



JANUARY 30, 2019

NATIONAL EMERGENCY ACTION PLAN 2019

POLIO ERADICATION INITIATIVE, AFGHANISTAN

NATIONAL EMERGENCY OPERATION CENTER, AFGHANISTAN



List of acronyms

AFP	Acute flaccid paralysis
AGE	Anti-government elements
BPHS	Basic package of health services
CBT	Cross-border Team
CWG	Communication working group
CDC	Centre for Disease Control
CBHC	Community based health care
CHW	Community health worker
DDM	Direct Disbursement Mechanism
DCO	District communication officer
DPO	District Polio Officer
DEMT	District EPI Management team
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunization
ES	Environment sample
FD	Focus district
FGD	Focus group discussions
FLW	Front-line worker
GPEI	Global Polio Eradication Initiative
HRD	High risk district
HRMP	High risk mobile population
HR	High risk
H2H	House to House
IAG	Islamic Advisory Group
ICM	Intra-campaign monitor/monitoring
ICN	Immunization Communication Network
IOM	International Organization for Migration
IPC	Inter-personal communication
ICN-SM	Immunization communication network-Social mobilizer
IEC	Information, Education, Communication.
IPV	Inactivated polio vaccine
KP/FATA	Khyber Pakhtunkhwa and the Federally Administered Tribal Areas
LQAS	Lot Quality Assurance Sampling
MoU	Memorandum of Understanding
MHT	Mobile health team
NEOC	National Emergency Operations Centre
NGO	Non-governmental organization
NEAP	National Emergency Action Plan
NID	National Immunization Day
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OPFPPE	Office of presidential focal point for polio eradication
OPV	Oral polio vaccine
PCM	Post-campaign monitoring
PEI	Polio Eradication Initiative
PEMT	Provincial EPI Management Team
PTT	Permanent Transit Team
RRD	Rural Rehabilitation and Development
REOC	Regional Emergency Operations Centre

RI	Routine Immunization
REMT	Regional EPI Management team
SIA	Supplementary immunization activity
SNID	Subnational Immunization Day
SOP	Standard operating procedure
S2S	Site to Site
TAG	Technical Advisory Group
TOR	Terms of Reference
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VHRD	Very high risk district
WHO	World Health Organization
WPV	Wild poliovirus

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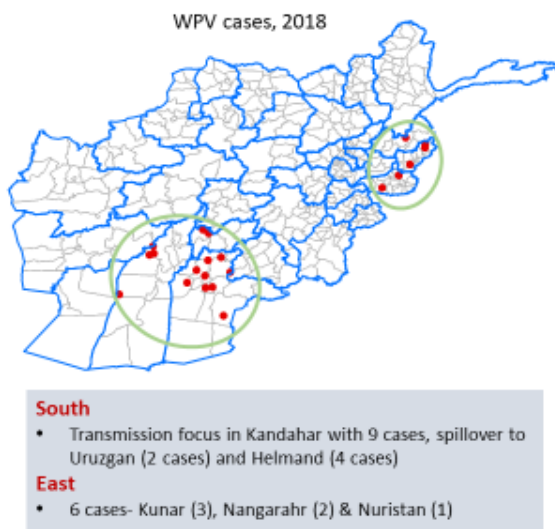
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1. Epidemiology

From 2016 onward, the number of infected districts has increased from 4 in 2016 to 9 in 2017 and 14 in 2018. Similarly, the number cases (13 in 2016, 14 in 2017 and 21 in 2018) and positive environmental samples (41 in 2016, 42 in 2017 and 83 in 2018) has increased significantly in the past three years. At the start of 2019, wild poliovirus transmission in Afghanistan is restricted to Southern and Eastern regions, with no polio cases detected from the rest of Afghanistan in 2018. Out of 21 polio cases in 2018, 15 cases are in the Southern region; while 6 cases are in the Eastern region. Ongoing transmission in the Southern region is due to indigenous local transmission, while that in Eastern region is part of the Northern corridor transmission involving bordering areas of both Afghanistan and Pakistan.

Polio transmission, 2018

Transmission limited to South and East region, importation to polio free areas stopped



ES positive outside endemic areas, 2018



Site	Date	Genetic	Response	Outcome
Kabul	28 Feb	Peshawar	3 SIAa	No secondary (in Kabul)
	28 June	Peshawar	3 SIAa	No secondary (in Kabul)
Herat	25 June	Kandahar	3 SIAa, DPa	No secondary / isolate
Khost	25 Sep	Kohat	3 SIAa	No secondary / isolate

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Southern region:

In 2018, 15 cases have been confirmed-transmission mainly in Kandahar (9 cases) with spread to neighboring provinces Helmand (4 cases) and Uruzgan (2 cases). In Kandahar, infected districts were Shahwali kot (3 cases), Spin Boldak (1), Khakriz (1), Arghandab (1), Maiwand (1) and Kandahar city (2). In Helmand, infected districts were Nadali (1) and Nawzad (3) districts. In Uruzgan 2 cases were seen in Shaheed Hassas district.

Eastern region

In 2018, 6 cases have been confirmed-3 from Kunar (Ghazi Abad district 2 cases and Chawki 1 case), 2 from Nangarhar (Kama and Pachir wa Agam districts) and 1 from Nuristan (Paroon district). Transmission in the East is part of Northern corridor transmission which spans both Afghanistan and Pakistan. Genetically-linked viruses have been detected in Nangarhar, Kunar and Kabul in Afghanistan, and in Pakistan in Khyber-Pakhtunkwa, Rawalpindi, Islamabad, and Lahore.

Outside endemic zones

No cases were detected outside of the provinces stated above, however, poliovirus was detected in environmental samples from Herat, Khost and Kabul. A strong and rapid response resulted in no further spread or continuation of transmission.

2. Progress on NEAP 2018

In 2018, the polio program placed extensive efforts to stop polio transmission. As overall, out of 5 objectives set in the NEAP 2018, three objectives were met, one objective was partially met but the main objective to stop transmission was not met.

Afghanistan maintains a sensitive surveillance system irrespective of access for SIAs. The number of zero-case reporting sites was expanded from 2461 sites in 2017 to 2,510 in 2018 and the number of reporting volunteers was increased from 28543 to 34,548 across the country. Afghanistan is collecting environmental samples from 20 sites located in 11 major population centers of 9 provinces of the country. An internal surveillance review was conducted in 2018 in all the regions except Southern region. A total of 132 stool samples from healthy children residing in chronically-inaccessible areas were tested and were negative for wild poliovirus.

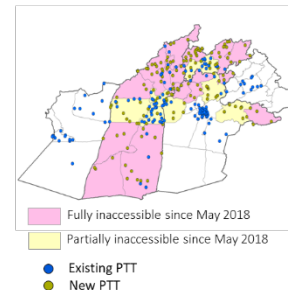
The program undertook a number of interventions to improve the quality of vaccination campaigns. These interventions included microplanning validation, revision of training guidelines, monitoring of training sessions for interventions, and direct oversight from National EOC monitors.

The country program maintains constant dialogue with AGEs at local, provincial and higher levels to ensure program neutrality for polio eradication and supporting activities. The program's access deteriorated in May 2018, when a ban on house-to-house activities was imposed in significant areas of Southern region.

The program continues to implement contingency plans to address the ban in the Southern region, including:

- Accelerated dialogue for access at all levels
- State of preparedness to implement 3 consecutive H2H SIAs as soon as access gained
- 263 additional permanent transit teams strategically deployed
- More than 360,000 children vaccinated with OPV using the opportunity of measles SIAs
- Site-to-site vaccination being implemented
- IPV+OPV SIAs

Expansion of PTTs for inaccessibility



Overall, there is high vaccine acceptance in Afghanistan. Recent opinion research showed that 98% of caregivers surveyed intended to give their children OPV every time it is offered. However, there are small pockets of refusals for vaccination, particularly in the Southern and Southeastern regions.

To further strengthen vaccine acceptance, the program conducts cluster level refusal analyses and develops action plans on campaign basis. A network of social mobilizers and an Immunization Communication Network (ICN) has been deployed to all high-risk areas. Qualitative analysis is being done to understand reasons of refusals (FGD), with systematic influencer engagement implemented according to local need, and media and social media engaged to address rumors.

As part of a framework of change, the following new interventions are being implemented:

- **External review of communication strategy:** Conducted in Nov/Dec 18; recommendations are incorporated into 2019 NEAP and CWG work-plan
- **EOC refusal oversight committees:** Newly-established at national & regional levels to take an interdisciplinary approach to resolving refusals
- **Expansion of network of influencers:** Review existing list of influencers (including from Pakistan) and refusal resolution committees

- **Strengthened engagement of ministry of Hajj and Auqaf:** Meeting for religious scholars (IAG)
- **Addressing other felt needs:** Initiated in high-risk areas of the South (Water supply/ sanitation, expansion of mobile health teams & sub-centers, expansion of nutrition services, support to outreach vaccination, community based education)

The Afghanistan program maintains close coordination with Pakistan in three corridors to increase access to high-risk mobile populations (HRMP). It has identified four types of HRMP and has specific strategies for each type:

- Long distance travelers within the corridors
- Nomads
- Straddling population
- Returnee / refugees

Formal and informal crossing points between Afghanistan and Pakistan have been mapped and vaccination teams have been deployed to vaccinate all children less than 10 years of age crossing the border.

To reach nomadic groups, specific SIAs are conducted in the Southeast upon entry in Afghanistan and specific PTTs are deployed in movement routes in the Southern and Western regions. Nomads movement tracing map is developed indicating routes, settlement by season and accordingly PTTs will be deployed.

Straddling populations have been mapped and focused for coverage in Eastern, Southeastern and Southern regions. Returnees are vaccinated at borders, in UNHCR/IOM centers and are included in SIA micro plans at the point of settlement.

Afghanistan and Pakistan are affected by a shared epidemiology and are treated as one epidemiological block. Jointly, both countries have identified three joint transmission corridors, namely the Northern, Central and Southern corridors. Joint corridor action plans were developed and are being implemented for all three corridors.

There is close coordination on operational and technical aspects at national and subnational levels which includes information sharing on surveillance, communication, population movement, SIAs and case response, as well as coordinated response to poliovirus detection.

One of the important factors in polio eradication is strong routine immunization. In 2018, EOC defined areas of cooperation with NGOs and managed to put concrete foundations for PEI-EPI collaboration. This includes refining the Request for Proposal requirements, signing MoUs, development of accountability framework, linking the MoU with contracts, and placing the MoU implementation in quarterly performance review of NGOs as a requirement. NGOs started targeting the areas with zero dose polio in Nov and Dec 2018 in high risk provinces. In addition, NGOs contribution in SIAs are quantified in terms of contributing monitors, vehicles, attending in intra campaigns review meetings and distribution of IEC materials and response to areas with Zero drop AFPs.

In addition, to ensure appropriate coverage, polio eradication field staff and NEOF staff support implementation of existing plans through direct support in microplanning, monitoring and social mobilization which will be further strengthened. Kandahar specific microplanning is being started.

Table 1. NEAP 2018 Progress by objective

	Goal/Objective in NEAP 2018	Status
Goal	To stop wild poliovirus transmission in Afghanistan by the end of the low transmission season (July 2018), with no WPV1 thereafter	Not achieved
Objective 1	To interrupt transmission in the focus districts of the Southern region and the VHRDs of the Eastern region by the end of the ongoing high transmission season.	Not achieved
Objective 2	To achieve and maintain high population immunity in the rest of the VHRDs and HRDs, ensuring no secondary cases following possible importation.	Achieved outside endemic zones
Objective 3	To achieve and maintain high population immunity among HRMPs	Achieved
Objective 4	To rapidly and effectively respond to any importation of WPV1 and/or emergence of VDPV2 into polio free areas of Afghanistan	Achieved
Objective 5	To maintain high levels of surveillance quality across the country with surveillance quality indicators meeting the global standards in all provinces	Achieved

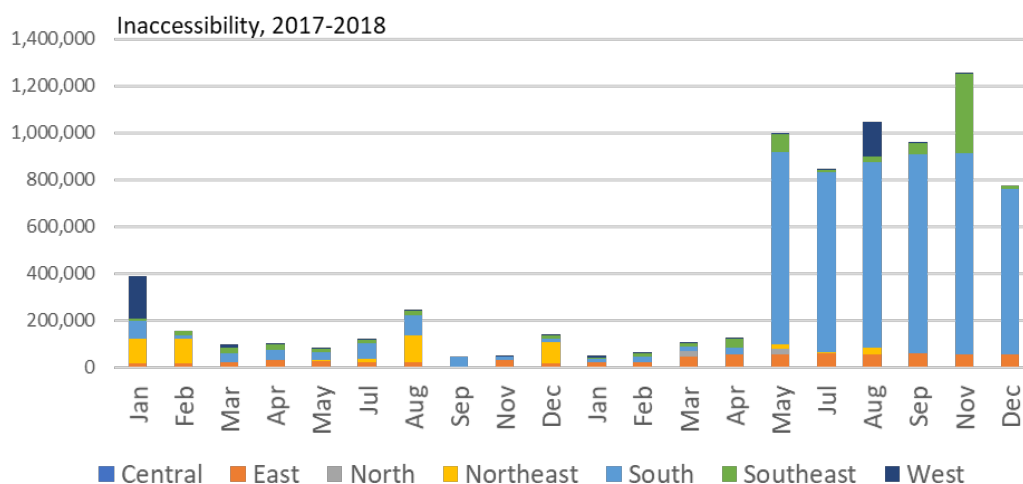
3. Challenges and risks to stopping polio

The program identified the following key challenges/ risks to stopping polio transmission in Afghanistan:

1. Inaccessibility, 2. High Population Mobility, 3. Refusal, 4. Sub optimal campaign quality, and 5. Low Routine Immunization coverage.

1. Inaccessibility: Since May 2018 the number of inaccessible children increased significantly. This has been due to continued ban on the house-to-house strategy in major parts of the Southern region where 860,000 children under five remained missed. In the Eastern region, small pockets of chronically-inaccessible children (59,900 children) in DAESH areas.

In addition to ban, active fighting occasionally also makes the children inaccessible. Though the program is maintaining dialogue at local, regional and global levels, still there is immense need to intensify neutral negotiations with AGEs at all of these levels.



The S2S immunization started in Dec 2018 in most of the banned areas. The results are good, however, not sufficient to interrupt polio virus transmission since bring all children and in particular the new born remains a matter of concern. Efforts will be placed to re-open H2H while improving the quality of S2S.

2. **High population mobility between Afghanistan and Pakistan** mainly in east region.

There is high population mobility between two countries. The main four groups were identified as:

- Long distance travelers within the corridors
- Nomads
- Straddling population
- Returnee refugees

The UNHCR data for 2018 shows that the number of registered refugees have been 13,274. In addition, 3,937 new Pakistani refugees from North-Waziristan Agency have been registered in Khost and Paktika provinces which makes their active stand population as 75,121.

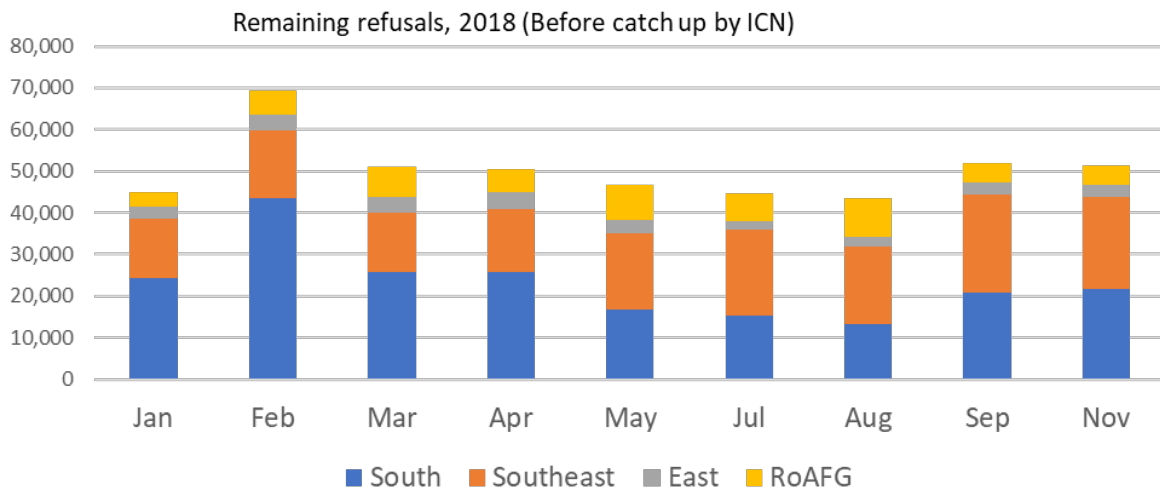
In previous NEAPs, one of the main groups that were left out of focus was the Internally Displaced Persons (IDPs). According to the UNHCR in 2018 as of Sep, 235,100 individuals have been displaced because of conflict.

In addition, figures for nomad's population and long distance travelers has remained as a challenge. Ensures mapping of nomads including development of assessment SOPs, problems in timely recruitment of nomads transient teams, further identification of their routes, and strengthening inter sectoral collaboration including data sharing with ARCS, UNHCR, Disaster Management Unit and Nomad's Independent directorate requires strengthening. Finally, assessment of straddling population requires to be tracked or conducted in Spin Boldak of Kandahar.

3. **Pockets of refusals** particularly in and around Kandahar as well as in the Eastern and Southeastern regions.

The main reason for refusal is the low awareness and misperception among communities mainly on religious and medical grounds. Evidence from national monitoring reports shows that in some cases use of non-local staff, involvement of young boys as front line workers, and lack of female social mobilizers are some of key challenges. In addition, there is room to further strengthen involvement other sectors including Ministry of Haj and Auqaf, community influencers and medical practitioners in the process. Some reports say that most of staff who are removed from the program because of poor performance at least make their families refusal. Furthermore, community fatigue, multiple doors knocking, lack of other social services, staff capacity, media crisis, low staff motivation, and evidence of misbelieve of few of the polio program staff on polio vaccine especially in the south region are additional challenges that needs to be addressed. Finally, there is need to further tailor communication tools to the specific communities and population groups.

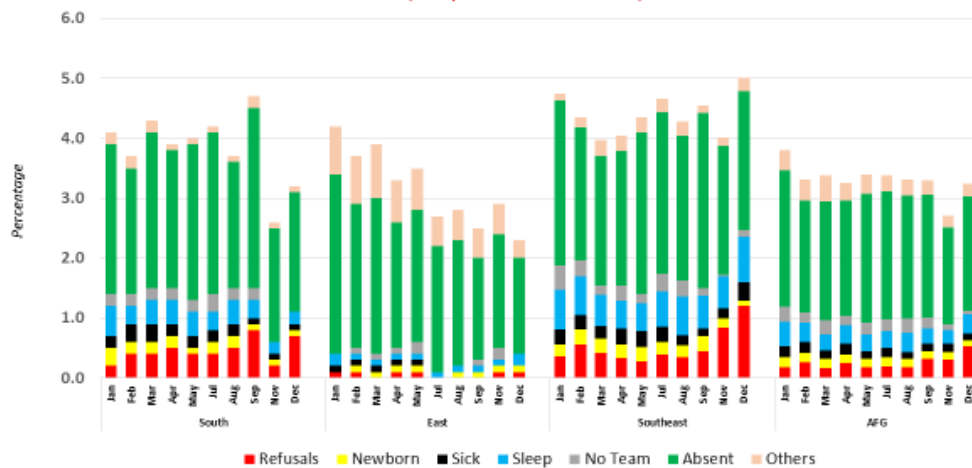
The refusal size as overall is not very high. Below figures shows the refusal figures for 2018:



4. Sub-optimal quality due to management issues in some key areas of none high risk which are fully accessible to the program, as well as those under control of AGE.

Improving program quality is one of the top priorities to eradicate polio which is prioritized and will be followed in the NEAP 2019. Program quality as a cross cutting factor contributes to the around 5% missed children in accessible areas as well contribute to address the challenges of HRMP and Refusal. Absent and refusal being two primary reasons for that, along with the children missed as newborn, sick or sleeping.

Missed children by reasons, Jan to Dec-2018 (only accessible areas)



Scope of Dec SNID was smaller than other SNIDs

Source: PCA data

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Reports shows some problems in staff selection, training, supervision, capacity building, on time payment, monitoring, poor accountability, cumbersome data collection tools, limited data use, gaps in follow up actions in between SIAs, failed LQAS lots with lack of investigation, poor implementation of revisit strategy, appropriate micro plans implementation, poor quality of markers and lack of female vaccinators and social mobilizers. In most of AGE areas, national monitors are not allowed to monitor the campaigns. Remote monitoring data use is sub optimal and there is lack of third party monitoring. PCA data validation initiative by east region in 2018 showed considerable discrepancies between validation data and PCA reports, however, improvements have been noticed during the course. Reports also say that there is interference in selection of staff from many sources. Selection committees either are not sufficiently empowered, or influenced or lack commitment to follow the guidelines.

The assessment of trainings in Aug 2018 showed that 22% of training session in east region lacked training tools. In addition, in all regions many teams did not have updated map and itinerary ranging from 23% in Nengahar to 9% in Kandahar.

5. **Low EPI coverage** in high-risk polio areas.

Strengthening routine immunization is a pillar of the polio eradication strategy. High routine immunization coverage establishes a strong base for population immunity to prevent polio. The RI coverage remains way low in polio high risk provinces. According to the latest survey (AHS, 2018), the lowest Penta 3 coverage are documented from few polio high risk provinces for instance Helmand (17.4%) Kandahar (29.5%) Uruzgan (3.1%) and Zabul (2%).

According to NGO contracts, they are supposed to cover the entire population of the province but since first of all the Health Facility locations are pre-determined and male distributed and secondly in the selection process of NGOs a system to verify responsiveness of financial proposals to the ground realities is missing. This results into existence of white areas and lack of financial resources to the NGO to cover the entire province. In addition, the system to follow up implementation of contractual obligations requires strengthening within the health system.

To cover the white areas for instance only in Kandahar, 42 mobile teams are funded by different sources which are supposed to deliver package of services including vaccination. These Mobile teams are either contracted with Provincial Health offices which is not in line with their mandate or to 6 more multiple agencies. This approach affects efficiency, accountability and coordination. Reports shows that the teams are not properly functional or in some cases with very low outputs. Similarly, thousands of CHWs are reported to be in the field but yet proper confirmation systems are not in place. On the other hand, increasing demand for RI requires further investment. The MoU signed between EOC and NGOs contains a full section on the PEI support to EPI. Yet, it needs to be fully realized.

4. Development and operationalization of NEAP 2019

For 2019, in the view of prevalent epidemiology and need to address the remaining challenges, the National Emergency Action Plan was developed through a bottom-up approach. Regional EOCs conducted workshops involving provincial teams to identify key challenges, interventions implemented in 2018, to inform and finalize the NEAP 2019 with view to addressing all remaining challenges.

Following these workshops, a national level workshop was conducted with regions to discuss and compile the interventions proposed by regions. A compiled document, developed as outcome of the workshop, was shared with regions for feedback. In addition, the NEAP incorporating feedback from regions and partners was presented to the TAG during its meeting in January 2019 where additional recommendations were made. The NEAP was discussed in Polio Policy Dialogue meeting, shared with NGOs of High-risk provinces as well as widely shared with partners. Comments were incorporated from all sources within NEAP 2019.

For effective operational of NEAP 2019, the program will take the below actions:

Review and strengthen governance and management

EOCs are playing a crucial role in providing oversight, coordination and management of the polio eradication effort. To strengthen EOCs, a workshop was conducted by CDC with all members of national and regional EOCs and require a follow up to provide ability to better demonstrate. A subgroup has been formed at the National EOC to revise the current organogram and working modality to ensure that the EOC structures are fit for the purpose. Currently three EOCs established at zonal level namely eastern, southern, south-east and west. They are coordinated and managed by national EOC. Since some high risk provinces such as Helmand is far way of regional EOCs as well as the northern

provinces remained disconnected with national EOC. The first policy dialogue meeting in 2019, has recommended establishing one EOC in northern to ensure maximum coordination, support and oversight.

Implementation plan

An implementation plan will be developed for the interventions of the NEAP, along with clearly outlined roles and responsibilities (Annexure I).

Costing

Costing of all interventions of the NEAP will be done and a budget prepared, which will be shared with GPEI global partners.

Accountability framework

The National EOC will develop an accountability framework encompassing all levels of the program to monitor implementation of the NEAP (Annexure II).

Coordination bodies

- Polio executive committee:
 - Chaired by H.E. the Minister of Health, H.E. Presidential focal point and participated by National focal point for Polio, country representative of WHO & UNICEF, and program executives
 - Meets monthly to review the progress and challenges in polio eradication and provide feedback to H.E. The President
- Polio partners dialogue:
 - Meeting of polio executive committee with donor partners
 - Meets quarterly to update and garner support of local donor partners
- Meeting of Council of Ministers on Polio:
 - Chaired by H.E. the Chief Executive
 - Meet biannually to ensure coordination with other line ministries
- National steering committee:
 - Chaired by H.E. the President
 - Meets biannually to review the progress and garner support from all parts of the Government including line ministries and Governor

5. Goal

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

6. Objectives

The NEAP 2019 has the following objectives:

1. To stop ongoing transmission in the Southern and Eastern regions
2. To achieve and maintain high population immunity in the rest of VHRDs and HRDs, ensuring no secondary cases following possible importation
3. To gain and maintain access through flexible approaches
4. To rapidly and effectively respond to any importation of WPV1 and/or emergence of any VDPV (and in particular VDPV type 2) into polio free areas of Afghanistan
5. To achieve and maintain high population immunity among HRMPs
6. To enhance program quality with main focus on high risk provinces/districts to reduce missed children to less than 5%
7. To improve vaccine acceptance contributing to a reduction in refusals
8. To maintain high levels of surveillance quality across the country with surveillance quality indicators meeting the global standards in all provinces

7. Residual risks

Even with full implementation of all interventions outlined in this NEAP, there remain factors beyond the control of the program which could derail progress. These include:

- Impact on the program due to any deterioration in access.
- Impact related to the fact that Afghanistan and Pakistan are one epidemiological block; both countries need to finish the job together.

8. Strategies/strategic interventions

Below are key strategies for 2019 to ensure progress towards a polio-free Afghanistan.

8.1 Conduct 3 NIDs and 6 SNIDs in 2019 along with IPV campaigns in polio high-risk areas. Using mOPV1 for at least 2 SIAs in high-risk areas.

8.2 Continued focus on identified high risk provinces and districts

8.3 Improving program quality in accessible areas with main focus on high risk provinces/districts

8.4 Maximizing reach in inaccessible areas

8.5 Intensify communication strategies to increase vaccine acceptance

8.6 Identification, mapping and coverage **of High Risk Mobile Populations with focus on the Eastern and Southeastern regions**

8.7 Maintain **sensitive surveillance** system

8.8 Improve inter-sectoral collaboration with main focus on high-risk provinces

8.9 Strengthen EPI and convergent services in polio high risk areas, particularly in the Southern region, with focus on Kandahar

Overarching focus

Southern region

For next 6 months, the country will focus on stopping transmission in **Kandahar province** (and city) which is the engine of transmission in the southern corridor.

- Intensify presence of most effective international and national staff (with capacity to work in the field)
- **Address quality gaps in all accessible** areas
 - Analyze reasons for missed children (due to absent, refusals and newborns) to identify geographical pockets and take corrective action.
 - Prepare cluster profiles including all elements of the program, remaining missed children, SIA, surveillance, communication efforts and EPI to reduce missed children
- **Ensuring maximum reach in inaccessible** area
 - Along with implementing and strengthening alternate strategies (i.e. site to site, PTT and IPV+OPV) for inaccessible areas, the efforts to gain access will be intensified including raising this at highest levels
 - Conduct SIADs (3 passages) of H2H/S2S campaigns in areas where allowed

Eastern region

While recognizing that the transmission in the Eastern region is shared with Pakistan, the program will:

- In coordination with Pakistan, review implementation of HRMP strategies by end Q1 to ensure that all HRMPs (including long distance travelers, returnee and IDPs) have been identified and reached
- A face-to-face meeting of northern corridor field level staff will be conducted to review and update the Northern corridor action plan
- Alternate strategies in chronically-inaccessible areas will be fully implemented and tracked
- Continue to focus on reducing missed children in accessible areas

Southeastern region

The program will rapidly and systematically address the issues of refusals in Paktika, gaps in campaign quality, strengthen identification and coverage among nomads in Ghazni and maximize efforts to reach children in inaccessible areas.

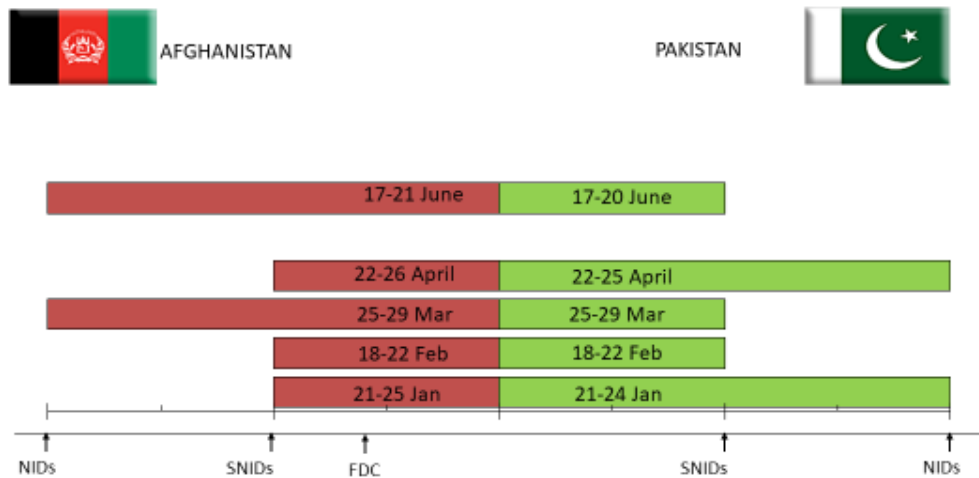
Rest of Afghanistan

While focusing efforts in South and East region, program will maintain high population immunity by improving

8.1 Conduct supplementary immunization activities

The program will conduct 3 NIDs and 6 SNIDs in 2019. Of these, 2 NIDs and 3 SNIDs will be conducted during the low transmission season whereas, 1 NID and 3 SNIDs will be implemented during high transmission season (Annexure IV). All SIAs in 2019 will be synchronized with Pakistan.

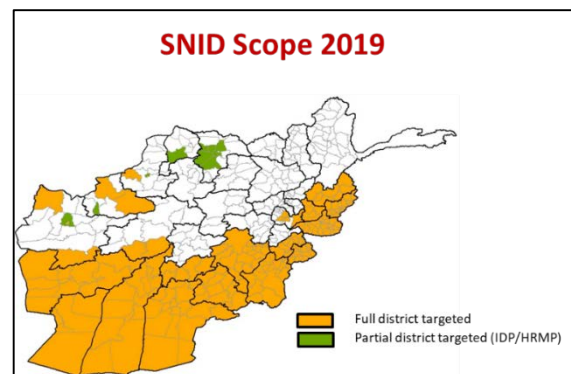
SIA schedule AFG & PAK, Jan to June 2019



The program is expanding the scope of SNIDs to include all of Nuristan province, and major clusters of HRMPs identified outside endemic areas.

IPV will be used in high-risk districts identified in Kandahar, Helmand, Uruzgan, Nangarhar, Kunar and Paktika.

Learning from the experience in Peshawar, Pakistan, the Afghanistan program will explore the feasibility of expanding the age of vaccination target group to under 10 years in selected areas of Nangarhar.



8.2 Focus on high-risk provinces and districts

The program will retain existing risk categorization of districts (as per the NEAP 2018), while further making adjustments reflecting evolving risks. For NEAP 2019, 15 FD, 34 VHRD and 37 HRD have been identified (Annexure III). Program will continue to focus on these districts with flexibility to include additional districts, if new and significant risk factors emerge.

Changes in risk categorization of districts				
Region	Province	District	2018	2019
Central	Ghor	Lal Wa Sarjangal	HRD	No HR
Central	Kapisa	Mahmud-e- Raqi	HRD	No HR
Central	Parwan	Charikar	HRD	No HR
East	Kunar	Ghaziabad	HRD	VHRD
North	Faryab	Ghormach	HRD	No HR
East	Kunar	Chawkay	No HR	HRD
East	Nangarhar	Kama	No HR	HRD
East	Nangarhar	Pachieragam	No HR	HRD
East	Nuristan	Poruns	No HR	HRD
North	Faryab	Almar	HRD	No HR
North	Faryab	Qaysar	VHRD	No HR
Northeast	Baghlan	Baghlan-e-Jadid	HRD	No HR
Northeast	Baghlan	Khost Wa Fereng	HRD	No HR
Northeast	Kunduz	Emamsaheb	HRD	No HR
Northeast	Kunduz	Aliabad	HRD	No HR
Northeast	Kunduz	Dasht-e-Archi	VHRD	No HR
Central	Kapisa	Nejrab	HRD	No HR
Northeast	Kunduz	Kunduz	HRD	No HR
Northeast	Kunduz	Chardarah	HRD	No HR
South	Zabul	Shinkay	HRD	No HR
West	Badghis	Muqur	HRD	No HR

Also, for intensified focus, Kandahar, Helmand, Nangarhar, Kunar, Paktika and Farah have been identified as high-risk provinces. These provinces account for 84% of all polio cases since 2010, with Kandahar accounting for 35% of all cases since then.

8.3 Improving program quality in accessible areas

The program will target to reduce and sustain the proportion of missed children to less than 5% at district and cluster level in high/risk areas. For LQAS, the aim will be to have lots passing at 90%, all visualization of LQAS data will be changed to reflect this.

Children missed due to any reasons are important. Absent and refusals form two of the largest group of missed children. Particular attention will be paid to newborn and infants during house visits so that they are not missed. This will be emphasized in training and monitoring, and supported with tailored communications.

The ICN is a valuable resource for polio eradication. In ICN areas, efforts will continue to strengthen the performance through enhanced monitoring and capacity development. Continued emphasis will be placed on overall efforts to reduce missed children and will be measured based on robust analysis of all reasons for missed children, including (but not limited to) refusals. The ICN will track both chronic absentee children and chronic refusals.

The program believes that in areas fully under Government control, there should not be any gaps in operations and will take urgent measures to address these. Various interventions planned for improving the quality of vaccination campaigns, increasing vaccine acceptance and reducing missed children in accessible areas are given below.

These interventions will also be applied to any newly accessible area to ensure high quality campaigns.

8.3.1 Data analysis and use

The program will analyze SIA coverage and monitoring data by access categories with the aim to minimize missed children in accessible areas. Capacity of regional and provincial teams will be strengthened to analyze and use SIA and surveillance data for intervention.

In some areas, data collection must be strengthened. To streamline this, the program will review all data streams being collected and will take steps to put in place corrective measures as necessary. Also, before introducing any new data streams or format/changing existing ones, regional and provincial teams will be consulted on feasibility, usefulness and additional workload associated with it.

Sanctity of data is important for being able to take informed and correct action. To address this, all data will flow through regional EOCs and strong action will be taken against any falsified data identified.

Disaggregated analysis of data at cluster level for important high-risk districts will be done to identify the focus-areas with issues and evaluate the trend, reasons, and impact of interventions.

The program will develop a profile of clusters with high proportion of missed children to identify the core issues and address them.

Process indicators such as team composition, team performance and supervision indicators will be analyzed, tracked and used for improvements. Also, the monitoring and coverage data of revisits will be analyzed in a disaggregated manner to identify and address gaps.

8.3.2 Frontline workers

The FLW efforts will focus on reducing missed children, particularly in VHRDs. The program will take below interventions for FLW selection:

- Formation, composition and functioning of FLW selection committee will be directly monitored by NEOCs.
- Selection committees will make transparent and active efforts to engage more females as FLWs including vaccinator, supervisor, ICN and ICM. Percentage of females as FLWs, particularly in urban areas, will be tracked over the round to monitor the progress.
- The program will review and strengthen system of accountability of FLWs and will track the implementation including removals based on objective documented criteria.

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

- Timely payments of FLWs will be ensured, i.e. before next campaign in SNID areas and within 1 month in non-SNID areas. This will be tracked from the national level
- DDM expansion will be ensured for transparency with flexibility in DDM/cash payment through financial committees wherever there are challenges in DDM implementation
- Rates of payment to FLWs will be reviewed in mid-2019 in view of inflation
- To address issues related to security of FLWs, support of security department will be garnered, including identification of security focal persons for every province. This will be coordinated by OPFPPE
- Support from security authorities will be garnered for PTT vaccination. They will help in vaccinating children on the move, including by vaccinating target age group children travelling in vehicles. PTTs will be provided with appropriate shelters furnished with important messages.

8.3.3 Training

In order to strengthen capacity building of selected frontline workers, the program will take the below actions to increase effectiveness of trainings:

- Review of training modality (venue, duration, incentive, methodology) to harmonize between operations and communications wherever feasible
- Review and strengthening of training monitoring process and analysis of training monitoring data after every campaign for corrective action
- The training of staff in 5 high-risk provinces to be 100% monitored by independent training monitors. Provincial and regional team members to facilitate training in these provinces at VHRD and HRD levels
- Revision of training committee TOR for 5 HR provinces and ensuring fully functioning provincial training committees

8.3.4 Microplanning

In 2018, program has successfully completed micro plan validation exercises in 290 out of 399.

- In 2019, program will complete microplanning exercise in the remaining districts as feasible.
- Microplanning validation exercise will be repeated during second half of 2019.

8.3.5 Focus on newborns and infants

Program will pay special attention to newborns and infants during vaccination campaigns including during revisit and catch up phase through:

- Emphasis on importance of vaccinating newborns and infants during training and monitoring
- Identification of households with newborns/infants by ICN in pre-campaign phase and support to vaccination teams during the campaigns
- Tailored communications for vaccinating infants
- Replacing male vaccinators and social moralizers with females at the most possible extent
- EPI support to PEI by ensuring and tracking newborn through the health system and in particular in the areas ban for H2H
- Raising awareness among women and community at large on the importance of newborn vaccination through communication network and priority health education within health facilities
- Close work with health system and providers for identification and follow up of pregnant women at the community level, coordinating and strengthening the activities of front line health workers,
- Improving accessibility of health service and vaccines through harmonizing existing and polio plus activities
- Identification of white and underserved areas (villages level) and coordinating them for inclusion within the outreach schedules with or without additional resources.

8.3.6 Revisit

Currently, the program is missing more than 4% children, including in high-risk areas. Most of the missed children are missed either due to absence or refusals. To cover these two categories, in particular children absent during the first visit, the program will take the below interventions to strengthen revisits.

- NEOCs will review the planning day and if needed, give flexibility of using 4th day as revisit day. This decision will be taken on a case-by-case as per the local context in provinces
- Timing of the daily revisit can be flexible and based on the local context. Where there are high number of refusals due to non-availability of decision makers at home, the program may consider special evening teams or evening revisits. Also, the ICN will visit those houses in the evening to meet and convince decision makers
- Strengthening supervision for same-day revisits and 5th-day revisits
- ICM checklist will be revised to strengthen specific component for daily revisits

- In ICN areas, support of ICN for revisits will be tracked and strengthened. All stakeholders will be actively supporting and monitoring the catch up activities.

Overall missed children (including absent children) tracking and vaccination will continue during catch up activities. Where necessary and feasible, catch up days will be extended.

8.3.7 Addressing vaccine acceptance issues

Although the overall proportion of refusals is very low in Afghanistan, it is noted that in certain clusters, the proportion of refusals as reason for missed children is high. The program has planned the below interventions as part of the NEAP 2019 for areas with high proportion of refusals, such as Kandahar and Paktika:

- Operations and communications will be fully integrated at strategic planning levels but more importantly at frontline levels (ICN and vaccinator teams), ensuring that any unvaccinated child found during house visits is immediately vaccinated not to present a missed opportunity for vaccination
- For refusals, mapping of geographical clustering and subsequent analysis of reason for clustering will guide prioritization and resolution strategies
- Refusal oversight committee at National, regional and provincial levels will be formed to track, guide and monitor implementation and effectiveness of strategies
- Integrated refusal resolution approach will be developed at provincial level by provincial oversight committees
- The program will review and revise list of influencers/ refusal resolution committees and enhance their IPC skills
- In non-government controlled areas, the program will explore ways to record the number of refusals to understand the extent and prioritize efforts
- Efforts of resolving refusals in between campaigns will be intensified and documented
- In order to minimize knocks-on-doors as well as reduce chances of false finger marking, the program will strengthen the triage system to take off pressure from FLWs (vaccinators and ICN). ICN-SM will not be held responsible for resolution of chronic refusals, rather they will be responsible for identifying and reporting them
- To strengthen the triage system, the program will conduct analyses on the proportion of refusals resolved by different levels to assess the effectiveness and optimize this approach

These interventions will be supplemented by enhanced engagement of stakeholders through interventions as outlines below:

- Quarterly basis advocacy meetings, IPC trainings, regular involvement of Wakil Guzars, elders, line departments, ministry of Haj and Awkaf, education, information & culture, women affairs, RRD, citizen charter and health staff
- Cluster level social mobilization and advocacy meetings of Mullahs, teachers and elders
- Engagement of CBHC, madaras and Juma Masjid Imams
- Engagement of influential doctors/health workers, traditional healers (Tabeeb) and polio survivors including conducting workshops in Eastern and Southern regions
- Training of Mullahs in selected districts
- Provincial and regional level Ulema conference involving the key elders and influentials from high-risk districts

8.3.8 Monitoring

Monitoring informs the program on quality of campaigns and guides the interventions for reducing missed children. The below interventions will be taken to strengthen monitoring:

- Monitoring of monitors, both PCM and LQAS, will be continued and outcomes will be tracked from national level
- LQAS cut off will be changed to 90% and all failed lots will be investigated and corrective actions by regional teams undertaken as necessary
- ICM will be strengthened by improving quality of ICM selection, training and supervision by REOCs
- Remote monitoring will be expanded to all high-risk areas and possible blind spots. Data from remote monitoring will be analyzed over the rounds to see the trends
- Free short code for incoming calls will be established for collecting FLWs and community complains, guidance
- The program will explore engaging third parties for campaign monitoring
- A pool of national/regional monitors with capability to move in AGE-controlled areas will be developed and increased to have at least 10 staff at national/ regional level. Their capacity will be built at national level, following which they will be assigned to the field in consultation with regional teams to high-risk areas on a campaign basis.

8.3.9 Capacity building of PEMTs

PEMTs are the leaders of polio eradication activities at provincial levels. All PEMTs need to be fully engaged and take leadership in implementation of SIAs as well as fostering a positive environment for collaboration and coordination with local partners. Towards this:

- The National EOC will institute a mechanism to track the engagement of PEMTs
- Workload and capacity of PEMTs will be reviewed and the possibility of placing additional human resource in SNID provinces will be explored
- SIA coordinators will be recruited in five high risk provinces (task shifting or sharing with the current PEMT Managers)
- For high-risk districts of Kandahar, a District level officer (DEMT) will be deployed for managing activities at district level

8.4 Maximizing reach in inaccessible areas

Accessibility for vaccination in Afghanistan is very dynamic and the program has seen an increase in inaccessibility since May 2018, particularly in the Southern and Southeastern regions resulting from a ban on house-to-house campaigns. Apart from these off-on bans, the program also faces chronic inaccessibility in some parts of the Eastern and Southeastern regions accounting for around 30,000 children missing vaccination opportunities.

For maximizing reach to children in inaccessible areas:

- The program will maintain neutrality for polio and will keep all level of AGEs informed about PEI activities for confidence building. In case of objection by AGE on some component of the program, REOC/regional teams to take decision in consultation with NEOC
- In case of ban/inaccessibility, dialogue at village, district and provincial level through local staff will be continued and if not resolved, national level will take it up to appropriate level for interventions
- For ban on house-to house-activity, e.g. in the Southern and Southeastern regions, the program will:
 - Develop a matrix to guide decision making for using site-to-site (S2S) approach
 - Negotiate S2S vaccination and implement in place of house-to-house vaccination

- Develop enhanced key messages and materials to explain why H2H is the only viable eradication strategy and to ensure that maximum number of target children including less than 1-year olds are vaccinated at their respective site
- Wherever S2S will conducted, there will be enhanced planning, mobilization and monitoring to achieve the maximum quality. SOPs for S2S will be further strengthened using the lessons learnt from previous implementations. Data from these campaigns will be analyzed in a disaggregated way for vaccination of infants
- As S2S vaccination is primarily a contingency plan and has shown to not reach coverage required for eradication, the program will continue to negotiate for house-to-house campaigns while conducting S2S campaigns. Preparedness will be maintained to start SIAs within 10 days of gaining access (push-button mechanism)
- For bans exceeding 3 months, additional vaccination opportunities will be used, e.g. IPV-OPV campaigns, addition of OPV to other vaccinations activities, intensifying EPI and mobile health teams. Also, Permanent Transit Team strategy will be reassessed in areas and strengthened as per access situation
- For chronic inaccessibility, e.g. the Eastern and Southeastern regions, the program will conduct:
 - Regular rationalization and redistribution of PTTs as per inaccessibility at entry/ exit and health facilities
 - Preparedness to conduct 3 passages of catch up SIADs within 10 days of opening up. IPV will be used in at least one of the rounds (push button mechanism) and two of the campaigns will target expanded age group depending on duration of inaccessibility
 - Polio Plus activities/ mobile health teams and IPV/OPV from health facilitates near chronically-inaccessible areas through BPHS NGOs as well as other actors having capacity to deliver
 - Additional vaccination opportunities, e.g. addition of OPV to other vaccinations activities and intensifying EPI

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

8.5 Communication

Based on the recommendations of the external communications review, the TAG, and taking into consideration the existing social data that exists across the program, the polio communications strategy has been updated as a separate and complementary document to accompany the NEAP (Annexure V). Priorities have been identified across the entire spectrum of communications, including advocacy, media and crisis communication, household and community engagement, and social mobilization. Key goals of the strategy include: increasing knowledge to support positive vaccination decisions; improving polio communication coordination to increase efficiency and effectiveness of efforts at all levels; increasing community trust in the polio vaccination program; and focusing on reducing missed children including refusals.

Activities include:

- Evidence-based messaging guide to ensure all components of the program are effectively communicating
- Development and training on crisis communication plan to quickly and effectively address emerging issues
- Improved coordination between NEOC and REOC through monthly conference calls, regular field visits, and other activities. Targeted workplan to enable evaluation and modification as appropriate
- Address the emerging and critical communications needs such as site-to-site vaccination and develop supportive communication tools and strategies
- Availability of tested and tailored materials to address targeted issues and priority audiences

- Strategic engagement of media for SIA-specific and ongoing support
- Revision of IEC materials (including billboards) to address fatigue
- Integrated engagement strategy to convert anti-vaccine influencers (religious and medical doctors)
- Convergence activities to be embedded in all communication plans, including routine immunization as appropriate.
- Community mobilization/sensitization will not only be campaign-based, but will continue on a regular basis through IEC and print and electronic media talks and conferences
- Increase use of social media/radios for targeting chronic refusals and anti-polio propaganda
- Gradual merging of RI and PEI as unified communication strategy

Improving the operations of the ICN:

- Social mobilization & community engagement activities
 - Continue deployment based on SOPs: focus on risk categorization (VHRDs)
 - Technical shifts to overall missed children; including absent children tracking with follow up vaccination during the catch up week
 - Intensified cluster-level profiling and planning, with focus on Kandahar
 - Move two-member team districts to regular ICN with female recruitment (where possible)
 - Strengthening of the application of management tools for selection, accountability in the field
 - Continue efforts to fully integrate ICN with vaccination teams

Tailored Social Mobilization and Community Engagement Activities

- Southern region
 - Expand coverage to all clusters with >1% refusals after a campaign
 - Improve integration/triage system to identify relevant influencers while reducing number of knocks on the door
 - Mobile religious teams: expand numbers in districts and improve capacity through dedicated training
- Southeastern region
 - Increase coverage of influencers in non-ICN districts which have increasing numbers of refusals
 - Strengthen coordination mechanisms to ensure proper selection, and adherence to accountability frameworks
 - Conduct local mobilization (local ulama workshops) to enlist local religious influencers' support
- Eastern region
 - Expand Refusal Response Team (if necessary): include a respected doctor, community influencer + ICN member to conduct house-to-house refusal negotiation
 - Conduct qualitative research on perception of expanded age vaccination in possible targeted districts focusing on Eastern region, when needed

Communication Review and Way Forward

Communication review recommendations	Ongoing communication activities	Way forward: Activity Highlights
Improved coordination and planning (NEOC partners and regional levels)	<ul style="list-style-type: none"> • Focused on developing more participatory and strategy CWG • Implemented monthly/quarterly regional SM and refusal planning 	<ul style="list-style-type: none"> • Improve regional coordination through monthly video call • Improve partner coordination through jointly developed action plan • Increased field communication fields from NEOC partners
Improve strategic communication (coordinated key messages and suite of materials)	<ul style="list-style-type: none"> • Evidence based rebranding effort • Identifying regional materials gaps • Creating core messages 	<ul style="list-style-type: none"> • Development of field tested key message/FAQ guide and training on usage at national and regional levels • Identifying priority audiences and issues for materials development • Jointly developed CWG priority materials grid and schedule
Develop and employ crisis communication strategy	<ul style="list-style-type: none"> • Ad Hoc responses coordinated between national and regional 	<ul style="list-style-type: none"> • Development of strategic crisis communication plan and tools/templates for consistent, effective and rapid implementation • Capacity development on use of tools/templates and effective crisis communication techniques at national and regional levels
Continue focus on management, training, coordination of ICN program	<ul style="list-style-type: none"> • Deployment of ICN and influencers to address missed children • Capacity development of ICN 	<ul style="list-style-type: none"> • Continue systematic application of tools in ICN selection, deployment, supervision and accountability • Develop tailored frontline-worker training modules for new SIA approaches and vaccination initiatives (e.g. site to site, all age vaccination, etc)
Improve Cross-Border Coordination	<ul style="list-style-type: none"> • Restructured Cross Border meeting to be more strategic and action oriented 	<ul style="list-style-type: none"> • Continue with action focused meeting and sharing of data.
Improved use of communication data and quality	<ul style="list-style-type: none"> • Data collection focusing on identifying missed children with reasons at the cluster level particularly in ICN areas. 	<ul style="list-style-type: none"> • Conduct a systematic assessment and regional assessment on social data use at cluster level • Review current data being collected and focus on generation and use of quality data

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

Noting the continued importance of HRMP overall, particularly in the Northern corridor and evidence of suboptimal reach to nomads, the program will take following measures in 2019:

A focal point for HRMP and cross-border activities will be identified at REOCs for coordinating this stream of work. The identified focal point will be part of the HRMP task team and coordinate with other line departments, relevant UN agencies and field teams including DPO/DCO/CHW/ICN for getting information on HRMPs. In addition:

- The program will focus on new IDPs, particularly those coming from and/or residing in endemic zones
- HRMP surveys will be conducted by the ICN in ICN districts of Eastern region and in Kandahar district on quarterly/biannual basis, where feasible.
- HRMP in non-endemic zones with linkage to endemic zones will be included in SNIDs.
- Nomads:
 - Nomadic plans for Southern and Southeastern regions will be reviewed to identify gaps in identification, microplanning and deployment of PTTs. Corrective actions will be taken on the basis of these findings. Nomad elders will be identified and engaged as focal point for SIAs, surveillance and RI.
- Cross border:
 - The program will continue vaccination at all cross-border points and international airports and explore new informal crossing points to deploy vaccination teams
 - Vaccination will be expanded to cover all age group at Torkham border and friend shape gate in Kandahar
 - Special SMs will be engaged at major cross-border vaccination points
 - Transit nodes will be reviewed and number of PTTs will be adjusted
- Returnees:
 - The program will continue to follow up on new returnees in coordination with OCHA/UNHCR/IOM and line departments and maintain a state of preparedness for major influx
- All major congregations will be identified and special vaccination opportunities will be provided

8.7 Maintaining sensitive surveillance

Afghanistan maintains a sensitive surveillance system through a network of reporting units and reporting volunteers. Surveillance indicators surpass the global indicators in all provinces of the country, irrespective of access status for SIAs.

In 2019, the program will undertake the following additional activities:

- Healthy Children Sampling in Inaccessible areas: Program recognizes that negative results may not mean anything epidemiologically however notes that quarterly sampling may uncover pockets of under immunized children. Healthy Children sampling will be conducted every quarter in the chronic inaccessible areas of South, Southeast and East.
- In line with Global Standards the program will ensure monthly sampling of environmental samples from the 20 identified areas in Afghanistan.
- Recognizing the need to ensure global confidence in the surveillance system in preparation for certification post viral transmission the program will conduct an External Surveillance Review in the second half of 2019.

8.8 Inter-sectoral approach in polio high-risk areas

In order to boost polio eradication efforts, the program will look at convergent interventions for addressing felt needs to increase vaccine acceptance and improving EPI coverage in polio high-risk communities.

To address other felt needs, the program will prioritize efforts in Kandahar and coordinate with other line ministries and UN agencies. Support from other line ministries will be garnered through the 'Polio high council' as well as the 'council of Ministers', chaired by H.E. Chief Executive. Interventions will focus on:

- Water supply and sanitation
- Community-based education
- Expansion of mobile health teams and sub-centers
- Expansion of nutrition services

To improve EPI coverage in polio high risk areas, the program will make three-pronged interventions. This includes enhancing PEI/EPI convergence by implementation of MOU between EPI, PEI and BPHS NGOs (Annexure VII), implementation of 'RI improvement framework' (Annexure VIII), and implementation of 'Enhancing EPI/PEI convergence in high risk districts' (Annexure IX).

PEI support to EPI will be strengthened by:

- Monitoring/ supportive supervision of EPI with focus on outreach and mobile sessions
- PEI field staff will support in improvement of EPI microplans
- Systematic engagement of ICN in demand creation
- Coordination between BPHS NGOs, polio eradication partners and PEMT/REMT will be enhanced using the floors of PCRs and REOC.
- PEI will share zero-dose AFP case data as well as monitoring feedback with EPI/NGO coordinator for intervention. BPHS NGOs will share information through REOC on actions taken for issues identified by polio partners.

8.9 Enhancing EPI/PEI convergence in high-risk districts

The geographic scope of this plan is in six provinces, namely Kandahar, Helmand, Nangarhar, Farah, Nuristan and Uruzgan. However, the main focus will be on Kandahar and Helmand provinces.

In total, 42 districts will be targeted: Kandahar (6), Helmand (13), Farah (4), Nangarhar (17), Uruzgan (1) and Nuristan (1).

Summary of interventions planned in 'Enhancing EPI/PEI convergence in high risk districts:

- Strengthening the provision of basic health services to the people of 42 high-risk districts with special focus to increase penta-3 coverage to >90% by the end of June 2021.
 - Establishment of sub-health centers: the facilities will be staffed with two-four vaccinators, one midwife and one nurse
 - Establishment of Mobile Health Teams
 - Training of new vaccinators for underserved and white areas
- Strengthen community-based polio immunization services through deploying permanent local teams (community contract)
 - This will be a two-member team and the first vaccinator will be female resident accompanied by her Mahram as the second vaccinator.
 - These teams will cover the entire village (depending on the size of village from 200-600 families, geographic distance maximum 1-2 km).
 - The vaccinators will deliver only OPV vaccines until their capacity is upgraded to eventually administer all vaccines.

9. Monitoring of NEAP implementation

Implementation of NEAP will be monitored on quarterly basis by 'Strategy working group' of National EOC by tracking the process against NEAP work-plan and progress on following key programmatic parameters against the objectives set in NEAP 2019

- Polio epidemiology: number and spread of poliovirus detected in human and environment
- Proportion of under immunized children among non-polio AFP cases
- Timeliness and effectiveness of response to any detected transmission of WPV or VDPV
- Proportion of missed children in SIAs
- Number of missed children due to inaccessibility
- Number of children missed due to refusals
- Key surveillance indicators
- Number of districts identified with high number of villages remained uncovered by RI outreach

Program will also conduct community based sero-prevalence survey in Kandahar and Jalalabad during first half of 2019.

The NEAP implementation status and effectiveness of strategies will be reviewed in July 2019 and changes will be brought in to address new challenges and enable mid-course corrections as necessary.

10. Annexures

- Annexure I: NEAP 2019 work-plan
- Annexure II: Accountability framework
- Annexure III: List of FDs, VHRDs and HRDs
- Annexure IV: SIA schedule of first half of 2019
- Annexure V: Communication action plan
- Annexure VI: Minimum standards of SIAs
- Annexure VII: MOU between EPI, PEI and BPHS NGOs
- Annexure VIII: RI improvement framework
- Annexure IX: Plan on Enhancing EPI/PEI convergence in high-risk districts