in Afghanistan are over populated and the current number of health services providers particularly vaccinator are not sufficient given the huge number of clients in the health facilities. The client's vaccinator ratio will be revised and additional vaccinators will be hired where needed. Beside this supportive supervision of these health facilities will intensified to make source that immunization coverage is optimal.

Activity 1.1.3.2 Developing SOPs for better patient flow to avoid missed opportunity:

Standard Operation Procedures (SOPs) will be developed to smoothly run patients flow and avoid missed opportunities. There will separate but coordinated SOPs at national, provincial and health facility levels. These SOPs will specify all activities at three levels to increase coverage, follow up defaulters and find unvaccinated children in the field.

Activity 1.1.3.3 Providing additional resources to implement the SOP for EPHS and urban immunization:

Urban immunization program to improve availability of routine immunization services in the urban settings: Routine EPI services in the urban settings are largely provided by Essential Package of Hospital Services (EPHS) implementers in the hospitals. The drawbacks of this process include limited prioritization of EPI services; frequent staff absenteeism; long waiting times; and long travel distances. Afghanistan is undergoing rapid urbanization process, with significant proportion of the population residing in urban slums and temporary nomadic settlements, often having limited access to and/or underusing immunization services. Improvement of the urban immunization services will lead to the rapid gains in immunization coverage owing to the large urban population groups. The urban vaccination program includes the following activities:

- Distribution of immunization services will be assessed;
- Map out white areas in the cities that have no access to the routine immunization services;
- Assess the current work force, resources and number of clients /waiting time in the EPI fixed centers in the urban areas;
- Provision of additional resources to reduce missed opportunity by referring target clients to EPI fixed centers;
- Planning outreach sessions by EPHS implementers or through other mechanisms;
- Raising awareness of the public regarding significance of immunization services using various communication tools.
- Strengthen monitoring & supportive supervision of the health facilities for improvement of immunization services.

Activity 1.2.1.1 Finalizing and operationalize communication strategy:

A technical team will be assigned to finalized the EPI communication strategy. This strategy will be operationalized in the field in close coordination with services providers and partners.

Activity 1.2.1.2 Engaging ICN and CHWs in routine immunization:

The Information and communication network and community health workers will be engaged in routine immunization program across the country. EPI will work closely with CHS, CHWs and with department of CBHS for further involvement of the community. CHWs will make the list of children who never received vaccines in the village. Outreach vaccinators will also provide list of defaulters to CHS and CHWs to refer these children to health facilities.

Activity 1.2.1.3 Inter-personal and group communication by vaccinators:

All eligible patients for immunization coming to Health Facilities (HFs) for any reason should be referred for immunization first. That is vaccinators should check immunization status of all patients and visiting HFs to make sure that all eligible clients are immunized. Outreach and mobile session vaccinators should have effective communication with community to make sure there is missed children in the community.

Activity 1.2.2.1 Engaging community health committees (Shuras):

Communities should be engaged via CHS and CWHs as well as Health Shura to make sure community is fully involved and aware of all immunization sessions taking place in outreach, mobile and fixed centers. Health Shura will make sure that all eligible children and women are refereed to HFs on time and no one children is missed.

Activity 1.2.2.2 Branding EPI program:

All business around the globe have its particular brand and people recognize them by their brands as well as their names. A good example is our sister program Anti Polio which is recognized by its special brand. National EPI will also have a particular brand and we will use EPI communication strategy to take this brand to the communities.

Activity 1.2.2.3 Strengthen Health Promotion Department (HPD) involvement into EPI communication:

Health promotion department will be involved in demand generation for immunization and active community involvement in EPI program.

Activity 2.1.1.4 Restructuring National EPI department

Based on need a technical team from National EPI was assigned to complete the task, considering below working methodologies:

- Review the current structure and downsize the current REMTs to PEMTs and establish new REMTs with the necessary staffing;
- Revise the TORs of key EPI staff such as PEMTs and REMTs managers, supervisors and the trainers.
- Develop TORs for the new proposed staff; regional communication officers and for the regional surveillance and data officers.

2.1.1.5: Review of the current EPI structure:

The context is changing rapidly but the EPI coverage remain stagnant for years and this required reforms. For example, new contracting modality of BPHS and EPHS (payment for performance) and shifting from contract management to performance management. To align with these changes, the EPI structure and functions also needs re-adjustment. There are several issues and challenges at national, regional and provincial levels as below:

National level:

- No direct line of command with the provincial EPI teams (supervision, reporting and technical support and evaluation)
- Overlapping and out of date of TORs between different units of NEPI.
- Shifting from contract management to performance management requires addition involvement of National EPI team in order to improve quality and increase coverage of immunization services.
- The situation is changing constantly therefore, it required revisions in roles and responsibilities within NEPI units.

Regional and provincial levels:

- All the REMTs perform their duties as the PEMTs for their respective provinces except supply of vaccines, and non-vaccine supply (practically we do not have REMTs)
- Some of the staff function since almost a decade and some of them may retire, advancement of knowledge and skill available in the market
- TORs of EPI staff are out of date, not responsive to the current situation, designed in a way which is not linked with the specific deliverables.
- Reporting lines needs revision as the current structure designed in a matrix form but it does not function this way.
- Due to new BPHS and EPHS contracting modalities the services providers, given their limited budget, they reduced their Human Resources (HR) at different levels and EPI services will suffer as a consequence.

- Afghanistan one of the two polio endemic countries with highest number of polio cases (21 in 2018) and low RI coverage in endemic provinces which requires substantial attention.

2.1.1.6: Structure Reforms at provincial level:

In order to address the current challenges such as unclear reporting lines, new contracting modality, low immunization coverage, shortage of supervisors We will propose the following reforms:

2.1.1.7: Recruitment of additional supervisors based on need

Supervision and monitoring play vital roles in program success, for this purpose, there should be enough Human Resources (HR) to monitor immunization related activities and conduct supportive supervision in the in the field. The current number of supervisors in each PEMT is not decided based on need, for conducting timely and effective supportive supervision. Therefore, the assigned technical team suggested increase in the number of supervisors in each province, considering number of health facilities in the province; geographical constraints; polio risk status of a province; and population density of a province as per table in annex.

2.1.1.8: Proposed solution to structure reforms at PEMTs:

Position	Number	Key qualification	Main responsibility
Provincial EPI Team Manager	34	Under graduate or intermediate degree with five years' experience	Planning, and management Provincial EPI Team
Provincial EPI Cold Chain Technicians	64	Undergraduate or intermediate degree with 2 years' experience	Supply vaccine and non-vaccine materials to HFs.
Provincial EPI Supervisors	143	Undergraduate or intermediate degree with 2 years of experience	Monitoring and Supportive Supervision
Surveillance/data officers	64	Undergraduate or intermediate degree with 2 years' experience	Surveillance of VPDs and collection of data and reporting.

Activity 2.1.1.1 Establishing REMT in 7 regions:

In order to address the current challenges such as unclear reporting lines, new contracting modality and low immunization coverage we will establish Regional EPI Management Teams (REMTs) in seven regions with new structure, new terms of references and new reporting lines. These REMTs will have the following structure and staff:

- Regional EPI manager one person
- Regional Trainers two persons Kabul with an exception that will have three trainers
- Regional Cold Chain Manager one persons
- Regional Cold Chain Technician three persons

- ❖ Provincial Focal Point one person per each province of the given region.
- ❖ Communication officer one person
- ❖ Surveillance/data officer one person

Table (5) Proposed staff, qualification, experience and main responsibilities of PEMTs

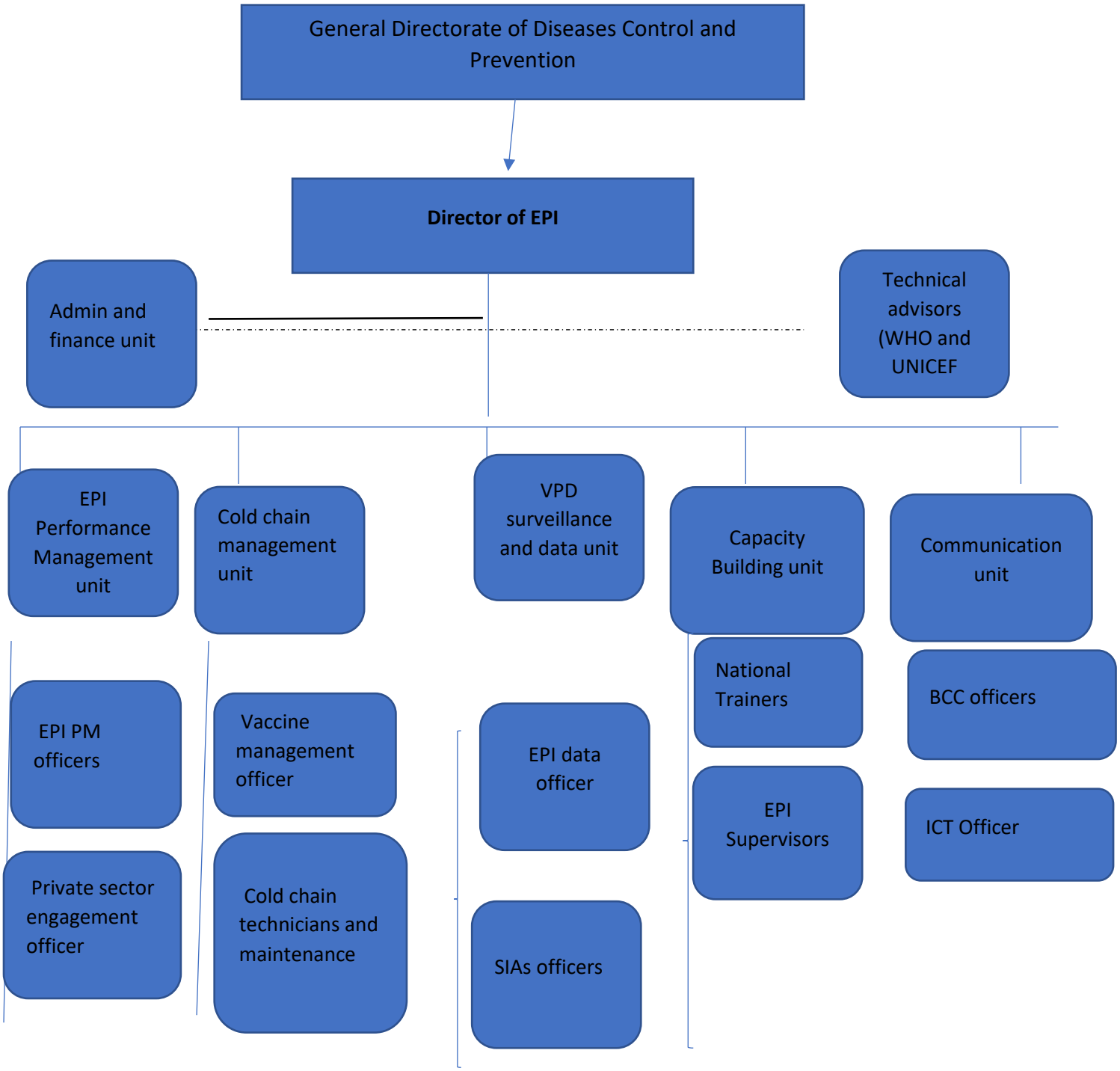
Position	Number	Key qualification	Main responsibility
Regional EPI Team Manager	7	Master degree with 7 years' experience	Planning, and management of REMT
Regional EPI Team Master Trainers	15	Undergraduate degree with 2 years' experience	Training of the related provincial personnel's
Regional EPI Team Provincial Focal Point	34	Undergraduate degree with 3 years' experience	Supervise and coordinate with provincial EPI Team
Regional EPI Cold Chain Manger	7	Under graduate degree with 4 years' experience	Management of cold chain, supply of vaccines and non-vaccine materials
Regional EPI Cold Chain Technicians	14	Undergraduate or intermediate degree with 2 years' experience	Supply vaccine and non-vaccine materials
Regional EPI Communication Officer	7	Undergraduate degree with 4 years of experience	Communicate with related provinces, distribution of IEC material and demand generation

Revision of PEMTs TORs: To address the recent challenges, we have revised the TORs in two parts:

- ❖ Qualification: good communication skills, languages skill both local and English, knowledge of basic computer programs and management and leadership skills have been added.
- ❖ Functions: The role and responsibility has been clearly defined in planning, coordination, supervision, monitoring, reporting and data management.

National level: In order to address the above mentioned challenges in national level we proposed the following reforms

- ❖ Align the TOR of NEPI with the National Strategic Plan of MOPH and current situation
- ❖ Align the TORs of units to the National EPI strategy and objectives
- ❖ Clarify roles, responsibilities and qualification of each position.


General Directorate of Diseases Control and Prevention
Director of EPI
Admin and finance unit
Technical advisors (WHO and UNICEF
EPI Performance Management unit
Cold chain management unit
VPD surveillance and data unit
Capacity Building unit
Communication unit
EPI PM officers
Vaccine management officer
EPI data officer
National Trainers
BCC officers
EPI Supervisors
ICT Officer
Private sector engagement officer
Cold chain technicians and maintenance
SIAs officers

Activity 2.1.2.1 Supervising BPHS/EPHS:

Engagement and mutual accountability with BPHS/EPHS service providers and other stakeholder's/service providers will be strengthened. It will be done through advocacy to MOPH leadership to make BPHS Service Providers accountable to NEPI on Routine Immunization; monitoring of implementation of the Accountability Framework for BPHS Service Providers; developing accountability framework for EPHS implementers with focus on strengthening routine immunization in the urban settings; encouraging administrative and disciplinary measures at all levels through NEPI, GCMU, BPHS and EPHS implementers, and other stakeholders for poor performers. Below activities will be conducted for enhancement of supervision and accountability.

- ❖ Performance appraisal of the current EPI supervisors
- ❖ Capacity building of supervisors
- ❖ Encouraging joint MOPH, Service Providers, and partner's supervision where appropriate
- ❖ Enhance supervision of outreach sessions
- ❖ Increasing frequency of supervision

Activity 2.1.2.2 Participating in the quarterly and bi-annual performance management review meetings:

Review meetings will be taken place quarterly at regional level and bi-annually at central level.

Activity 2.1.3.1 Developing a SOP for EPI staff activities and reward/ sanction mechanisms:

Standard Operation Procedures (SOPs) will be developed for EPI staff performances evaluation. This SOPs will contain all activities conducted by staff and reward and punishment mechanism will be operationalized based on this SOPs.

Activity 2.1.3.2 Appraisal of EPI staff from top to down biannually:

All EPI staff at all levels will be appraised bi-annually. Provincial staff will be appraised by PEMT managers and REMTs and National EPI staff will be appraised by NEPI manager.

Activity 2.2.1.1 Conducting training need assessment:

Continues learning play vital role in good performances. Therefore, all EPI staff will be assessed and training will be conducted based on need.

Activity 2.2.1.2 Conducting initial training:

All newly recruited vaccinators must get initial training before joining job as vaccinator in health facilities.

Activity 2.2.2.1 Conducting training need assessment:

Training need assessment will be conducted all levels and based on need training will be conducted.

Activity 2.2.2.2 Developing training guidelines:

Training guidelines and SOPs will be developed based on Immunization in Practice (IIP) and Mid-Level Management (LLM) guidelines. Attempts will be made to spend more time on practical work than theory.

Activity 2.2.2.3 Conducting initial training for nurses and midwives:

Nurse, midwives and CHWs who are involved in immunization program will be given special trainings regarding immunization.

Activity 2.2.3.2 Refresher trainings for PEMT, REMT and NEMT:

Build management and technical capacity of the EPI staff at all levels: it will be done through:

- Mid-Level Management (MLM) training
- Immunization in Practice (IIP).
- Learning from other successful immunization program through international study tours

Activity 2.2.3.3 Quarterly review meetings at the PEMT level:

Review meetings will be conducted quarterly at provincial levels.

Annex:

Revision of current TORs of key EPI staff:

TOR for REMTs Manager:

Qualifications:

- Master degree in epidemiology, public health or community medicine from a recognized university.
- Fluent in English and fluent in local languages.
- Strong command of Microsoft (MS) office.
- Competent in internet and email communication.
- Familiarity with local geography and social context of the relevant region.
- Seven years' experience in immunization or public health program in Afghanistan
- Ability to travel to all provinces and districts in the region.
- Good report writing, presentation and communication skills.

Planning, management and coordination:

- Lead the provincial EPI Management Teams (PEMTs) of the relevant region.
- Ensure vaccine supply to the provinces.
- Utilize the available resources effectively and efficiently at regional level.
- Synchronize PEMTs plan and make sure from implementation of the plans.
- Represent Routine Immunization Program in all health related forums in the regional and national level
- Coordinate immunization activities with EPI partners such as UN agencies, PEI, BPHS/EPHS implementing Service Providers and other stakeholders at regional level.
- Appraisal of the REMTs staff according to their TORs.
- Plan, manage and supervise trainings in close coordination with regional trainers and PEMT managers
- Contribute to outbreak investigation of Vaccine Preventable Diseases (VPDs), planning and monitoring
- Contribute to Comprehensive Multi-Year Plan (cMYP) revision and update

Supportive Supervision and Monitoring:

- Development annual and quarterly supervision and monitoring plans based on evidence and reports.
- Ensure that supervision and monitoring plan has been implemented
- Ensure that all vaccines reach to the related provinces in the region.
- Make decision based on supervisory and monitoring findings.
- Monitor all supplementary immunization activities in the region.
- Provide regular feedback (written and face to face) to the provincial focal points.

Communication and community involvement:

- Ensure that REMTs have effective communication with all stakeholders at regional level.
- Ensure that all IEC material are available, properly distributed and displayed in provinces of the region.
- Ensure effective engagement of other governmental entities and sectors in EPI/PEI in regional provinces.
- Make appropriate plan for refusal conversion and ensuring its implementation in regional provinces.
- Ensure that all planned outreach and mobile session are conducted at relevant provinces.
- Ensure that no white area exist in the region.

Reporting and data management:

- Ensure timeliness, completeness and accuracy of monthly reporting in region.
- Ensure data usage at regional and provincial levels taken place.
- Ensure all Adverse Event Following Immunization (AEFIs) are regularly reported from all regional provinces.
- The REMT manager report to NEPI manger.
- Any other activities assigned by NEPI manger.

TOR for regional trainer:

The REMTs needs two trainers in its structure except the Kabul REMT with three trainers given the large number of provinces. The total number of trainers in REMTs will be 15 persons.

Qualifications:

- Undergraduate degree in public health, medical, nursing or midwifery however, graduate degree in public health will be given preference.
- Two years' experience in training planning and conduction particularly in health related field.
- Minimum three years' experience in public health and two years' experience in immunization program.
- Resident of the relevant province/region
- Fluent in Pashto and Dari with good command on English
- Command of MS Office
- Good interpersonal communication skills
- Travel to provinces is mandatory

Planning and management.

- Conduct training need assessment in the region and its relevant provinces.
- Plan and conduct necessary trainings such as initial, refreshers and introduction of new vaccine and switch of one vaccine to another in the region in close coordination with the REMT and PEMT managers.
- Coordinate training related activities with partners and stakeholders.
- Develop, revise and update training guidelines based on new research findings in the field of immunization and in alignment with the policy of MOPH.
- Conduct Training of Trainers (TOTs) and workshops in the provinces based on need related to RI and SIAs in the region.
- Ensure that all vaccinators received necessary trainings in the field on time.

Reporting and feedback:

- Provide monthly, quarterly and annual report to the NEPI and REMT managers.
- Ensure that training guidelines are available, distributed and utilized in the field.
- Provide feedback to the REMT, PEMTs and field staff when needed
- Keep record (databases) of all trainings and human resources.

TORs for PEMT manager:

Qualifications:

- Medical Doctor (MD) or Undergraduate degree in public health, nursing or midwifery from a recognized university
- Good command on English and fluent in local languages.
- Command of MSs office especially on Word, Excel and PowerPoint.
- Competent in internet and email communication.
- Familiarity with local geography and social context of the relevant province.
- Five years' experience in immunization program in Afghanistan
- Ability to travel to all districts of the province including inaccessible areas
- Good report writing, presentation and communication skills

Planning, management and coordination:

- Lead the EPI team at provincial level
- Ensure vaccine supply to health facilities timely.
- Utilize the available resources effectively and efficiently
- Prepare provincial monthly, quarterly and annual immunization plan.
- Represent Routine Immunization Program in all health related forums.
- Coordinate immunization activities with EPI partners such as UN agencies, PEI, BPHS/EPHS implementing Service Providers and other stakeholders.
- Appraisal of the PEMTs staff according to their TORs.
- Plan, manage and supervise trainings
- Contribute to outbreak investigation, planning and monitoring
- Contribute to Comprehensive Multi-Year Plan (cMYP) revision and update

Supportive Supervision and Monitoring:

- Development of supervision and monitoring plans on monthly, quarterly and annual bases
- Ensure that supervision and monitoring plan has been implemented
- Ensure that all vaccines reach to remote and inaccessible areas through outreach and mobile strategies.
- Make decision based on supervisory and monitoring findings.
- Ensure that immunization data is of high quality
- Ensure achievement of key EPI indicators by each health facility
- Monitor all health facilities at provincial level at least once throughout the year.
- Monitor all supplementary immunization activities in the field.
- Provide regular feedback (written and face to face) to Service Providers and health facility staff
- Ensure that all outreach and mobile sessions are conducted according to plan

Communication and community involvement:

- Ensure effective communication between health facilities, health Shura and community health workers.
- Ensure active community involvement in the program
- Ensure that all IEC material are available, properly distributed and displayed.
- Ensure effective engagement of other governmental entities and sectors in EPI/PEI
- Make appropriate plan for refusal conversion and ensuring its implementation.
- Encourage community involvement in outreach and mobiles sessions.

Reporting and data management:

- Ensure timeliness, completeness and accuracy of monthly reporting
- Ensure data usage at health facility, district and provincial level for improvement of the program.
- Ensure all Adverse Event Following Immunization (AEFIs) are regularly reported
- Ensure all the feedback received from national and regional levels are considered and pursued
- The PEMT manager report to REMT manager and PHDs.
- Any other activities assigned by supervisor

S. No	Province	No of health facilities	Supervisor /20 health facilities	Geography constraints (score)*	Polio risk (score) **	Population density score ***	Total score	Available Supervisor	All including the current
1	Badakhshan	87	4	1	0	0	1	1	5
2	Badghis	51	3	0	0	0	0	1	3
3	Baghlan	115	6	1	0	0	1	1	7
4	Balkh	91	5	0	0	0	1	2	6
5	Bamyan	67	3	1	0	0	1	1	4
6	Farah	30	2	1	0	0	1	1	3
7	Faryab	57	3	1	0	0	1	1	4
8	Ghazni	78	4	1	0	0	1	1	5
9	Ghor	55	3	1	0	0	1	1	4
10	Hirat	110	6	0	0	1	1	2	7
11	Jawzjan	36	2	1	0	0	3	1	2
12	Kabul	226	11	0	0	1	1	2	12
13	Kandahar	80	4	0	1	1	2	2	6
14	Kapisa	30	2	0	0	0	0	1	2
15	Khost	45	2	0	0	0	0	1	2
16	Kunar	44	2	1	1	0	2	1	4
17	Kunduz	50	3	0	0	0	0	2	3
18	Laghman	33	2	1	0	0	1	1	3
19	Logar	47	2	0	1	0	1	1	3

20	Nangarhar	115	6	0	0	1	1	2	7
21	Nimroz	21	1	1	0	0	1	1	2
22	Paktika	50	3	0	0	0	0	1	3
23	Paktia	49	2	1	0	0	1	2	3
24	Parwan	51	3	1	0	0	1	1	4
25	Samangan	34	2	1	0	0	1	1	3
26	Takhar	65	3	1	0	0	1	1	4
27	Urozgan	50	3	1	1	0	2	1	5
28	Wardak	51	3	0	0	0	0	1	3
29	Zabul	50	3	0	1	0	1	1	4
30	Helmand	83	4	1	1	1	3	1	7
31	Noorestan	22	1	1	1	0	2	1	3
32	Sar-e-Pul	40	2	1	0	0	1	1	3
33	Panjsher	25	1	1	0	0	1	1	2
34	Daikondi	62	3	1	0	0	1	1	4
Total		2100							143

*: 1- geographical constraints indicate existence. 0- indicates does not exist

**: 1- indicates high risk polio provinces. 0-indicate no-high risk provinces

***: 1- indicates provinces with major populated city. 0- indicates with no major populated city supervision takes in cities longer due to population density

Islamic Republic of Afghanistan
Ministry of Public Health
National Emergency Operations Center (EOC)

Afghanistan proposal for:

Enhancing PEI/RI convergence in high-risk districts

Dec 2018

Acronyms

AADA	Agency for Assistance Development Afghanistan
AHS	Afghanistan Health Survey
AHDS	Afghan Health and Development Services
CBV	Community based vaccinator
CDC	Center for Disease Control
CMR	Child Mortality Rate
DDM	Direct Disbursement Mechanism
DHS	Demographic Heath Survey
EU	European Union
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunization
ES	Environmental Sample
FLW	Front-line worker
GCMU	Grants and Contracts Management Unit
GPEI	Global Polio Eradication Initiative
HF	Health Facility
HSS	Health System Strengthening
ICN	Immunization Communication Network
IMB	Independent Monitoring Board for Polio
IMR	Infant Mortality Rate
LQAS	Lot Quality Assurance Sampling
MHT	Mobile Health Team
MMR	Maternal Mortality Rate
MoPH	Ministry of Public Health
NGO	Non-Governmental Organizations
NEAP	National Emergency Action Plan
OPV	Oral polio vaccine
PCM	Post-campaign monitoring
PEI	Polio Eradication Initiative
PEMT	Provincial EPI Management Team
PHCC	Provincial Health Coordination Committee
PHD	Provincial Health Director
PHO	Provincial Health Office
PPT	Permanent Polio Team
SIA	Supplementary immunization activity
SNID	Subnational Immunization Day
SWG	Strategic Working Group
SHC (PHC)	Sub Health Centers (Primary Health Care centers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Council
WB	World Bank
WHO	World Health Organization
WPV1	Wild polio virus type 1

Acknowledgement

The Ministry of Public Health sincerely appreciates the hard work of the group assigned to develop this proposal including Government members of EOC, WHO, Unicef, BMGF, CDC, EPI department, GCMU department, Aid Coordination and HSS directorate, EOCs of south and east regions, provincial teams of Kandahar, Helmand, Uruzgan, Nengarahar, Nooristan and Farah provinces, NGOs namely the AADA, BARAN, BRAC, AHDS and CHA. Special appreciation to Dr. Abdul Wali Ghayur NGO Coordinator who led the process and drafted the proposal.

Polio eradication has been the highest priority for the Government of Afghanistan in particular the Ministry of Public Health as well as all the GPEI partners and donors. This proposal is aligned with the priorities set forth under “Framework of Change” and will significantly contribute to interrupt transmission of polio virus and enhancing routine immunization services in high-districts of south and east.

I acknowledge the support of BMGF in advance for considering this joint proposal by MoPH and its partners. BMGF among the GPEI partners has played the leading role in Polio Eradication which with no doubt will be recorded in the global public health history.

Dr Ferozuddin Feroz
Minister of Public Health
Islamic Republic of Afghanistan

Executive summary

Despite significant progress in Afghanistan, the health system is facing challenges of access, utilization and gaps at the MoPH to discharge its stewardship functions. According to AHS (2018), 18% of people do not seek health care because they assume health facilities are too far or they do not have transport cost. Community awareness and participation is limited. Insecurity, lack of staff especially female, poor infrastructure and high illiteracy rates are additional contextual challenges which poses great challenges to the country health system.

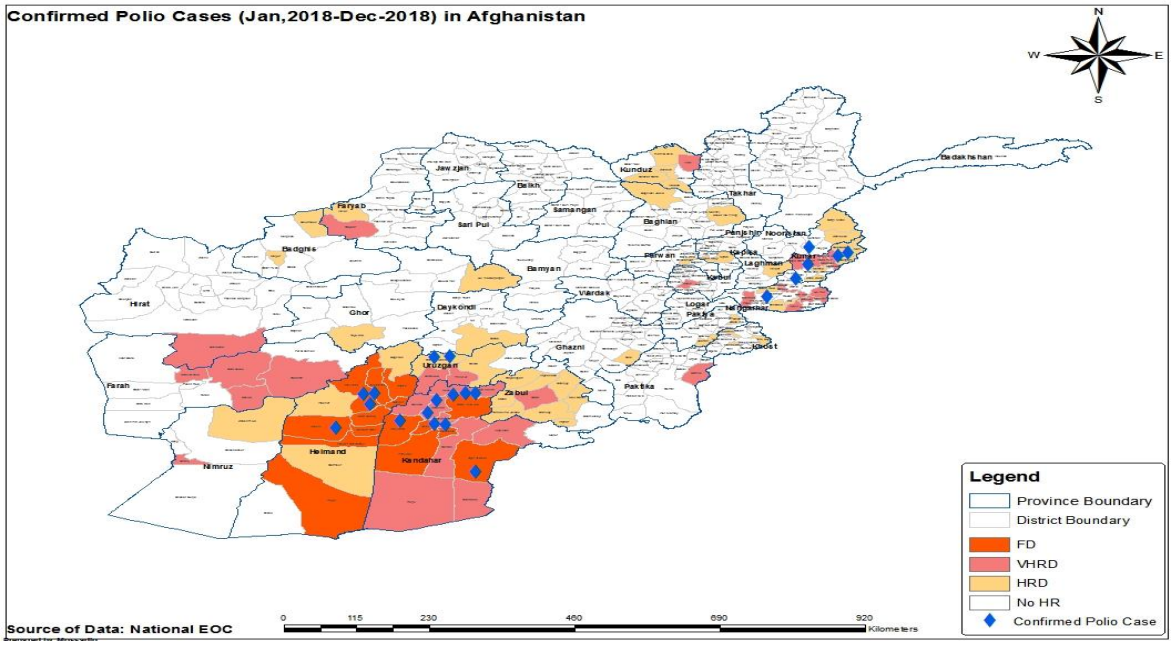
The low routine immunization coverage and outbreaks of Polio are the two significant public health challenges focused on this proposal. The PEI efforts, because of inaccessibility, refusals, suboptimal program quality, HRMP and low RI coverage has not been able to stop circulation of the WPV1 virus. To date in 2018, there are 21 positive WPV1 cases and 64 positive environmental samples. Both number of cases and positive environmental sample show increase as compare to 2016 and 2017.

Table 1 Number of cases and +ES Afghanistan

Year	2016	2017	2018*
Number of cases	13	14	21
Number of Positive Environmental samples	41	42	64
Number of Infected districts	4	9	14

According to table 1, the number of infected districts is over tripled than 2016. In 2018, 5 cases are in east region in the districts of Kama, Pachir u agam, Chawki, Ghaziabad and Paroon districts. The rest of 16 cases are in south region. In Kandahar there are 9 cases in six districts of Kandahar city, Shahwali Kot, Spin boldak, Khakrez, Arghandab and Maiwand districts. The 7 other cases in the south are in the districts of Nadali, Nawzad, of Helmand province and Shaheed Hasas district of Urozgan province.

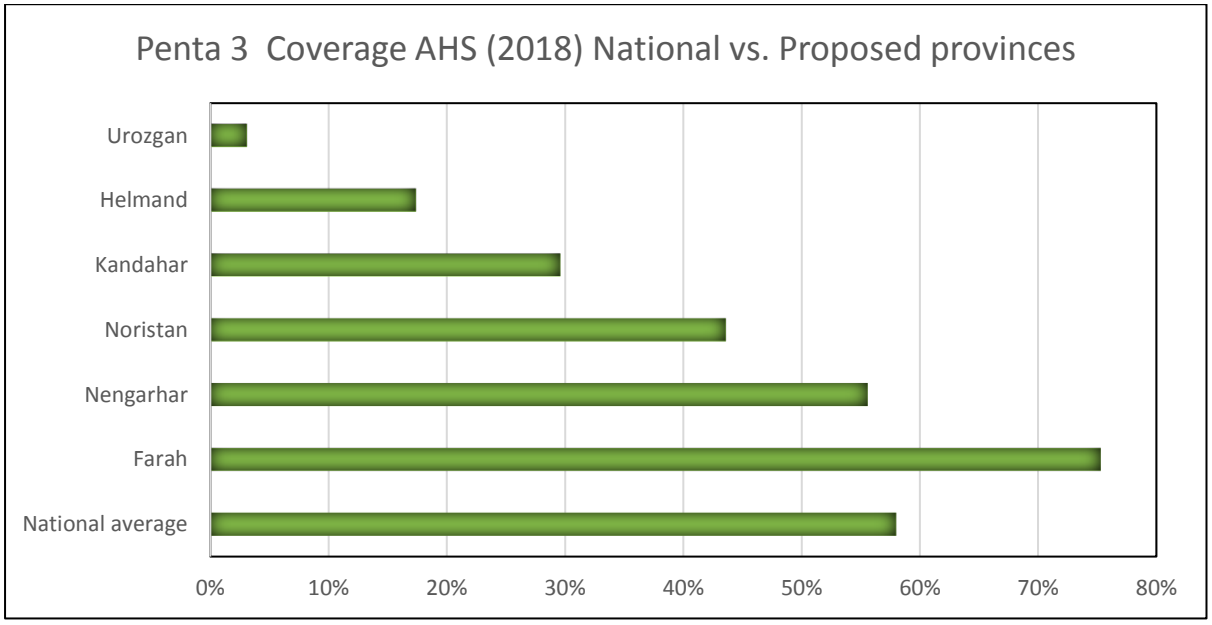
Figure 1Distribution of WPV1 cases 2018



The routine immunization coverage remains low. Full immunization coverage is reported at 50.7% while Penta3 coverage is 60.8% (AHS, 2018). According to the same source, Penta 3 coverage in rural areas is 58% while this is 69% at urban areas. Similarly, there is a noted inequality between the poor and the rich. Penta 3 coverage in lowest income quintile is 43% while this coverage is 73% at highest income quintile at national level. People residing in high-risk districts are considered as rural population with mostly low-income status.

In addition, the AHS (2018) provincial breakdown shows alarming figures for RI coverage in Uruzgan, Kandahar and Helmand provinces:

Figure 2: AHS (2018) Provincial Penta 3 coverage



According to the assessment conducted in the provinces of Kandahar, Helmand, Shaheed Hassa district of Uruzgan, Farah, Paroon district of Nooristan and Nengarhar provinces, through provincial health offices (PHOs) and BPHS implementing NGOs, approximately 650,644 individuals do not have proper access to health services. This indicates that around 150,000 under five children are deprived from basic health services including routine immunization.

Not only the people living in those districts are in dire need for health services but they also require other basic social services such as access to safe drinking water, school, sanitation facilities, community-based nutrition programs including supplementary feeding, municipality services (in city of Kandahar for example) and basic infrastructure including roads and bridges.

Addressing all these needs not only requires the MoPH further actions but also the actions of all partners, donors and line ministries within the government of Afghanistan as allies.

The Afghan EOC is fully on board across the health sector, therefore, addressing some of the basic needs is being coordinated with UN agencies mainly the Unicef and other line ministries. **Areas of support proposed in this proposal, therefore, focuses on addressing few priority gaps within service delivery system of PEI and RI**.

Proposed interventions and activities within this proposal is already aligned and synergized with the support provided by Gavi to the country and also there are no duplications or contradictions with any other initiative in the pipeline within the donor and partner systems.

Funding of the proposed interventions will certainly result into significant positive changes to stop the WPV1 transmission and boost routine immunization coverage in those high-risk provinces and districts.

The proposal is developed through an inclusive process by a working group from partners including EOC, Unicef, WHO, EPI department, BMGF, CDC, Grants and Contracts Management Unit and Aid Coordination and HSS directorate led by NGO coordinator. The principles of alignment, efficiency, effectiveness, sustainability and feasibility have been considered throughout the development process.

The geographic focus of this proposal on south and east regions endemic for polio cases. In total 42 districts will be targeted through the proposed interventions in these six provinces. The distribution of districts is as following: Kandahar (6), Helmand (13), Farah (4), Nengarhar (17), Urozgan (1) and Noristan (1). The largest proportion of this funding will go to Kandahar and Helmand provinces in the south.

Goals and objectives

Goal: The goal of this proposal is to contribute to the interruption of polio virus transmission and strengthening routine immunization in the high-risk districts of south and east regions of Afghanistan.

Objectives:

1. Strengthening the provision of basic health services to the people of 42 high-risk districts with special focus to increase penta-3 coverages to >90% by the end of June 2021.

2. Strengthen community-based Polio immunization services through deploying permanent local teams (community contract).

3. Strengthening capacity of R/PEMT teams and ensure their effective performance.

Key activities and areas for coordination in this proposal are: establishment of 82 Sub Health-Centers (SHCs) in scenario 1 or 62 SHCs in scenario 2, deploying 1 MHT in Paroon district, facilitate upgrading more SHCs to EPI fixed centers, training of 165 new vaccinators in scenario 1 or 125 vaccinators in scenario 2, deploying 301 permanent local teams from within communities to work for the same community with special focus to recruit female vaccinator under community elder's supervision, and finally, recruiting one provincial SIA manager in five high-risk provinces bound with performance-based payment.

The key indicators for achievement are: Increase in Penta3 coverage in children under one year with separate target for each province, OPV3 coverage and contacts per person per year.

Responsibilities of the partners for the implementation of this support are summarized in table below:

Table 2 Responsibilities of the partners for implementation of the support

Organization	SWG member	Roles and responsibilities of partners in the implementation of this proposal
Gov/EOC Director	Yes	Potential option for Project/Financial Management. Coordination and oversight of funds through SWG
UNICEF	Yes	Potential option for Project/financial management, procurement and management of Implementing Partners' sub-contracts. TA
World Health Organization	Yes	Potential option for Project/financial management, procurement and management of Implementing Partners' sub-contracts. Technical Contribution in form of trainings and use of PEI network for monitoring
World Bank	No	Co-Funding of Related activities (principally BPHS funded activities).
European Union	No	Co-Funding of Related activities (principally BPHS funded activities).

Organization	SWG member	Roles and responsibilities of partners in the implementation of this proposal
Canada	No	Co-Funding of Related activities (principally BPHS funded activities).
USAID	No	Co-Funding of Related activities (principally BPHS funded activities).
CGPP	Yes	Technical assistance, work with NGOs to guide smooth implementation of the initiatives
BMGF	Yes	Funding the interventions, TA and Monitoring
CDC	Yes	Provide TA where applicable
Grants and Contracts Unit of the MOPH	No	Technical Contribution for streamlining reports of NGOs and support the sustainability
NGO Implementing Partners	No	Implementation, contribution from their current resources for smooth implementation of the interventions. NGOs already selected will be contract based on single source method.
REOCs	No	Verification of NGOs performance
Community influencers	No	Donation of houses for SHCs, actively support CBVs

Monitoring and Evaluation will be managed as an inbuilt component as well as externally evaluated. Robust supervision is also part of the arrangements. LQAS or quarterly coverage review (through 1 surveyor per district per quarter) will be used to monitor the field interventions. Evaluation of interventions will be made by end 2019 and efforts will be made to have an external evaluation.

The sustainability of the planned activities is likely because the MOPH: (i) will pilot test activities to make sure that they are effective before expanding them i.e. CBVs in Shahwalikot and Nawzad; (ii) focus on activities (such as immunization, and basic maternal child health promotion) that are regarded as highly cost-effective; (iii) use workers on contract so as to avoid long-term obligations and allow flexibility in re-deployment of staff; and (iv) rely, wherever possible, on existing human and financial resources to carry out new activities (e.g. existence EOC and partner capacities and use of NGOs resources). Inclusion of subcenters in the current SEHATMANDI and future health project will be considered a priority and will be included in the system at first possible opportunity.

There are no major risks involved in the implementation of the planned activities. The total budget required is predicted in two scenarios. In scenario 1, 82 SHCs will be established while in scenario 2, 62 SHCs will established. The total required budget for scenario 1 is estimated **$9,380,087** while for scenario 2, the required budget is **7,634,783 for 30 months**. For auditing since the funds will be transferred to UNICEF, the UN processes will be involved.

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Background:

After two decades of war, when the Taliban fell, based on the surveys in 2002, Afghanistan suffered from some of the worst health indicators in the world including a maternal mortality ratio (MMR) of 1600 per 100,000 live births, child mortality rate (CMR) of 257 per 1,000 livebirths and an infant mortality rate (IMR) of 165 per 1,000 live births. Antenatal Care was only 5.5% and DPT3 coverage was only 19.5%.

In response to this desperate situation the Ministry of Public Health (MOPH), with donors and partners, undertook a series of bold reforms, launched in March 2003: (i) it established a Basic Package of Health Services (BPHS) which focused on the most critical and cost-effective services, including immunization; (ii) it contracted with NGOs to deliver the BPHS, and (iii) it contracted the third-party for monitoring and evaluation.

The results are now incrementally evident and the health indicators significantly improved. According to 2017 estimates, MMR is estimated at 600/100,000 live births (MoPH fact sheet, 2017). The latest survey in 2018, indicates that the infant mortality rate (IMR) has fallen to 41 per 1,000 livebirths and Child Mortality to 50 per 1,000 livebirths. The same survey found that Antenatal care is now 63.8% and Penta 3 coverage has reached 60.8%.

Despite significant progress, still the health system in Afghanistan is facing significant challenges. Though the decline in IMR is very encouraging, however, it is still higher than that of the Chad or Somalia and the Antenatal Care coverage remains very low compare to South Asian standards. Another indication that Afghanistan is lagging behind is measles coverage which is 66% nationally with only 28% of the districts having over 80% coverage of measles vaccine AHS (2018). Fully immunization coverage is only 50% and outbreaks of polio still continues in south and east regions of the country.

The health system is facing challenges of access, utilization and gaps at the MoPH to discharge its stewardship functions. According to AHS (2018), 18% of people do not seek health care because they assume health facilities are too far or they do not have transport cost. Community awareness and participation is limited. Insecurity, lack of staff especially female, poor infrastructure and high illiteracy rates are additional contextual challenges which poses great challenges to the country health system.

The low routine immunization coverage and outbreaks of Polio are the two significant public health challenges focused on this proposal. The PEI efforts, because of inaccessibility, refusals, HRMPs, suboptimal program quality and low RI coverage has not been able to stop circulation of the WPV1 virus. To date in 2018, there are 21 positive WPV1 cases and 64 positive environmental samples. Both number of cases and positive environmental sample show increase as compare to 2016 and 2017.

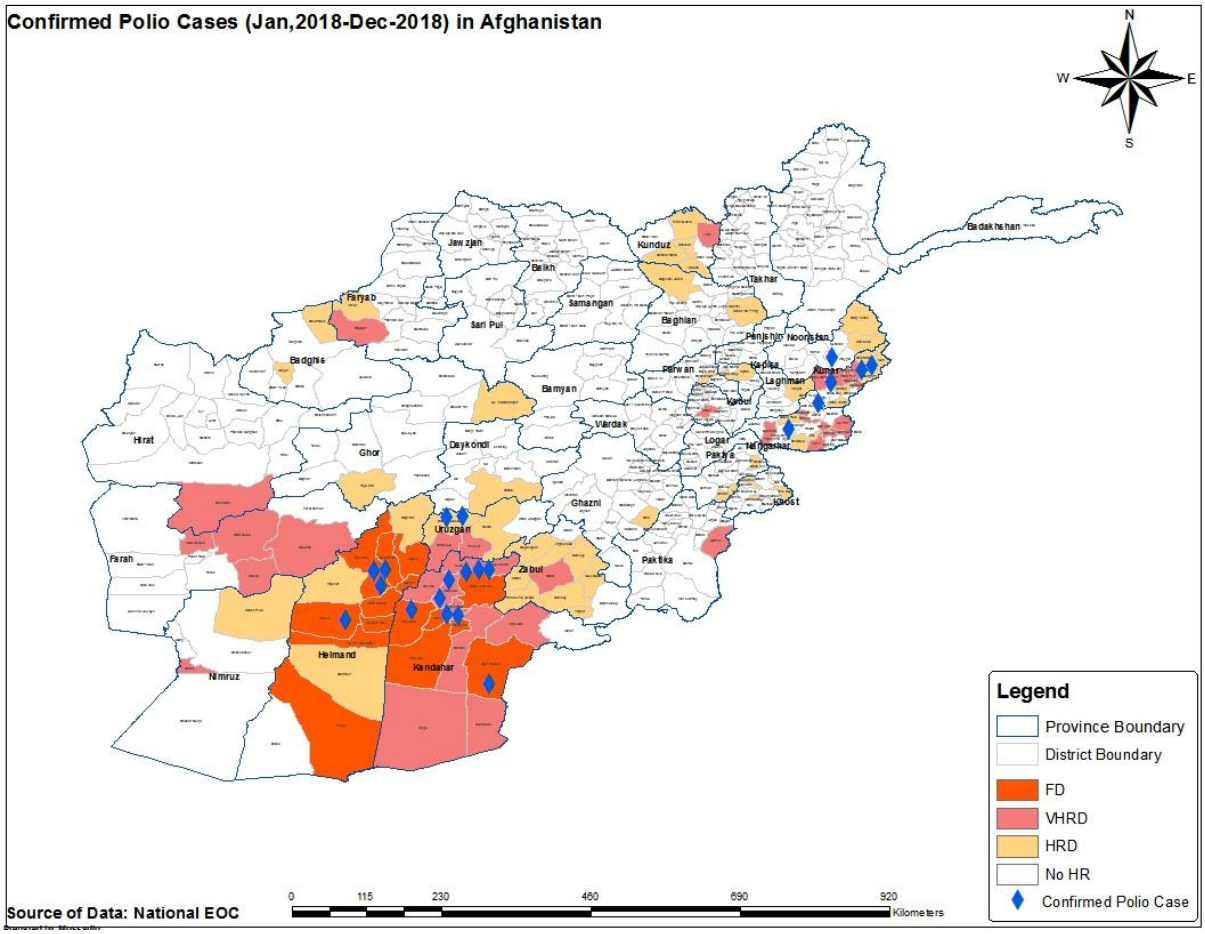
Table 3 Number of cases and +ES Afghanistan

Year	2016	2017	2018*
Number of cases	13	14	21
Number of Positive Environmental samples	41	42	64
Number of Infected districts	4	9	14

*as of week, 49 of 2018.

According to table 1, the number of infected districts is over tripled than 2016. In 2018, 5 cases are in east region in the districts of Kama, Pachir u agam, Chawki, Ghaziabad and Paroon districts. The rest of 16 cases are in south region. In Kandahar there are 9 cases in six districts of Kandahar city, Shahwali Kot, Spin boldak, Khakrez, Arghandab and Maiwand districts. The 7 other cases in the south are in the districts of Nadali, Nawzad, of Helmand province and Shaheed Hasas district of Urozgan province.

Figure 3Distribution of WPV1 cases 2018



The latest immunization coverage survey in 2013 reports full immunization coverage of 50.7% at national level. This coverage is reported in Kandahar 5.7%, Helmand 7.8%, Noristan 7.5%, Farah 2.5%, Uruzgan 15.3% and in Nengarhar 34.7%.

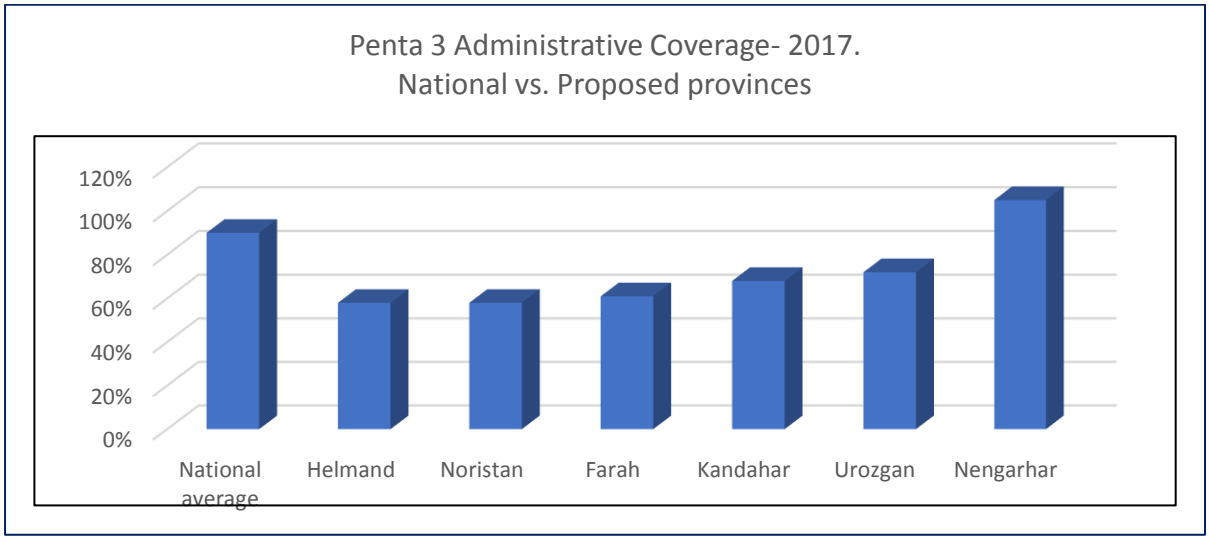
In addition, the DHS, 2015 reports full immunization coverage of 46% and a Penta 3 coverage of 58%. At the provincial level, coverage with all basic vaccinations shown to be lowest in Nooristan (1%), Urozgan (2%), Kandahar (16%). In Helmand, Farah and Nengarhar the estimates were 49.9%, 39.6% and 77.9% respectively.

Penta3 coverage at national level is 60.8% (AHS, 2018). According to the same source, Penta 3 coverage in rural areas is 58% while this is 69% at urban areas. Similarly, there is a noted inequality between the poor and the rich. Penta 3 coverage

in lowest income quintile is 43% while this coverage is 73% at highest income quintile at national level. Population reside in high-risk districts are considered to be rural with mostly low-income status.

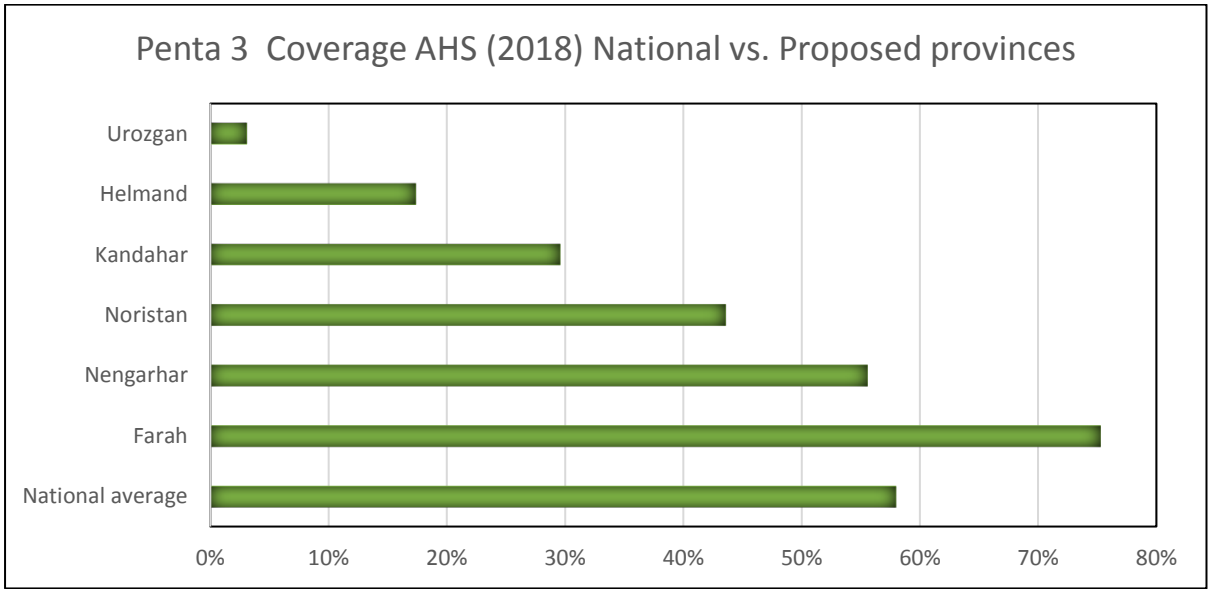
According to both survey and RI administrative reports, the coverage shows reductions from 2015 towards 2018. Currently, in the five provinces covered in the proposal, the RI coverage according to administrative reports is lower than the national average (except Nangarhar):

Figure 4: Penta 3 administrative coverage in targeted provinces of south and east regions



In addition, the AHS (2018) provincial breakdown shows alarming figures for RI coverage in Uruzgan, Kandahar and Helmand provinces:

Figure 5: AHS (2018) Provincial Penta 3 coverage



In addition, according to the assessment conducted in the provinces of Kandahar, Helmand, Shaheed Hassa district of Uruzgan, Farah, Paroon district of Nooristan and Nengarhar provinces, through provincial health offices (PHO) and BPHS implementing NGOs, approximately 650,644 individuals do not have proper access to health services. This indicates that around 150,000 under five children are deprived from basic health services including immunization.

Not only the people living in those districts lack health services but they are also in dire need for other basic social services such as access to safe drinking water, school, sanitation facilities, community-based nutrition programs including supplementary feeding, municipality services (in city of Kandahar for example) and basic infrastructure including roads and bridges.

According to AHS (2018) the percentage of '" Never educated people" at national level is 62.5%. The highest percentages are seen in the provinces of Kandahar (87.7), Uruzgan (95.6), Helmand (84.1), Farah (80.2) and Noristan (91.7). Only in Nengarhar it is over the national average (68.5). The same survey also indicates that at national level only 25% of households have improved toilet facilities and 24% of children have an adequately diverse diet.

In summary, the country as overall but particularly the polio high-risk provinces and districts which are the main focus of this proposal are facing significant challenges including lack of access to health and other social services, low literacy and awareness rates, poor socio-economic conditions and lack of infrastructure coupled by insecurity.

In response, the Ministry of Public Health and its partners developed the "framework for change" where five priorities are set to focus including inaccessibility, refusals, program quality, HRMPs and RI strengthening.

Resistance against polio vaccine and continued transmission in these areas have several reasons. Among these, lack of access to social services mainly the health services have been one of the main factors. The people highly demand more than polio drops but responding to at least basic needs will not only require the MoPH action but also the actions of partners, donors and other line ministries within the government.

The Afghan EOC is fully on board across the health sector, therefore, addressing some of the basic needs will be coordinated with UN agencies mainly the Unicef and other line ministries. **Areas of support proposed in this proposal, therefore, focuses on addressing few priority gaps within service delivery system**. The WB SEHATMANDI project will start on Jan 2019 through NGOs who will run the existing hospitals and BPHS HFs, however, white areas will still exist because of lack of HFs.

Proposed interventions and activities within this proposal is already aligned and synergized with the support provided by Gavi to the country and also there are no duplications or contradictions with any other initiative in the pipeline within the donor and partner systems.

Funding of the proposed interventions will certainly result into significant positive changes to stop the WPV1 transmission and boost routine immunization coverage in those high-risk provinces and districts.

Proposal development process

The proposal is developed by a working group from partners including EOC, Unicef, WHO, EPI department, BMGF, CDC, Grants and Contracts Management Unit and Aid Coordination and HSS directorate. The process was led and the proposal was drafted by the NGO Coordinator. The principles of alignment, efficiency, effectiveness, sustainability and feasibility have been considered throughout the development process.

The draft was presented to the Strategic Working Group and finally approved by H.E. Minister of Public Health.

Geographic Focus

The geographic focus of this proposal is six provinces. Four of the six provinces are high-risk provinces namely, the Kandahar, Helmand, Nengarhar and Farah.

The rest two, Noristan and Uruzgan are not high-risk provinces but have high-risk districts of Paroon (in Norsitan province) and Shaheed Hassas (in Urozgan province) with polio cases. Kunar province, which is also called a high-risk province is not part of this proposal because already sufficient resources are invested.

In total 42 districts will be targeted through the proposed interventions in these six provinces. The distribution of districts is as following: Kandahar (6), Helmand (13), Farah (4), Nengarhar (17), Urozgan (1) and Noristan (1).

The largest proportion of this funding will go to Kandahar and Helmand provinces. In Farah province only 4 sub-health centers (SHCs) and in Negarhar 21 (SHCs) will be established.

Any positive lessons learned will be cascaded to the rest of provinces.

Goals and objectives

Goal: The goal of this proposal is to contribute to the interruption of polio virus transmission and strengthening routine immunization in the high-risk districts of south and east regions of Afghanistan.

Objectives:

1. Strengthening the provision of basic health services to the people of 42 high-risk districts with special focus to increase penta-3 coverages to >90% by the end of June 2021.

2. Strengthen community-based polio immunization services through deploying permanent local teams.

3. Strengthening capacity of R/PEMT teams and ensure their effective performance.

Objective 1: Strengthening the provision of basic health services to the people of 42 high-risk districts with special focus to increase penta-3 coverages to >90% by the end of June 2021.

Key interventions and strategies:

1.1. Establishment of Sub-health centers: Sub-health centers will provide immunization and basic maternal and child health services. The space for service delivery will be contributed by community or rented. Therefore, no construction is required for the HF. According to the MoPH policy, the facility will be staffed with two vaccinators, one midwife and one nurse. Annex (5) provides the details for their distribution. In summary, there will be 28 in Helmand, 26 in Kandahar, 2 in Urozgan and 4 in Farah province. In east region, there will be 21 in Nengarhar and 1 in Noristan province. Th total number of required sub health centers is 82 centers. In scenario 2, sixty-two SHCs will established and there will reduction of 10 SHCs for each of the Nengarhar and Kandahar provinces. Indeed, in scenario 2, those SHCs with less than 3000 population or requested for the city center will be postponed to a later stage with rethinking of need, maximize effect utilization of current resources or other possible strategies.

Sub health center will provide fixed, outreach and mobile immunization services as well as basic maternal and child health services based on the BPHS package.

1.2 Establishment of Mobile Health Teams: According to the assessment, only one MHT is required for the Paron district of Noristan province. The population living in that district are quite dispersed in small villages which will remain deprived from services unless an MHT is visiting the villages at least 6 times in a year to ensure all vaccines are provided and pregnant women are receiving four ANC visits.

1.3 Upgrading more sub health centers to EPI centers

The criteria currently used for upgrading will be revised in Jan 2019 and more sub health centers with the support of Gavi and partners will be upgraded. Therefore, in the current proposal, it is not reflected. However, EOC will actively trace this element which is also reflected in the Routine Immunization Improvement Framework (RIFF) being developed.

1.4 Training of new vaccinators

Since there is lack of detailed information about number of trained vaccinators, in order to be sure sub health centers are properly functioning, there is need to train 165 new vaccinators. 164 will be posted in sub health centers and one of them will be deployed in MHT of Paroon district of Norsitan province. In scenario two, 125 vaccinators will be trained for 62 SHCs and 1 MHTs in Paroon district.

1.5 Increasing demand for utilization of immunization services

There is pressing need to increase demand for immunization through mass IEC campaigns, community involvement, incentivize supply and demand sides and finally

improve the quality of care to build the trust within communities. These areas will be covered through upcoming Gavi HSS proposal.

1.6 Improve urban immunization and replicate public private partnerships which will be considered within the Gavi HSS proposal. The private sectors outlets with different capacities and structures exist across the country. There have been pilots conducted and the results are yet to be reviewed in-depth for more meaningful replication through Gavi funds.

Objective 2: Strengthen community-based polio immunization services through deploying permanent local teams (community contract)

Lesson learned so far indicate that unless the immunization workers are local residents supported by community influencers such as Malik, Arbab, Wakil, religious leaders and heads of tribes, we may not achieve a better coverage.

The recent KAP survey 2018 also revealed top three reasons for no vaccination were 1, Place too far and travel conditions are poor. 2. There are no vaccination services in their community and 3. Don't know when the child is due for vaccination.

The field reports mention that considerable number of operation and ICN staff are non-residents. The, communities are afraid of spying and drone attacks. On the other hand, non-local residents are not familiar with the families and there is a complete disconnect between community influencers and vaccinators. Efforts are going on to revisit the staffing pattern across operation and communication network as part of "framework for change".

Lessons learned from deployment of Permanent Polio Teams (PPTs) and Village Health Volunteer (VHV) from east region indicates that involvement of local residents are critically important. PPT approach failed because of mis management, recruiting non-resident vaccinators and lack of cold chain and vaccine supplies.

The IMB 16th report call for transformative as well as incremental changes. Community Based Vaccinator (CBV) of Pakistan seems to be a transformative successful approach, therefore, considering all these lessons learned and in line with the "framework for change" we propose a modified version of PPTs through systematic involvement of community influencers who will be part of selection and performance management of their local residents (community contract).

The contract with local residents will be a simple contract signed by both team members and one or two local influencers and the provider NGO.

The following overarching guidelines will be applied while rolling out the intervention:

1. The first vaccinator must be female resident accompanied by her Mahram as second vaccinator (father-daughter, husband wife, sister-brother). Due to demands of work, under-age, pregnant women, or lactating mothers is not be recommended. However, if need be can be recruited. If female is not found in a village/villages, male recruitment is not allowed.

2. The size of families they cover will be the entire village (depending on the size of village from 200-600 families, geographic distance maximum 1-2 km). Low range i.e. 200 family is only allowed if the village has no more houses and the distance is over 2 km from the nearest village or HF.

3. The criteria: one female and one male as one team, introduced by community influencers, local resident, age over 20 years, literacy is preferred.

4. Selection process:

    a. Implementer will map areas in manageable sizes
    b. Contacts influencers (in areas where Village development council or Shura exists will be the contact point) and provides full information about the initiative and assuring the communities to protect the dignity of their female volunteers, highlight the importance of polio eradication for their children and community, highlight the job finding opportunity for the their local residents, assuring them of coordinating addressing their needs and possibility of community reward if all children are immunized and no polio case is seen in their area at least for three years.
    c. The role of community influencers will include nomination of candidates based on criteria, extending their support to ensure all their village/villages children are immunized, safe guarding, problem solving and being part of performance review.

5. Once candidates are selected a contract signed by community influencers, and each of the members of the team will be awarded to the community which also define the supportive role of community influencers and duties of volunteers.

6. Payment: each vaccinator will be paid a lump sum amount of equivalent to $ 120 per month. Payment will be made based on performance on quarterly basis after review by supervisor and community influencers. If full coverage is not achieved, unless the reason is beyond the control of vaccinator, 50% of payment will be deducted. At least 20 houses will be verified by supervisor to see if all eligible children are immunized. Meanwhile, in cases for low coverage, supervisor will contact the community elders to support or introduce another couple.

7. Implementer will supply cold chain and vaccines based on a pre-determined schedule from nearest BPHS HF. Since cold chain has been a problem, ice packs if need be can be supplied from solar freezers (which has the capacity to produce 60 ice packs in a day) financed through Gavi.

8. Implementer will also develop reporting system and train the vaccinators by itself or through other partners. The vaccinators will deliver only OPV vaccines until their capacity is upgraded and eventually administer all vaccines. (upgrading to administer other vaccines will be revisited by SWG).

The need for the number of teams has been assessed and only two districts which has the highest number of polio cases in the country are targeted which includes Shawalikot and Nawzad districts in the south. The need is to have 301 two-member permanent teams as following:

Table 4 Distribution of CBV teams across target districts

Province	District	Total Pop.	>5 Pop	# of villages	# of proposed teams	# of proposed supervisors	# of WPV1 in 2018
Kandahar	Shahwali kot	159,445	31,969	917	183*	36 (1 per five teams)	3
Helmand	Nawzad	293,000	58,600	356	118	24	3

*each team will on average cover 5 villages in Shawalikot while 3 villages in Nawzad because of geographic spread.

Detail guidelines will be developed once the proposal is approved.

Objective 3: Strengthening capacity of R/PEMT teams and ensure their effective performance

Handling both RI and SIAs for one PETM manager has been a challenge which has significantly affected the quality of SIAs. In order to streamline the processes, the SWG decided to recruit one SIAs manager for each of the five high risk provinces. These managers will have equal authority to PEMTs except for the cold chain management to coordinate and lead SIAs on behalf of Government.

PEMT managers are already receiving bonus after each SIA. In addition, some other PEMT member such as cold chain officer is also receiving bonus. The SIA Manager will have a fixed salary and a higher amount as bonus bound to performance which will be transferred on quarterly basis after his performance review by EOC national monitors using a matrix and guidelines for performance review. The TORs of SIA manager is aligned to properly manage SIAs (Annex 4). The draft of performance matrix is attached as (Annex 5) to this proposal.

These SIA managers will be contract based and will be selected jointly by National EOC and provincial PHDs. A committee will further review the details after approval of this proposal.

Implementation arrangements

Management of support: Government of Afghanistan, Unicef and WHO are the potential options to be the funds receiver in the country and responsible entity for financial management and reporting. Donor preference will be detrimental to chose the funds receiver.

Oversight and Coordination: At national level, oversight and coordination will be provided through SWG. At provincial level, the PHD as the sub national EOC manager and the chair of Provincial Health Coordination Committee will be the lead focal point for coordination and oversight of the processes through his team, partners as well as the existing coordination forums. Further adaptations will be made in line with the regulatory requirements of funds receiver.

NEOC will work closely with PHDs and NGOs for every single step especially staff recruitment and will ensure that the operational hurdles which has failed many interventions in the past do not affect the intended implementation of the activities.

Implementers: Implementer will be the already selected BPHS implementers of the concerned province which will be contracted by the funds receiver based on their rules in close cooperation with the SWG.

Technical Assistance requirements: The EOC, Provincial PHDs and national level polio partners will use their current systems and staff to technically support implementation of the interventions.

Role of GCMU: GCMU will support review of the performance of NGOs, compile their HMIS reports in alignment with SEHATMANDI project reports and support inclusion of the sub health centers into any future window of opportunity with the support of EOC to ensure sustainability.

Table 5 Responsibilities of the partners for implementation of the support

Organization	SWG member	Roles and responsibilities of partners in the implementation of this proposal
Gov/EOC Director	Yes	Potential option for Project/Financial Management. Coordination and oversight of funds through SWG
UNICEF	Yes	Potential option for Project/financial management, procurement and management of Implementing Partners' sub-contracts. TA
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USAID	No	Co-Funding of Related activities (principally BPHS funded activities).
CGPP	Yes	Technical assistance, work with NGOs to guide smooth implementation of the initiatives
BMGF	Yes	Funding the interventions, TA and Monitoring
CDC	Yes	Provide TA where applicable

Organization	SWG member	Roles and responsibilities of partners in the implementation of this proposal
Grants and Contracts Unit of the MOPH	No	Technical Contribution for streamlining reports of NGOs and support the sustainability
NGO Implementing Partners	No	Implementation, contribution from their current resources for smooth implementation of the interventions. NGOs already selected will be contract based on single source method.
REOCs	No	Verification of NGOs performance
Community influencers	No	Donation of houses for SHCs, actively support CBVs

Monitoring and Evaluation

NGOs will provide quarterly reports of their performance separately for this project to PHD. In addition, NGOs will provide service data through national HIMS system to GCUM and HMIS departments of MoPH. The PHD will verify the reports and will send it to the fund's receiver for release of payments.

Supervision of interventions will be the responsibility of the NGO. However, EOC monitors from national, regional and provincial level will time to time monitor the project. Remote monitoring system will also be used (where possible) to monitor Community Based Vaccination team's deployment and use.

LQAS or quarterly coverage review (through 1 surveyor per district per quarter) will be used to monitor the field interventions.

Evaluation of interventions will be made by end 2019 and efforts will be made to have an external evaluation.

Auditing

The audit of the project will be part of funds receiver annual audit systems.

Sustainability

The interventions proposed in this proposal are in line with the policies of MoPH. Sub Health Centers is also part of BPHS and because of funding shortage in SEHATMANDI establishment of new sub health centers were excluded. The MoPH is also applying for Gavi HSS support bridge funding to fill the gaps in the funding of its plans. However, since the needs are huge, it may not be able to fill all the gaps. All the donors are in agreement and through the SEHATMANDI project already over 300 "sub-centers" are operating.

The sustainability of the planned activities is likely because the MOPH: (i) will pilot test activities to make sure that they are effective before expanding them i.e. CBVs in

Shahwalikot and Nawzad; (ii) focus on activities (such as immunization, and basic maternal child health promotion) that are regarded as highly cost-effective; (iii) use workers on contract so as to avoid long-term obligations and allow flexibility in re-deployment of staff; and (iv) rely, wherever possible, on existing human and financial resources to carry out new activities (e.g. existence EOC and partner capacities and use of NGOs resources). It is important to be realistic in assessing sustainability in Afghanistan and to use an appropriate time horizon. Given the depth of poverty and a limited ability to collect taxes, the Government will not be able to finance a reasonable level of health services within the next 10 years. In the long-term the prospects are much better especially given the growing economy. Inclusion of subcenters in the current SEHATMANDI and future health project will be considered a priority and will be included in the system at first possible opportunity.

Risks and mitigation strategies

Looking to the nature of activities there seems to be no major risks, however, in order to be assertive of the smooth implementation of the proposed interventions, the following risks are predicted:

Table 6 Risks and Mitigation strategies

Risks	Mitigation strategies
Insecurity and active fighting	The BPHS NGOs are fully functional in insecure areas of the country except for Daesh areas. In addition, fear of active fighting is limited and in case it happens; will be temporary based on previous experiences.
Staff availability especially female	The national salary policy provides room for paying hardship to health workers which will be normally applied. NGOs will be required to provide job opportunities for the Mahrams of female health workers. For CBVs since the female with her Mahram will work for their own community, the chances are high to find such couples.
Availability of trained vaccinators for SHCs	For SHCs current available vaccinators will be deployed. Until additional vaccinators are trained, the midwife and the nurse who are already trained for vaccination during pre-service training will be required to administer vaccines until the new vaccinators are trained.
Literacy of CBVs	The literacy of CBVs is not mandatory. In order to better train and use them, pictorial training and reporting tools that are available on the shelf will be adapted.
Selecting the CBV from among different villages with different elders	The village with the highest number of families will have the priority. In cases, where villages have similar population, customary measure such as balloting or any other mechanism agreed by the elders can be used
Timely procurement of services	The procurement TORs for services is already in place which will be adapted to funds receiver systems. Based on any system, single source contracts will be make with current BPHS implementers which is much easier than open bidding.

Annexes

Annex 1 Work plan

Work Plan and schedule of key activities

No	Objective/Activities	Timeline										Responsible Office/Officer	Collaborator/s	Assumptions
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10			
1. Strengthening the provision of basic health services to the people of 42 high-risk districts with special focus to increase penta-3 coverages to >90% by the end of June 2021														
1.1	Proposal submission											SWG	SWG	
1.2	Proposal negotiations											Unicef	SWG	
1.3	Development of TOR for SHCs contract											EOC	GCMU	
1.4	Development of SOPs for monitoring											EOC	SWG	
1.5	Orientation workshop											Unicef	EOC	
1.6	Reassessment of the sites											PHD/NGO	Unicef	
1.7	Selection of providers											Unicef	EOC/GCMU	
1.8	Negotiations with providers											Unicef	EOC/GCMU	
1.9	Signing the contracts											Unicef	MoPH	
1.10	Monitoring of the intervention											PEI/Third party monitoring	EOC	
1.11	Evaluation of the intervention											TBD		
1.12	Putting the intervention in the upcoming											EOC/GCMU	MoPH	

	BPHS/EPHS funding project													
1.13	Preparation for handing over the intervention to new BPHS implementers											GCMU	EOC	
1.14	Selection of the candidates as new vaccinators											Imp. NGO	EOC	
1.15	Training of new vaccinators											WHO	HSS/EOC	
2. Strengthen community-based immunization services through deploying permanent local teams.														
2.1	Detailed mapping of the sites											REOC/NGO	EOC	
2.2	Development of SOPs											Unicef/EOC	SWG	
2.3	Development of the TORs for each category of staff											Unicef/EOC	SWG	
2.4	Develop TOR for implementer											EOC/GCMU	SWG	
2.5	Selection of supervisors											NGO	REOC	
2.6	Selection of CBV teams											NGO	REOC	
2.7	Provision of short-term trainings											NGO	EOC	
2.8	Monitoring of the intervention											EOC/PEI	SWG	
2.9	Evaluation of the intervention											EOC	SWG	

3. Strengthening capacity of R/PEMT teams and ensure their effective performance														
3.1	Finalize the performance matrix													
3.2	Recruit managers													
3.3.	Quarterly performance review											EOC	PHD	

Annex 2 Budget Scenario 1

No	Main Interventions	Details	Y1 $	Y2 $	Y3$ (six M)	Total	Assumptions
Objective 1: Strengthening the provision of basic health services to the people of 42 high-risk districts with special focus to increase penta-3 coverages to >90% by the end of June 2021.							
1	Vaccinators salary	$ 160 per vaccinator including outreach (165)	$264,000.00	$316,800.00	$158,400.00	$739,200.00	vaccinator salary $ 120 ; $ 2.6 for 15 days outreach
2	Midwives salary	$ 450 per month (83 midwives)	$332,000.00	$398,400.00	$199,200.00	$929,600.00	
3	Nurse salary	$ 350 per month (83 nurses)	$249,000.00	$298,800.00	$149,400.00	$697,200.00	
4	Supplies	$ 800 per month	$664,000.00	$796,800.00	$398,400.00	$1,859,200.00	
5	Consumables	$ 200 month	$166,000.00	$199,200.00	$99,600.00	$464,800.00	
6	Fuel (winter)	$ 50 per month	$41,500.00	$49,800.00	$24,900.00	$116,200.00	
7	Rent PHCs	$ 200 per month	$164,000.00	$196,800.00	$98,400.00	$459,200.00	
8	Rent MHT	$ 1000 per month	$10,000.00	$12,000.00	$6,000.00	$28,000.00	only for Paroon district
9	Stationary	$ 50 permonth	$41,500.00	$49,800.00	$24,900.00	$116,200.00	
10	Supervisors salary	$ 400 (8) supervisors	$32,000.00	$38,400.00	$19,200.00	$89,600.00	2 for KDN, 2 Hel, 2 Nen, 1 Farah, 1 Paroon
11	Perdiems	$ 100 month	$83,000.00	$83,000.00	$49,800.00	$215,800.00	
12	Contingency costs	$ 100 month	$83,000.00	$99,600.00	$49,800.00	$232,400.00	
13	Training of new vaccinators	$ 800 per vaccinator traning	$132,000.00	$13,200.00	$13,200.00	$158,400.00	
14	Total Operations		$2,262,000.00	$2,552,600.00	$1,291,200.00	$6,105,800.00	

No	Main Interventions	Details	Y1 $	Y2 $	Y3$ (six M)	Total	Assumptions
15	Admin cost 10% NGOs		$226,200.00	$255,260.00	$129,120.00	$610,580.00	
Total cost objective 1			**$2,488,200.00**	**$2,807,860.00**	**$1,420,320.00**	**$6,716,380.00**	
Objective 2: Strengthen community-based immunization services through deploying permanent local teams.							
16	CBV salary	$ 120 per CVB (302)	$362,400.00	$434,880.00	$217,440.00	$1,014,720.00	
17	Supervisors salary	$ 200 (60)	$120,000.00	$144,000.00	$72,000.00	$336,000.00	1 supervisor for every 5 team Shawali kot, for every 3 team Nawzad
18	Training of new vaccinators	$100	$30,200.00	$3,200.00	$3,200.00	$36,600.00	
19	Training of supervisors	$100	$6,000.00	$3,200.00	$3,200.00	$12,400.00	
20	Stationary and printing	$ 300 per month	$6,000.00	$7,200.00	$6,000.00	$19,200.00	
21	Transpport for supervision and community involvement	$ 2000 per month	$40,000.00	$48,000.00	$24,000.00	$112,000.00	
22	Communication	$ 10 per month per supervisor	$6,000.00	$7,200.00	$3,600.00	$16,800.00	
23	Monitoring	$ 300 per month per monitor	$6,000.00	$7,200.00	$3,600.00	$16,800.00	2 independent monitors per district
Total Operations			$576,600.00	$654,880.00	$333,040.00	$1,564,520.00	
Admin cost 10%			$57,660.00	$65,488.00	$33,304.00	$156,452.00	
Total cost objective 2			**$634,260.00**	**$720,368.00**	**$366,344.00**	**$1,720,972.00**	

No	Main Interventions	Details	Y1 $	Y2 $	Y3$ (six M)	Total	Assumptions
Objective 3: Strengthening capacity of R/PEMT teams and ensure their effective performance							
13	Salary of SIA manager	5 managers $ 400 month	$22,000.00	$24,000.00	$12,000.00	$58,000.00	
14	Peformance based payment	$ 600 month	$33,000.00	$36,000.00	$18,000.00	$87,000.00	
Total cost objective 3			**$55,000.00**	**$60,000.00**	**$30,000.00**	**$145,000.00**	
15	Designated national officer	3000	$36,000.00	$36,000.00	$18,000.00	$90,000.00	
Total cost			**$3,158,460.00**	**$3,564,228.00**	**$1,804,664.00**	**$8,527,352.00**	
16	Funds receiver Admin charges	at 10%	$315,846.00	$356,422.80	$180,466.40	$852,735.20	
Grand total			**$3,474,306.00**	**$3,920,650.80**	**$1,985,130.40**	**$9,380,087.20**	

Budge Scenario 2

No	Main Interventions	Details	Y1 $	Y2 $	Y3$ (six M)	Total	Assumptions
Objective 1: Strengthening the provision of basic health services to the people of 42 high-risk districts with special focus to increase penta-3 coverages to >90% by the end of June 2021.							
1	Vaccinators salary	$ 160 per vaccinator including outreach (125)	$200,000.00	$240,000.00	$120,000.00	$560,000.00	vaccinator salary $ 120 ; $ 2.6 for 15 days outreach
2	Midwives salary	$ 450 per month (63 midwives)	$252,000.00	$302,400.00	$151,200.00	$705,600.00	
3	Nurse salary	$ 350 per month (63 nurses)	$189,000.00	$226,800.00	$113,400.00	$529,200.00	
4	Supplies	$ 800 per month	$504,000.00	$604,800.00	$302,400.00	$1,411,200.00	
5	Consumables	$ 200 month	$126,000.00	$151,200.00	$75,600.00	$352,800.00	
6	Fuel (winter)	$ 50 per month	$31,500.00	$37,800.00	$18,900.00	$88,200.00	
7	Rent PHCs	$ 200 per month	$124,000.00	$148,800.00	$74,400.00	$347,200.00	
8	Rent MHT	$ 1000 per month	$10,000.00	$12,000.00	$6,000.00	$28,000.00	only for Paroon district
9	Stationary	$ 50 permonth	$31,500.00	$37,800.00	$18,900.00	$88,200.00	
10	Supervisors salary	$ 400 (8) supervisors	$32,000.00	$38,400.00	$19,200.00	$89,600.00	2 for KDN, 2 Hel, 2 Nen, 1 Farah, 1 Paroon
11	Perdiems	$ 100 month	$63,000.00	$63,000.00	$37,800.00	$163,800.00	
12	Contingency costs	$ 100 month	$63,000.00	$75,600.00	$37,800.00	$176,400.00	
13	Training of new vaccinators	$ 800 per vaccinator traning	$100,000.00	$10,000.00	$13,200.00	$123,200.00	

14	Total Operations		$1,726,000.00	$1,948,600.00	$988,800.00	$4,663,400.00	
15	Admin cost 10% NGOs		$172,600.00	$194,860.00	$98,880.00	$466,340.00	
Total cost objective 1			**$1,898,600.00**	**$2,143,460.00**	**$1,087,680.00**	**$5,129,740.00**	
Objective 2: Strengthen community-based immunization services through deploying permanent local teams.							
16	CBV salary	$ 120 per CVB (302)	$362,400.00	$434,880.00	$217,440.00	$1,014,720.00	
17	Supervisors salary	$ 200 (60)	$120,000.00	$144,000.00	$72,000.00	$336,000.00	1 supervisor for every 5 team Shawali kot, for every 3 team Nawzad
18	Training of new vaccinators	$100	$30,200.00	$3,200.00	$3,200.00	$36,600.00	
19	Training of supervisors	$100	$6,000.00	$3,200.00	$3,200.00	$12,400.00	
20	Stationary and printing	$ 300 per month	$6,000.00	$7,200.00	$6,000.00	$19,200.00	
21	Transpport for supervision and community involvement	$ 2000 per month	$40,000.00	$48,000.00	$24,000.00	$112,000.00	
22	Communication	$ 10 per month per supervisor	$6,000.00	$7,200.00	$3,600.00	$16,800.00	
23	Monitoring	$ 300 per month per monitor	$6,000.00	$7,200.00	$3,600.00	$16,800.00	2 independent monitors per district
Total Operations			$576,600.00	$654,880.00	$333,040.00	$1,564,520.00	

Admin cost 10%			$57,660.00	$65,488.00	$33,304.00	$156,452.00	
Total cost objective 2			**$634,260.00**	**$720,368.00**	**$366,344.00**	**$1,720,972.00**	
Objective 3: Strengthening capacity of R/PEMT teams and ensure their effective performance							
13	Salary of SIA manager	5 managers $ 400 month	$22,000.00	$24,000.00	$12,000.00	$58,000.00	
14	Peformance based payment	$ 600 month	$33,000.00	$36,000.00	$18,000.00	$87,000.00	
Total cost objective 3			**$55,000.00**	**$60,000.00**	**$30,000.00**	**$145,000.00**	
15	Designated national officer	3000	$36,000.00	$36,000.00	$18,000.00	$90,000.00	
Total cost			**$2,568,860.00**	**$2,899,828.00**	**$1,472,024.00**	**$6,940,712.00**	
16	Funds receiver Admin charges	at 10%	$256,886.00	$289,982.80	$147,202.40	$694,071.20	
Grand total			**$2,825,746.00**	**$3,189,810.80**	**$1,619,226.40**	**$7,634,783.20**	

Annex 3 M&E framework

Indicator	Data Source for indicator	Baseline Value	Source for Baseline	Date of Baseline	Target	Date for Target
Increases in Penta 3 coverage for under age one	Household survey	17.4% Helmand	Afghanistan Household Survey	2018	>70%	June 2021
Increases in Penta 3 coverage for under age one	Household survey	29.6% Kandahar	Afghanistan Household Survey	2018	>80%	June 2021
Increases in Penta 3 coverage for under age one	Household survey	55.6% Nangarhar	Afghanistan Household Survey	2018	>90%	June 2021
OPV 3 coverage in children under one year as average in target provinces	Household survey	TBD	TBD		>90%	June 2021
Contacts/person/year with the healthcare system	HMIS	0 visits /person/ year	HMIS reports	2018	1.0 / Person / Year	2021

Annex 4 TOR of SIA manager

Islamic Republic of Afghanistan
Ministry of Public Health
National Emergency Operations Center
TOR for SIA Manager position

TITLE: SIA manager
DURATION: One year with possible extension
SALARY: Equivalent to $ 300 fixed and $ 500 performance based (performance payment will be made quarterly)
REPORTS TO: Provincial Health Director
LOCATION: Five polio high-risk provinces

OVERALL RESPONSIBILITIES/Objective:

The SIA manager is based in the capital of the province. The manager leads the immunization SIAs with special focus on Polio Eradication at provincial level under supervision of PHD/REOC and NEOC and works collaboratively with PEMT of the province.

SPECIFIC RESPONSIBILITIES

1. Lead polio campaign planning, coordination and implementation in the province including coordination for Vit A and Mebendazole supplementation based on schedule with relevant departments and stakeholders;
2. Ensure implementation of SIA chronogram in respective province;
3. Maintain strong level of coordination with stakeholders at provincial level;
4. Ensure quality micro-planning conducted/revised during SIA campaign;
5. Lead the selection committee for PEI staff selection and ensure staff are selected according to the guidelines;
6. Strong follow up of the quality of training for all FLWs/supervisors/coordinators in line with approved SOPs/guidelines;
7. Support implementation of Accountability Framework at all levels at the province;
8. Provide daily update during pre, intra and post campaign to NEOC;
9. Oversight on data flow, timely use of the data and reporting to NEOC;
10. Ensure investigation of LQAS failed lots and implementation of SoP for low performance clusters and districts;
11. Co-chair the evening meetings with respective PHD and take appropriate actions where applicable;
12. Ensure post campaign review meeting conducted and the outcome well captured for upcoming SIA micro-planning;
13. Participation in field monitoring where possible;
14. Support PHD for ensuring multi-sectoral collaboration;
15. Any other task assigned by line manager

QUALIFICATIONS:

1. Afghan national
2. Medical staff. MD will be preferred.
3. At least five years of work experience. Similar experience will be preferred.

4. Familiar with English language and computer skills.
5. Famous in honesty and hard working.
6. Fluency in one of the official local languages.
7. Ability to work harmoniously with colleagues in a complex and demanding environment and good team management skills.
8. Ability to travel to districts when needed.

Selection methodology:

Positions will be announced from Kabul and provinces
Current PETM are encouraged to apply
The position will be recruited under the panel:

1. Four members from EOC strategic working group (from among the Gov, WHO, UNICEF, CDC, BMGF, CGPP, President office)
2. PHD of respective province

Selection will be done in Kabul (efforts will be made to complete all on the same date).

Probationary period: 3 months

Performance review: Performance will be reviewed on quarterly basis using Performance Framework tool through two national EOC staff and PHD of respective province. In addition, national monitors reports during SIAs will be used for performance review of SIA manager.

Annex 5 Performance review matrix of SIA manager

No	Indicator	Target	Means of verification	Remarks	Weight
1	Respective province has an evidence based micro plan before each SIA	1 per SIA	Copy of plan	It is recommended to cross check with at least on area in the field on random bases	15 scores
2	Staff selected as DPO, DCO, social mobilizers, supervisors/ FLWs are meeting the criteria of national guidelines	At least 25% in first quarter with an incremental 25% in subsequent quarters until it reaches 100% in the first year	National monitors reports, Recruitment audit, records, check of national identities of staff during field visits	Exceptions will be accepted in AGE areas. If SIA Manager is under pressure at provincial level will have to report to NEOC. NEOC is obliged to keep the report confidential and assign a national team to investigate and take actions.	15 scores
3	Findings of national and provincial monitors are turned into an improvement plan and actions are taken	Actions taken for 100% of required actions/summary of findings shared by national EOC after each SIA relevant to his areas of responsibility. For the rest of the feedback, he has to show written document of communication with relevant sources.	It will differ from action to action which will be scrutinized by performance review team.	NEOC is responsible to summarize findings and share it with province after each post SIA review	15 scores
4	Lots of failed LQAS has been investigated and appropriate actions are taken.	Actions are taken based on investigation report.	Copy of improvement plan for failed lot.		15 scores

5	Post campaign review meetings conducted, summarized and actions taken for improvement.	100% of SIAs had a post SIA review meeting. Findings are summarized and actions are taken,	Copy of post SIA review summary Evidence on taking actions to fill the gaps where possible		15 scores
6	Campaign chronogram implemented at all stages of SIA	Agreed chronogram is coordinated/Implemented	Point by point review of chronogram actions. Considering justifications		25 scores

Scoring: taking less than 50 scores for the first quarter, less than 60 scores after the second quarter are considered as failed.
Scores 50-60: will be eligible to receive 40% of PF based payment
Scores 60-70: will be eligible to receive of 60% PF based payment
Scores 70-80: will be eligible to receive 80% of PF based payment
Scores 80-90: will be eligible to receive 90% of PF based payment
Scores 90-100: will be eligible to receive 100% of PF based payment
Scores 95-100: will be eligible to receive of 100% of PF based payment plus an appreciation letter by SWG

Annex 6 Provincial Distribution of SHCs

Kandahar province

District	Total population	Children <5	Children <1	Size of HRMP population	Number and type of fixed HFs	Number of mobile health teams	Proposed New PHCs		Priority
							Distance from nearest HF	Population to covered	
Kandahar city	596423	119285	23857	15000	CHCs-8 RH1	0	1-Topkhana Sub District# 1(2KM)	9000	2
							2-Mala Jath District# 2 (Muslim Chok) (1KM)	11000	2
							3- Haji Arab District# 2 (4KM)	8500	2
							4-Zarha Qomandani(3KM)	7000	2
							5-Distrect # 3(6KM)	12000	2
							6-Sara Ghundi (5KM)	7500	2
							7-Distrect # 9 (Dabaroo Pul) (3KM)	9500	2
							8- Aino Mina 2(12KM)	7000	2
							9- Gulshan Mina Distrec t# 5 (13KM)	8000	2
							10-Mir Bazar (6KM)District # 7	11500	2
Panjwai	95082	19016	3803	1254	CHC-2 BHC-3	0	1-Safedrawan (18km)	12000	1
							2-Khanjakak (22km)	8000	1

							3-Zang Abad(19km)	9000	1
							4-Salawat (23km)	7500	1
							5-Regwa(18km)	7500	1
Shah Wali Kot	47349	9470	1894	1621	CHC-2 BHC-1 SHC-2	MHT-3	1-wach bakhtoo (45km)	8425	1
							2- Baburan(6km)	6000	1
							3- Soznai(32km)	5600	1
Boldak	109837	21967	4393	2521	DH-1 BHC+1 BHC-2 SHC-2	MHT-2	1-Sarban Kalay(21km)	6000	1
							2-Badurzo Kalay (18km)	5400	1
							3-Hussainzi Kalay(16km)	4000	2
Zahri	93669	18734	3747	125	CHC-1 BHC-2	MHT- 1	1-Mira Khor(34km)	6548	1
							2- Kotizi(19km)	7000	1
Maywand	64030	12806	2561	1584	CHC-2	MHT-2	1-Kantainer Bazar(21km)	7152	1
							2-Shakoor Kariz (16km)	2457	1
							3- Kala Shamir(15km)	7812	1

Public Health Directorate

List for the establishment of the New Health Facilities in Helmand province 2018

S.No	District Name	Place for new HF	Type of HF	Distance from Nearest HF	Estimated Population
1	Baghran	Wala Khor	BHC	45 Km	14500
2	Baghran	Baghni (Wanay)	SHC	24 Km	9500
3	Baghran	Mayagan	SHC	33 Km	11300
4	Washer	Laar	SHC	42 Km	13600
6	Mos Qala	Sarang	SHC	15Km	7400
7	Mos Qala	Shah Raga	BHC	16Km	9000
8	Lashkar Gah (boost)	Wazir Manda	SHC	20 Km	3500
9	Lashkar Gah (boost)	Mahajirin	BHC	10 Km	16400
11	Lashkar Gah (boost)	Kariz	BHC	10kM	15000
12	Lashkar Gah (bocst)	Trizkh Nawar	SHC	18 Km	13000
13	Marja	Wakir Wazir Charahi	SHC	21 Km	8000
14	Marja	Sistny	SHC	40Km	14000
15	Marja	Shor Shorak	SHC	20 Km	6000
16	Grsishk	Haydar Abd	BHC	35 Km	19000
17	Kajaki	Jod Raz	SHC	31 Km	8000
18	Kajaki	Shiry	BHC	37 KM	17500
19	Kajaki	Abdar	SHC	24 Km	5600
20	Nadali	Bari Gul Bazar	SHC	29 Km	11500
21	Nadali	Hewad Bazar	SHC	28 Km	6800
22	Khanashine	Qarya Abdullah Khan (Malakhan	SHC	17 Km	7000
23	Nawzad	Qarya Khaway	SHC	22 KM	15000
24	Nawzad	Hazar Khak	SHC	17 Km	14000
25	Nawzad	Mama Kariz	SHC	28 Km	16000
26	Sangin	Qary Zard Rigai	SHC	13 Km	5900
27	Garmsir	Deh Bala	SHC	15 Km	11000
28	Garmsir	Karwan Rah	SHC	220 Km	9500
29	Nawa	Khuja Ahmad Ghondai	SHC	14 Km	5500
30	Nawa	Khisraw Abad	SHC	23 Km	7000

Prepared by : PEI/EPI team

Certify by : PPHD Helmand

Nangarhar province

S #	District	Total population	Children <5	Children <1	Size of HRMP population	Number of mobile health teams	Proposed New PHCs	Distance from nearest HFs by KM	Total populatin of new proposed HFs	Priority
1	khogiani	137767	27553	5511	651	0	koz biar	11	7000	1
2	khogiani	121011	24202	4840		0	Torgahr	14	5000	1
3	Shirzad	69915	13983	2797	301	0	Tormay	11	3200	2
4	Agam	44874	8975	1795	258	0	koz/bar sabar	11	7000	1
5	Nazyan	120087	24017	4803	241	0	Milawa	12	3000	2
6	Hisarak	32478	6496	1299	263	0	Jokan	11	5000	1
7	kozkonar	58014	11603	2321	235	0	kotiTaran	5	8000	1
8	Jalal abad	114072	22814	4563	821	0	Camp farm hada	5	3000	2
9	Gushta	70599	14120	2824	791	0	Warsak	11	3200	2
10	Chaparhar	63593	12719	2544	65	0	Ghazo/Tarako kily	8	11000	1
11	Behsood		23974	4795	1893	0	Zangoi	8	10000	1
	Behsood	119871				0	Sarban ali/Mirano kaly	7	9000	1
12	Jalal abad	114072	22814	4563	791	0	Moqam khan	4	3000	2
13	kama	81071	16214	3243	327	0	Safdari	9	3000	2
14	Dehbala	49519	9904	1981	169	0	Nari Oba	11	6300	1
15	Jalal abad	239968	47994	9599	218	0	Ghaojak	5	10000	1
16	Batikot	798332	159666	31933	137	0	Nowaqil	8	7300	1
17	Momandara	47354	9471	1894	120	0	Hazar Nao	10	3300	2
18	Achin	105740	21148	4230	235	0	Deh sarak	11	4000	2
19	Dara-e-Noor	52519	10504	2101	421	0	Shamal Kandao	11	3000	2
20	Dor baba	24544	4909	982	198	0	Sasobi	13	3000	2
21	Lal pora	21570	4314	863	458	0	Garbad	11	10300	1

Nooristan province

District	Total population	Children <5	Childre n <1	Size of HRMP populat ion	Numbe r and type of fixed HFs	Numb er of mobile health teams	Proposed New PHCs		Number of current vaccinators	Number of new vaccinators needed
							Distance from nearest HF	Population		
Paroon	14027	2805	561	96	4 HFs (1 CHC+, 1 BHC and 2 SHCs)	0	16 KM	1150	6	1
Mom village							1 MHT	For small pockets of within the district	0	1

Farah Province

DistName	Population to be covered	Distance from nearest HF	Village	Facility Type	Need for vaccinator	Priority
Balablok	5500	7 km	Dawlat Abad	Sub Health Center (SHC)	2	1
Khaki safied	6500	13 km	Nang Abad	Sub Health Center (SHC)	2	1
Gulistan	6000	12 km	Khenjak	Sub Health Center (SHC)	2	1
Shibikoh	5800	11 km	Mohammad Abad	Sub Health Center (SHC)	2	1

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