National Emergency
Operations Centre, Afghanistan

NATIONAL EMERGENCY ACTION PLAN 2023

Polio Eradication Initiative Afghanistan

Message from the HE Health Minister

Polio eradication continues to be the highest priority of the Ministry of Public Health. Despite some minor challenges the program faces, there has been tremendous progress in improving vaccination reach, campaign quality, and vaccine acceptability, which lead to a reduction in immunity gaps. Polio campaigns resumed right after the transition in November 2021, earlier inaccessible areas now being covered through house-to-house or site-to-site strategies, and around 3 million children were reached additionally, who remained inaccessible for almost 4 years. The Poliovirus surveillance system is maintained without any interruption "sensitivity indicators above globally recommended targets", Cross-border coordination was re-established and Emergency Operations Center for Polio Eradication is restructured for better performance.

Wild Poliovirus type-1 is now at its historical lowest, absence of any WPV1 cases since Aug 2022 in Afghanistan is revealed the hope to stop poliovirus transmission which will further lead us to polio eradication. these are indeed tremendous achievements for a country facing enormous and complex challenges.

I am pleased to share with you Afghanistan's polio program National Emergency Action Plan (NEAP) for 2023, providing a solid roadmap of what it will take to stop polio transmission in the country. Emergency Operations Centers continue to drive the implementation of the NEAP in a coordinated way. Through the efforts of the EOCs, we have seen unprecedented coordination and oversight of polio efforts and importantly, improved accountability.

In 2023, the EOCs will continue to lead and manage Afghanistan's effort to stop poliovirus transmission. Based on the lessons learnt over the past years, Government and partners have clearly articulated the strategies and priorities for 2023 which include: Stopping WPV-1 transmission in the East, Rapidly boosting population immunity in the South and South-east, Build capacity for timely and high-quality response to WPV-1 (and cVDPVs) outside the East, Achieve uniformly sensitive surveillance, including for high-risk geographies and populations, as well as interventions to improve campaign quality, addressing high-risk mobile populations, and improving vaccine acceptance to reduce refusals.

This document clearly articulates how we intend to build on recent successes, reverse setbacks, measure results, create an enabling environment, maintain neutrality, foster coordination and implement accountability.

There are a number of challenges that stand in the way of stopping polio in Afghanistan, most notably suboptimal campaign quality, stagnating number of refusals particularly in the South-east, high population mobility, persistent low routine immunization coverage in polio high-risk provinces and ongoing outbreak in the East and in South Khyber Pakhtunkhwa.

I continue to be encouraged by the drive and stamina the EOC teams have, in finding new solutions to address the challenges faced by the program. We are now starting to see results and these efforts must be further strengthened in 2023 to further close off any immunity gaps.

I continue to be inspired by the heroic efforts of the thousands of people who are at the frontline of Afghanistan's fight to stop polio despite the challenges they face during their efforts for polio eradication. We must pay special tribute to those that have lost their lives in the past years – they are the real heroes of the program and we will strive to ensure an end of polio in their honor.

The Islamic Emirate of Afghanistan is grateful for the continued support of the international community specially WHO, UNICEF, BMGF, Rotary International, CDC in this collective effort. The opportunity to stop polio transmission is the best it has ever been, due to massive gains in childhood immunity, stronger surveillance, and improved operations. Continued support through 2023 and beyond will be critical to protect past investments and gains made, and most importantly, ensure that children worldwide are protected from polio forever. The Ministry of Public Health appreciates the technical and financial support of all partners and donors. Working together with our partners, I am optimistic that Afghanistan will soon be polio-free.

Sincerely,

Dr. Qalandar Ebaad
The Minister of Public Health

Acronyms

AFP	Acute flaccid paralysis
AHS	Afghanistan Health Survey
APIMS	Afghanistan Polio Information Management System
ARCS	Afghan Red Crescent Society
BPHS	Basic package of health services
bOPV	bivalent oral polio vaccine
COVID-19	Coronavirus Disease 2019
CVDPV	Circulating vaccine Derived Poliovirus
EMRO	Eastern Mediterranean Regional Office
EOC	Emergency Operations Centre
EPHS	Expanded package of health services
EPI	Expanded Programme on Immunization
ERC	Expert Review Committee
FLW	Front-line worker
GPEI	Global Polio Eradication Initiative
HRMP	High Risk Mobile Populations
IAG	Islamic Advisory Group
ICM	Intra-campaign monitor/monitoring
IDPs	Internally Displaced Persons
IOM	International Organization for Migration
IPV	Inactivated polio vaccine
KAP	Knowledge Attitude Practices
LQAS	Lot Quality Assurance Sampling
NEOC	National Emergency Operations Centre
NIAG	National Islamic Advisory Group
NGO	Non-governmental organization
NEAP	National Emergency Action Plan
NID	National Immunization Days
nOPV2	Novel Oral Polio Vaccine
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OPV	Oral polio vaccine
PCM	Post-campaign monitoring
PEI	Polio Eradication Initiative
PEMT	Provincial EPI Management Team
POB	Polio Oversight Board
PRSEAH	Prevention and response to sexual exploitation, abuse and harassment
PTT	Permanent Transit Team
REOC	Regional Emergency Operations Centre
RI	routine immunization
REMT	Regional EPI Management team
RRL	Regional Reference Laboratory
SIA	Supplementary immunization activity
TAG	Technical Advisory Group

UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
tOPV	trivalent oral polio vaccine
WASH	Water Sanitation Hygiene
WHO	World Health Organization
WPV	Wild poliovirus

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1. Epidemiology and Situational Overview

Since 2020, Afghanistan has witnessed considerable improvement in the overall polio epidemiology, as indicated by significant reduction in the number of WPV-1 cases and positive environmental samples. The country reported two WPV-1 cases in 2022, one each from the East Region (Dara-e-Pech district of Kunar province) and South-east Region (Dila district of Paktika province). This compares to four WPV-1 cases in 2021: three from the North-east and one from the South-east regions. The WPV-1 case reported from Paktika province was genetically linked with a positive environmental sample across the border in Quetta and the case reported from Kunar province was genetically linked with the human cases of 2021 reported from Emamsaheb district of Kunduz province in the North-east. Of the eight genetic clusters in Afghanistan in 2020, only two (YB3A and YB3C) have been seen in 2022. Thus, aside limitations of geographic there is also reduction in the genetic diversity of the WPV-1 cases.

A total of 22 environmental samples tested positive for WPV-1 in 2022, all in the East region, compared to only one positive isolate in 2021. The genetic sequencing results of all these samples are internally linked with the earlier WPV-1 positive environmental sample and WPV-1 cases reported from Kunar and Kunduz provinces.

Afghanistan did not report any cVDPV2 cases in 2022, compared to 43 cVDPV2 cases from 28 districts in 2021. The last cVDPV2 case in Afghanistan was reported from Wardak province in the Central region with onset of paralysis on 9 July 2021.

The South region, a traditional polio reservoir and once the engine for WPV-1 transmission in Afghanistan (38 WPV-1 cases in 2020), has not reported any WPV-1 from any sources since 2021. The last WPV-1 detection in the South was from an environmental sample in Helmand province in February 2021. It is important to note that the South still has the largest pool of susceptible children in the country and a wide immunity gap. Both vaccination reach and quality are well below the standards required for eradication - there have been no house-to-house campaigns in Kandahar province since mid-2021 and in several districts of Zabul and Uruzgan provinces since May 2018. This represents significant risk for a potential explosive polio outbreak following any poliovirus importation into the region.

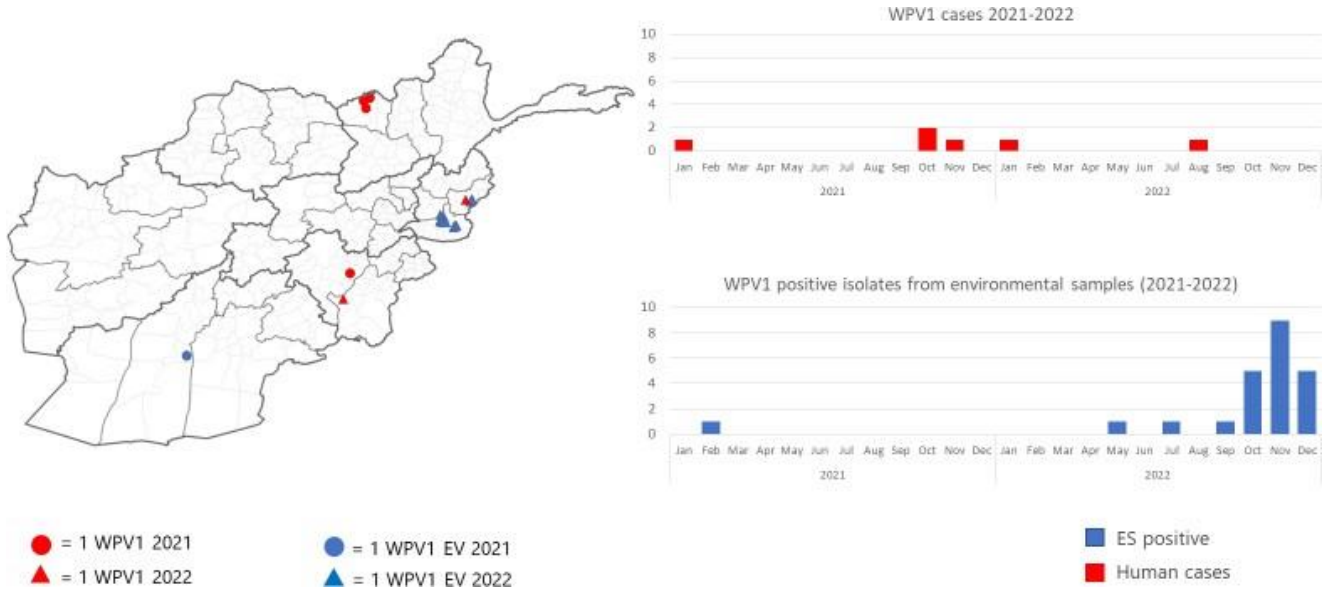
Continued WPV-1 transmission in the East, intensified during the second half of 2022 (and early 2023), is a major concern. In addition to a WPV-1 case in August 2022, all 22 WPV-1 positive environmental samples in the country during 2022 were reported from the East, from four districts of two provinces: Nangarhar and Kunar. As such, the East represents the only remaining focus of endemicity in Afghanistan. It is pertinent to note that polioviruses related to WPV-1 transmission in the East were detected in the North-east region in 2021, indicating a potential for expansion of transmission. Identifying and reaching pockets of missed children and optimizing surveillance are therefore critical to quickly interrupting ongoing transmission in Afghanistan. The programme's highest priority is to stop WPV-1 transmission in the East.

The South-east region, epidemiologically critical in Afghanistan's polio eradication context, reported a solitary WPV-1 case in January 2022, with no WPV-1 detection from any other source. Encouragingly, the programme made significant strides in 2022 in expanding house-to-house vaccination campaigns and their quality in the South-east. However, ongoing intense WPV-1 transmission in the adjoining South Khyber Pakhtunkhwa province of Pakistan represents a significant importation risk. The risk is high, given the pockets of missed children including refusals in the South-east, as indicated by the SIAs and surveillance data. Paktika province reported a WPV-1 case in January 2022 and recently an environmental surveillance site has been added.

WPV-1 transmission was confined to the high-risk regions (East and South-east) in 2022. The North-east region, which reported three WPV-1 cases in 2021, did not have any WPV-1 detection in 2022. Considering the isolation of long-chain WPV-1 in the North-east in 2021 and the ongoing intense outbreak in the East region, it is critical to maintain sensitive surveillance and high-quality polio vaccination across the country, particularly in the East, to mitigate the ongoing risks.

The WPV-1 transmission in Pakistan in 2022 was mostly isolated to South Khyber Pakhtunkhwa. Endemic WPV-1 transmission was not detected in the greater Peshawar block or the Quetta block in the northern and southern epidemiological corridors respectively. As mentioned earlier, continued WPV-1 transmission in South Khyber Pakhtunkhwa in the central epidemiological corridor is concerning and represents a significant risk of WPV-1 spread to South-east Afghanistan.

The genetic characterization of WPV-1 isolated in Afghanistan during 2022 is consistent with limited WPV-1 circulation at present. Except for two genetic clusters (YB3A and YB3C), all genetic clusters previously detected in Afghanistan since 2020 have not been seen in 2022. The last detection of genetic cluster YB3C was in January 2021, however, given the rather limited time since its last detection, it is difficult to confidently rule out its transmission. The genetic cluster YB3A continues to be detected only in the East, indicating its local transmission. There is still caution on its possible circulation outside the East due to relatively short timeframes since its detection elsewhere as well as some long chain/orphan isolates in this chain of transmission.



2. Progress on NEAP 2022

2022 was yet another challenging year for the polio eradication programme in Afghanistan. The house-to-house vaccination strategy, which has proven to be the best campaign modality to reach all children, could not be implemented across the country due to opposition from local leadership in many of the provinces. In the polio reservoir areas, particularly in the South region, the quality of campaigns was compromised due to the implementation of mosque-to-mosque and site-to-site modality mostly in Kandahar, Urozgan, and Zabul provinces, which resulted in more than 300,000 children remaining unreached during each campaign.

In general, six out of the eleven objectives set in NEAP 2022 were met and five were partially met.

NEAP 2022: Summary of progress by objective

	Goal/Objective in NEAP 2022	Status
Objective 1	Resume and maintain house-to-house vaccination campaigns across the country to build and sustain population immunity against wild polioviruses or circulating vaccine derived poliovirus	Partially achieved
Objective 2	Maintain preparedness for rapidly responding to any cVDPV2 detection as per the SOPs	Achieved
Objective 3	Complete the restructuring of the Emergency Operation Centre (EOC) and fully functionalize it by the end of Quarter 1 2022 towards addressing the remaining gaps in the programme implementation	Achieved
Objective 4	Engage community members and leaders to increase acceptance and demand for vaccination by addressing vaccine refusals through effective and locally appropriate communication-social mobilization strategies	Partially achieved (88% targeted caregivers stated their acceptance for the vaccine)
Objective 5	Ensure safety and protection of polio health workers at the forefront and communities through maintaining effective infection prevention and control for COVID-19 transmission during polio eradication activities	Achieved
Objective 6	Ensure safety and protection of polio health workers at the forefront from all forms of violence during polio eradication activities	Partially achieved
Objective 7	Promote gender equality at programme planning and implementation level, appropriate to Afghanistan context	Achieved
Objective 8	Achieve and maintain high population immunity among HRMPs	Achieved
Objective 9	Enhance programme quality with focus on high-risk provinces/districts to uniformly reduce missed children to less than 3% at the sub-provincial level, with special emphasis on effectively reaching the new-born and infants	Partially achieved
Objective 10	Maintain sensitive and high-quality surveillance for polioviruses across the country with consideration for possible expansion of environmental surveillance, as feasible	Achieved
Objective 11	Improve the availability of social data to track rumours and monitor community attitudes towards polio vaccine	Partially achieved

While the security situation generally improved following the political transition in August 2021, it has not fully stabilized across the country. Security incidents were reported throughout 2022 ranging from targeted attacks on minority communities and law enforcement agencies, to bomb blasts and IED attacks on vehicles. Polio campaigns suffered a major setback following the attack on polio vaccination workers during the February 2022 NIDs in Takhar and Kunduz provinces, which resulted in the loss of life of eight polio vaccination workers. These incidents seriously impeded the

programme's efforts to improve women's participation in subsequent campaigns with the percentage of women vaccinators reduced in Jalalabad from 72% in March 2021 to zero in June 2021, with a continued sense of insecurity.

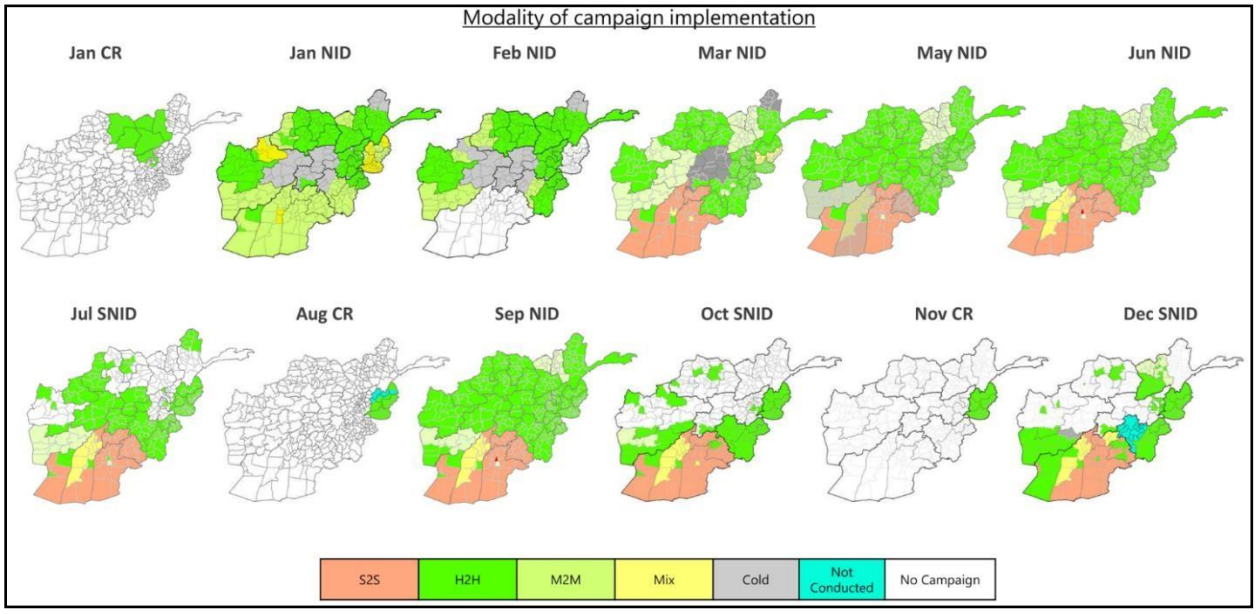
The SIAs access and quality related challenges from 2020 that continued in 2021 were gradually addressed following the political transition. Taking advantage of improved national geographical access, starting with the November 2021 NIDs, a regular and extensive campaign schedule followed in 2022. In total, six NIDs, three SNIDs and three case response campaigns were implemented during 2022, with five of the six NIDs taking place in the first half of the year. Despite overall improvement in access for polio vaccination campaigns after August 2021, a number of children remained unreached during the initial part of 2022 as the house-to-house vaccination strategy could not be uniformly implemented across the country. In fact, some areas that were implementing house-to-house vaccination campaigns prior to the political transition were not able to implement the same during 2022. This led to a significant increase in the number of unreached children in those areas. While in the January 2022 NIDs, 52% percent of the targeted children were reached through the best modality, this proportion gradually improved to about 80% percent in the September NIDs. The South-east region resumed house-to-house vaccination in March and the East region in May. However, due to the inability to implement house-to-house campaigns in several provinces, including the critical South region, 188,447 targeted children remained unreached until the end of 2022.

Inconsistent vaccination coverage, especially in the South, poses a significant threat to the current state of epidemiology. In order to build on the progress made in 2022 towards stopping WPV-1 transmission, it will be important to implement high quality house-to-house campaigns across the country in 2023.

Total Target Population and percentage reached through H2H modality, Campaigns in 2022

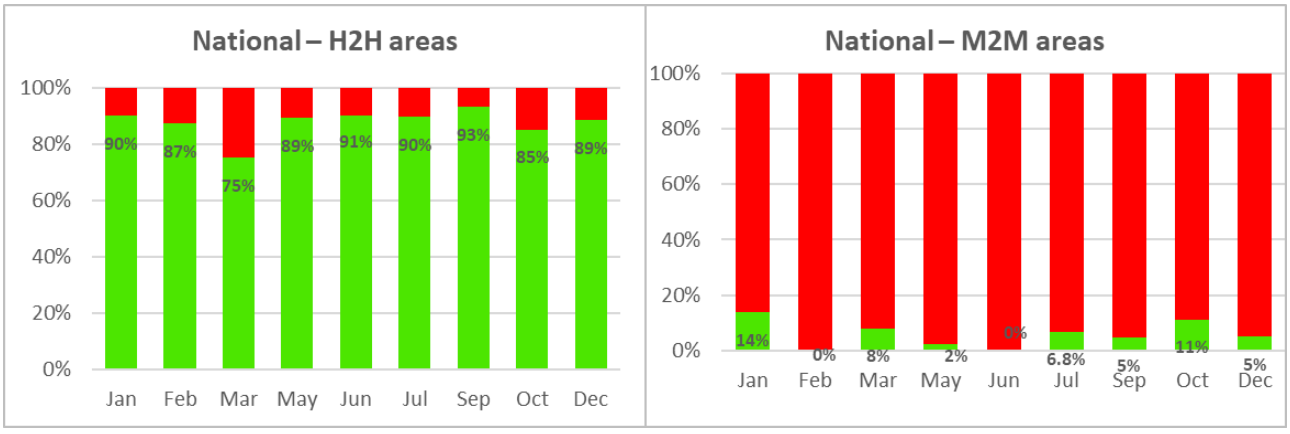
Campaign	Total target	Percentage of target covered through H2H
January NIDs	9,999,227	52
January Case Response	3,578,511	100
February NIDs	9,999,227	53
March NIDs	9,999,227	62
May NIDs	9,999,227	76
June NIDs	9,999,227	76
July SNIDs	6,735,192	77
August Case Response	1,144,312	100
September NIDs	9,999,227	80
October SNIDs	5,806,653	75
November Case Response	1,144,312	100
December SNIDs	6,989,497	68

Campaign implementation modality by district: January - December 2022



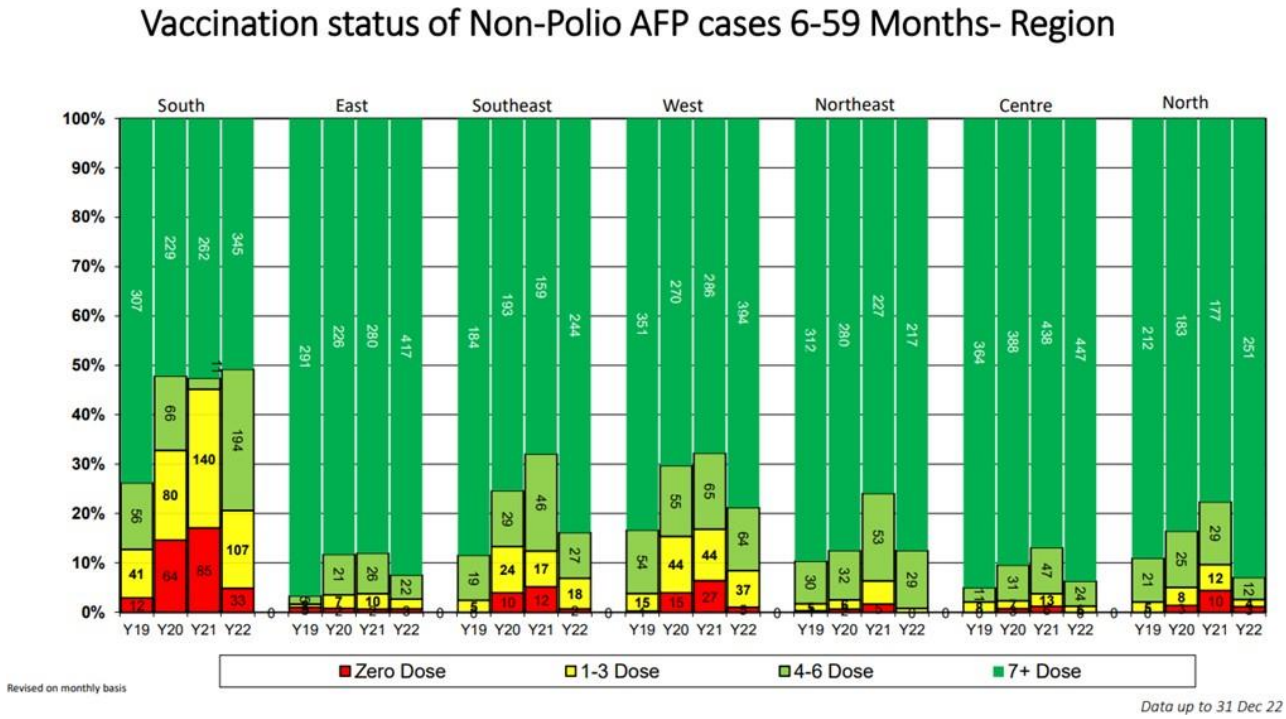
As per the reported administrative coverage data, site-to-site and mosque-to-mosque campaigns could reach a maximum of 50% of targeted children. This low coverage is mainly due to inability of women to take children to the mosques, absence of other adults in the house to take the children to the vaccination site during the campaign, low number of mosques and vaccination sites in some districts, and inadequate motivation amongst community members to walk to vaccination sites from their homes. LQAS results showed only 6% passed in areas with mosque-to-mosque modality compared to 88% passed in areas where house-to-house modality was implemented.

Comparison of LQAS results by campaign modality, campaigns in 2022



Clustering of refusals in the South and South-east regions is contributing to already low population immunity due to the inability to implement house-to-house campaigns in the South and quality issues

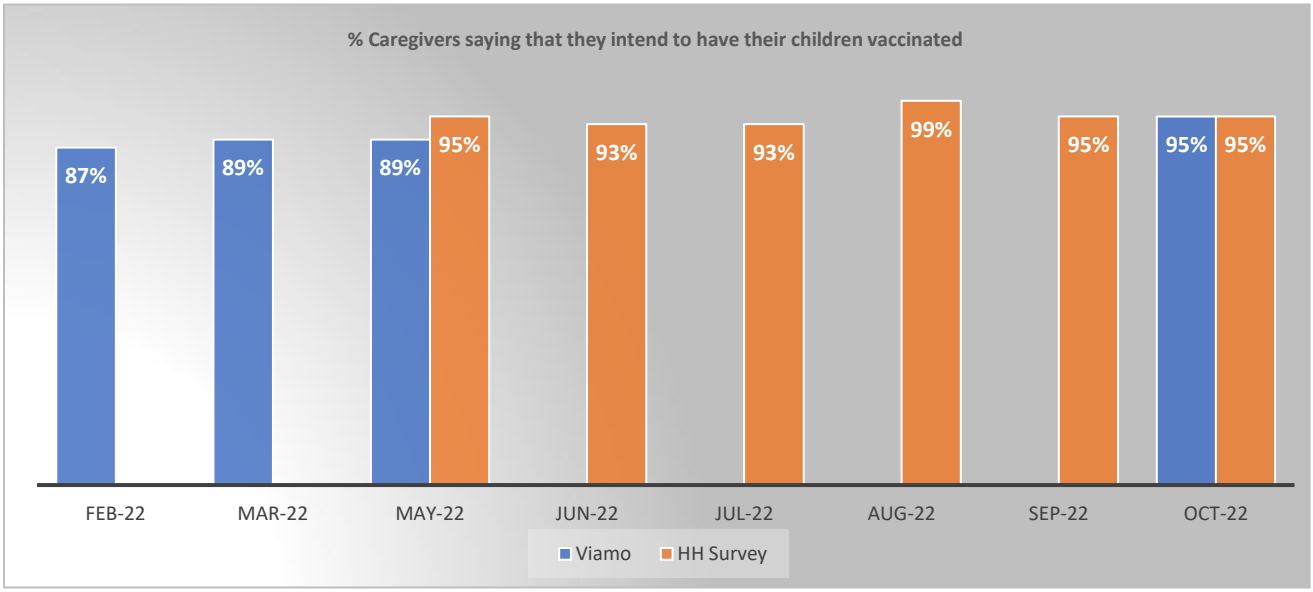
in newly accessible districts with house-to-house implementation in the South-east. The available surveillance data on the vaccination status of acute flaccid paralysis (AFP) cases indicates little increase in the population immunity gap across the country despite the intensive campaign schedule followed in 2022.



In 2022, the programme continued to address low vaccine uptake especially in areas implementing suboptimal campaign modalities in the South. A variety of communication, community engagement and social mobilization activities were deployed including working with influencers such as religious leaders, grandmothers, and local authorities. Two streams of community mobilizers were deployed (full-time and campaign based) to address peculiarity and intensity of activities during and between campaigns.

UNICEF used U-report, Viamo remote surveys, and caregiver surveys to further understand community perception, awareness, and acceptance of polio vaccinations during the November and December campaigns. U-report is a social messaging tool targeting registered users (mostly youths), while Viamo is a telephone-based random survey. Caregiver surveys, which are paper-based, were conducted by frontline workers who administered short questionnaires to caregivers in areas not covered by telephone services. Data gathered throughout the year using each of these means shows that most respondents implied they would vaccinate their children during campaigns. The most common reasons for not vaccinating child during campaigns, particularly in the South, included husband not being at home and mother unable to travel to the mosque. The programme has used

this data to inform communication and community engagement gaps and appropriate deployment of frontline social mobilizers for community engagement and mobilization.



During 2022, the programme took several measures to improve the reach and quality of vaccination campaigns, focusing on hot spots in the East (Nangarhar, Kunar), South (Kandahar City), and South-east regions. Female participation within the polio frontline workforce generally decreased in 2022 compared with 2021. This is more pronounced in the South, particularly in Kandahar city. In the September NIDs, women made up 17.1% of the campaign workforce nationally in house-to-house areas, compared with 1.4% in those areas of the South implementing mosque-to-mosque/site-to-site modality, including in Kandahar City. The programme continues to work closely with women and introduced innovative ideas such as a women engagement officers' group that conducts weekly activities engaging caregivers in the South and reaching homes outside campaign activities.

The programme continues to provide polio vaccination to children under 5 years of age through visits to health facilities across the country for other medical reasons. Additionally, 480 Female Mobilizers/Vaccinators recruited across 392 health facilities in the East, South, South-east, and West regions have been raising awareness among caregivers and supporting health facilities in vaccinating children with OPV and routine childhood vaccines.

Throughout the year, GPEI partners supported the implementation of integrated services for EPI strengthening in the South and Southeast region with direct or indirect support from the polio programme. Of the planned 115 new BPHS+ facilities to be established, 100 were completed and functional. Each of the BPHS+ facilities had two vaccinators (one for fixed site and another for outreach). Seventy-six mobile health and nutrition were deployed (53 in South and 23 in Southeast) providing polio vaccinations to 643,763 children <5 years. Up to 78,572 children <2 years (zero dose)

received penta-1. The mobile health and nutrition teams screened and referred 42,9833 children with malnutrition. WASH facilities (segregated sanitary toilets and handwashing facilities) established in 22 schools serving 56,492 school children and in nine health facilities and communities serving 409,700 populations.

Polio frontline workers continued to support monitoring of the Basic Package of Health Services (BPHS) and responded to humanitarian emergencies including the earthquake in the South-east in June 2022. In most parts of the country, Permanent Transit Teams (PTT) continued vaccination of children and a rationalization exercise was completed focusing PTTs in areas with unreached children.

3. Key Challenges and Risks

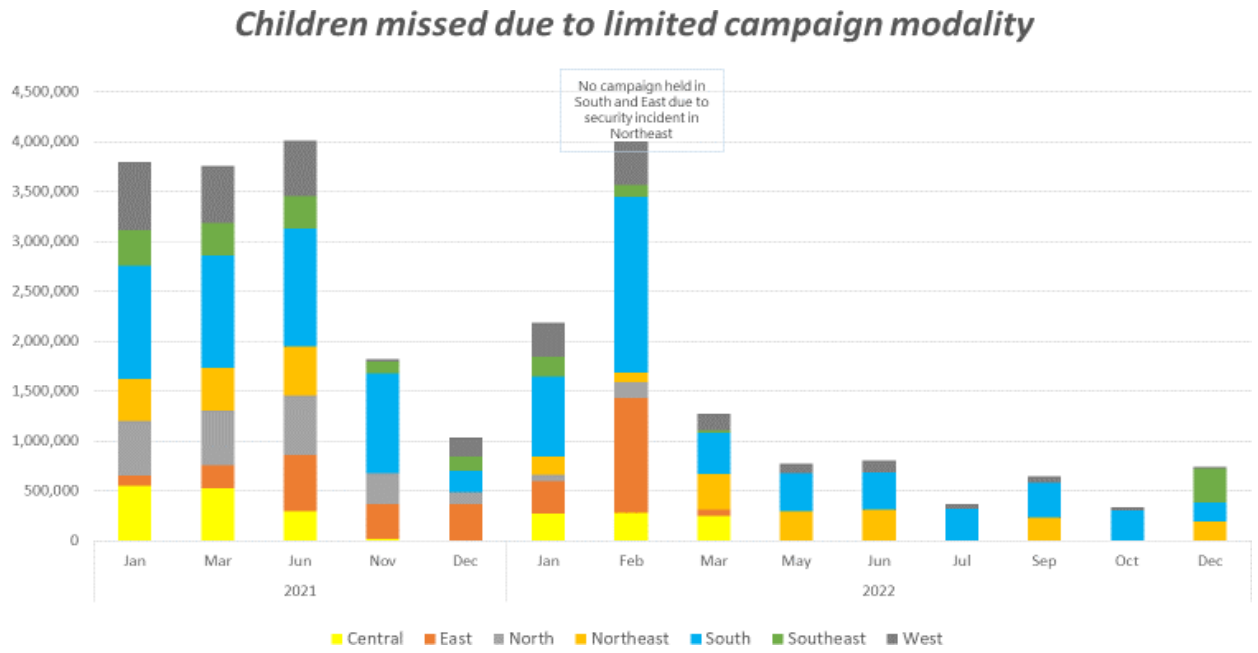
The programme has identified the following significant challenges and risks to stopping poliovirus transmission in Afghanistan:

1. Inability to implement house-to-house campaigns in critical areas, particularly in the South and North-east (Kunduz and Takhar provinces)
2. Suboptimal campaign quality
3. Stagnating number of refusals particularly in the South-east
4. High population mobility
5. Persistent low routine immunization coverage in polio high risk provinces
6. Ongoing outbreak in the East and in South Khyber Pakhtunkhwa

Inability to implement house-to-house vaccination

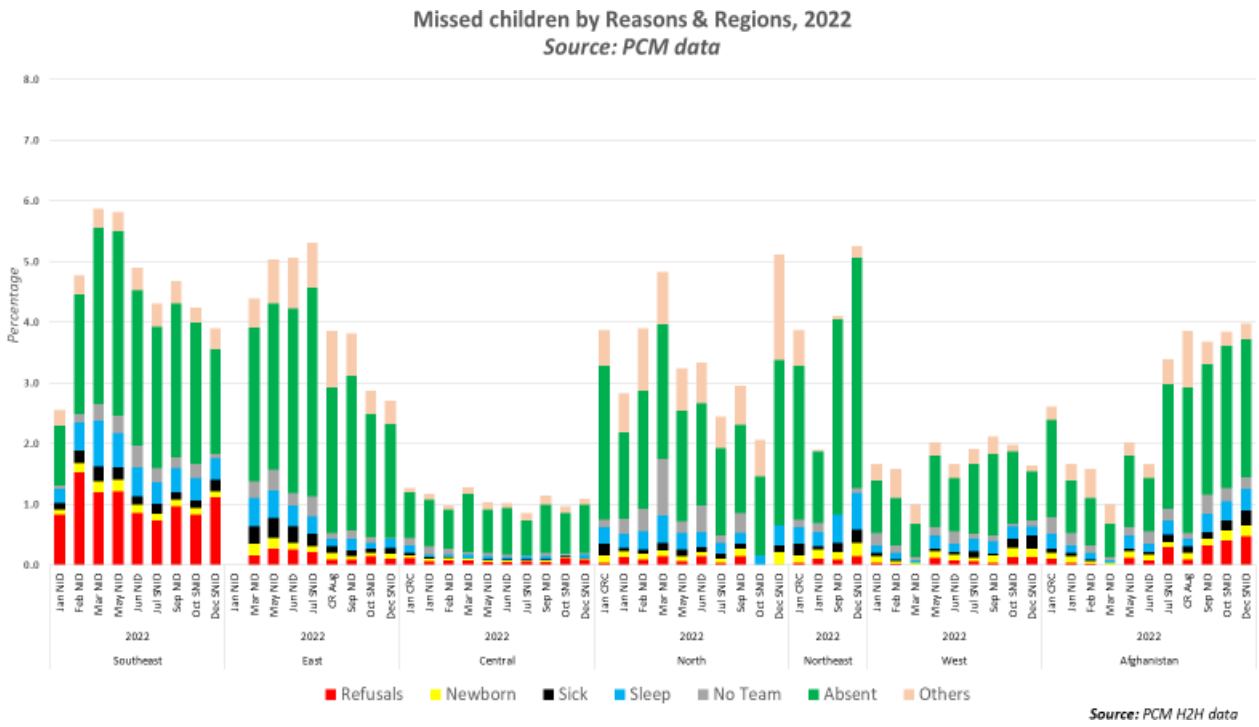
As previously noted, incremental gains were made in areas with house-to-house modality in 2022. However, unreached children remain a challenge and restrictions on implementing house-to-house modality in some provinces and districts , particularly in traditional reservoir areas of the of the South as well as in Kunduz and Takhar provinces in the North-east remained a significant challenge and risk (see graph). This is particularly concerning as Kandahar city has historically been a driver of transmission and 37% of the high-risk districts in Kandahar, Uruzgan and Zabul provinces do not have house-to-house modality and together account for a large proportion of unreached children. Since December 2022, house-to-house campaigns have also been suspended in Ghazni province in the

South-east, amplifying the risk of transmission due to the ongoing WPV-1 outbreak in South Khyber Pakhtunkhwa.



Suboptimal campaign quality

The programme continues to face the challenge of compromised campaign quality resulting in gaps in immunity levels in areas implementing house-to-house campaigns largely due to issues around frontline worker selection, management and accountability. Although the overall campaign quality in several areas is improved, in-depth data analysis indicates that the quality of SIAs is not uniform at the sub-district level. This is particularly true for the critical areas of the South (including areas with house-to-house campaigns in Helmand province), the South-east (mainly in Paktika and Ghazni provinces) and the East (mainly in Nangarhar province). Improving campaign quality is one of the priorities for interrupting transmission and will be an important focus during 2023. The December 2022 SNIDs post-campaign independent monitoring data for areas implementing house-to-house campaigns indicates approximately 8.6% missed children in the South, 5.3% in the North-east, 3.9% in the South-east and 2.7% in the East, with the primary reasons being 'child absence' in the East and South and 'refusal' in South-east (see graph).



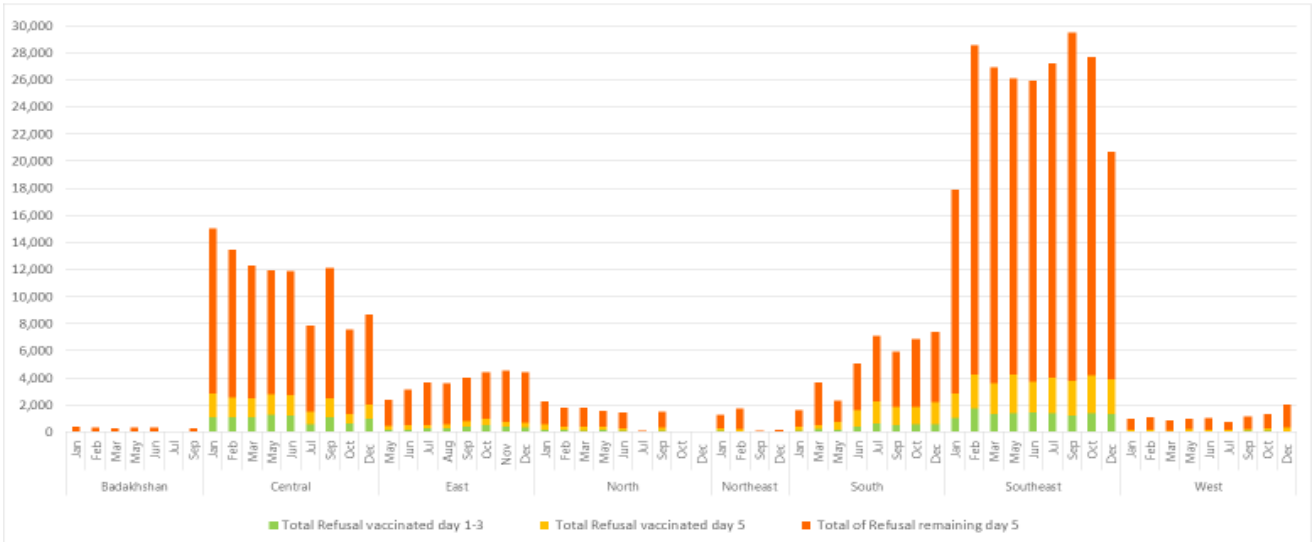
Reasons for suboptimal quality as indicated by the field monitoring reports include interference in selection of polio frontline workers, limited female participation, suboptimal quality of training, supervision and monitoring, issues in appropriate microplan implementation, suboptimal accountability, limited data use, and gaps in follow-up actions between SIAs including lack of implementation of corrective measures following investigation of failed lots. In many instances, suboptimal commitment at the local level results in suboptimal ownership and urgency. One of the main reasons for failed lots identified by the investigation reports is the lack of proper implementation of the revisit strategy, which leads to a high proportion of absent children.

Stagnating number of refusals

Clusters of refusals**,** particularly in the South-east (Khost and Paktika), South, East and Central regions are a significant concern with resulting high numbers of chronic refusal families being reported. Although the total number of reported refusals in the South appears low (around 5,000 children), this was a result of zero recordings in areas where house-to-house modality is not implemented. In the South-east, the apparent decrease in total remaining refusals in December is due to no campaign taking place in Ghazni province. There has been an increase in refusals in the East, particularly in Nangarhar province while in Kunar province there are nearly 2,000 remaining refusals. The graph below shows the trend in refusals in 2022, although this does not reflect those areas not implementing house-to-house campaigns or reflect the 'hidden' refusals in communities.

Reported, Covered, Remaining Refusals by region, by campaign – 2022

Source: *Reported Administrative data*



The key reasons for refusals continues to be misperception on vaccine, religious objection, campaign fatigue, other demands due to lack of health and development services, particularly in marginalized and underserved communities.

Qualitative feedback reports from campaign monitors also indicate that use of non-local staff, involvement of young male volunteers and lack of female mobilizers/vaccinators add to challenges around community acceptance of the polio vaccine. These are exacerbated by staff capacity and low staff motivation. In the context of Afghanistan, the participation of female frontline workers in campaigns is limited, on average at around 17%. Improvement in female participation at all levels particularly frontline workers is directly correlated with an increase in vaccine uptake due to increased access to households. For example, in the Central region, where house-to-house modality is implemented, female participation increased from 25% in the May NID to 27% in the September NID, this led to an increase in the reported coverage of 0.9%.

With more than one and half million new births every year in Afghanistan, reaching newborns is an operational and communication challenge due to a variety of factors including the cultural practice of keeping newborns inside the house for 40 days after birth and the absence of women vaccinators.

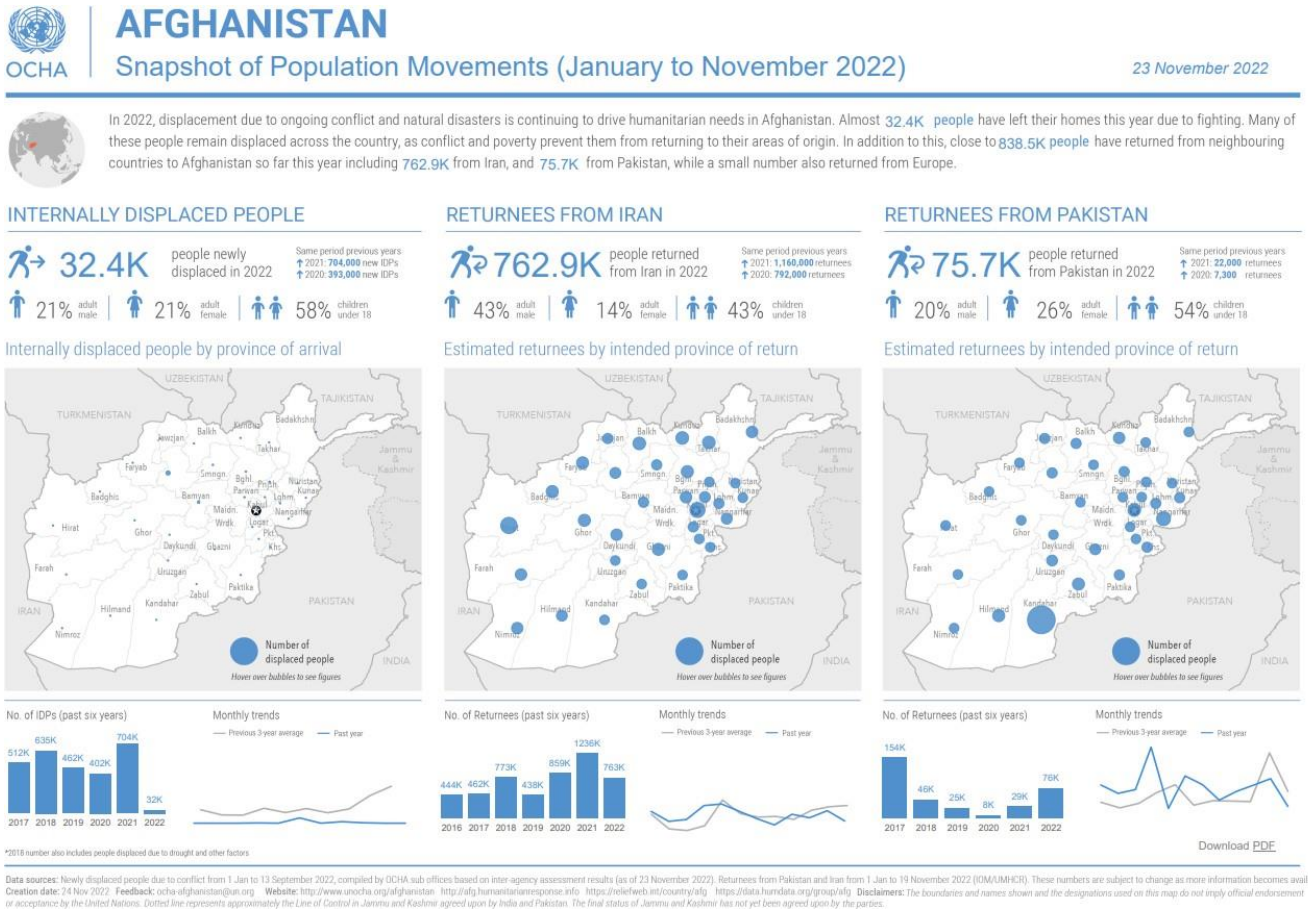
High Risk Mobile Populations moving between Afghanistan and Pakistan

Pakistan and Afghanistan are one epidemiological block, and the two countries share strong socio-cultural ties as well as trade and commercial links. Cross border movement continues to pose a significant challenge for the programme for both SIAs and surveillance. This movement is not only confined to activity along the shared border but also includes seasonal workers from communities elsewhere in Afghanistan.

The programme has identified four main high risk groups:

- Straddling population within the corridors
- Returnee refugees/displaced populations
- Nomads (seasonal and others)
- Long distance travelers

The OCHA Afghanistan snapshot shows the number of returnees from Pakistan was 75,700 while from Iran it was 7,62,900 (as of 23 November 2022). In the same year there were 32,400 internally displaced people in the country.



Source: OCHA Afghanistan

A precise estimate of the nomadic population and long-distance travelers is challenging. The programme continues to focus on the mapping of nomads, timely deployment of transit teams on key routes of nomadic movement, further identification of any missed routes, and strengthening inter-sectoral collaboration with the ARCS, UNHCR, Disaster Management Unit and the Nomad's Independent Directorate. Regular cross-border coordination meetings are held with the EOCs of both

Afghanistan and Pakistan at national and subnational level with continued information sharing on high-risk mobile populations.

Low EPI coverage in high-risk polio areas

Routine EPI is one of the main strategies for achieving polio eradication. High EPI coverage provides a strong foundation of population immunity which in turn minimizes the risk of poliovirus transmission. The routine immunization coverage has remained low in many of the polio high risk provinces, particularly in the South. Vaccination status data for non-polio AFP cases shows that nationally 17% of non-polio AFP cases aged 6-59 months were “zero dose” for routine immunization in 2022. There is a need to scale up efforts t o improve EPI service delivery in these provinces, including the birth OPV dose strategy.

There are many challenges to improving routine immunization coverage. These include inaccurate target population, difficult terrain, with dispersed populations that reside far from health centers. The Afghanistan routine immunization service delivery is part of the basic primary healthcare package provided through NGOs selected via a competitive bidding process. Recently there has been uncertainty in contracting and funding the NGOs which inhibits long term planning. Outreach visits to provide routine immunization are relatively costly and visits are infrequent due to underbudgeting.

The National EPI has been facing a high burden of work as they are primarily responsible for the COVID-19 vaccine deployment and simultaneously faced rising number of measles cases in 2022 which required several outbreak response activities culminating in a nationwide measles campaign in November.

Challenges during 2022 included no access to white areas, insufficient budget, very few health facilities as well as governance and accountability issues, and poor monitoring and supervision.

4. Development and operationalization of NEAP 2023

In view of the current situation and challenges, the 2023 NEAP was developed using a consultative approach with key stakeholders and partners at national and sub-national level.

The NEAP 2023 focuses on high-quality implementation of the recommended strategies and approaches aiming to end WPV-1 transmission in Afghanistan by the end of 2023 and reaching the certification standards for surveillance.

Overall programme management at the regional and provincial level

The EOC under the leadership of HE the Minister of Public Health has been restructured and functionalized and will lead the implementation of NEAP 2023. The Regional and provincial EOCs will coordinate all activities related to polio eradication, including routine EPI strengthening, to achieve the goal of stopping the WPV-1 transmission. The R/PEOCs will provide technical support to the Public Health Departments (PHDs) and Regional and Provincial EPI Management Teams (R/PEMTs) through the PEI partners, liaise and guide them to implement all components of the programme in a quality manner. In regions with no regional EOC, the above regional level functions and coordination will be undertaken jointly by in-country GPEI partners.

In the provinces, the PHDs in coordination with regional teams, will support the REMT/PEMTs in implementing PEI activities. The PHDs will ensure support of all health department functionaries including staff of the BPHS/EPHS NGOs and REMT/PEMT in the implementation of SIAs as well as for effective functioning of AFP surveillance in their respective province. The PHDs will also liaise with the Provincial Governor's office to ensure inter-sectoral collaboration between PEI and other line departments. The PHD will lead the organization of provincial task force meetings under the chairmanship of the Provincial Governor for planning and implementation of SIAs. The PHD, in coordination with GPEI partners, will ensure that the meetings of the provincial task force are held in an effective way, and any support required from other line departments including police, security, education, Hajj and Awquf departments, is obtained

through the provincial task force and Provincial Governor. The GPEI supported staff at the national, regional, and provincial will facilitate and support the technical and programmatic decision making while maintaining coordination across all the levels.

Implementation of plan

The NEAP workplan will be jointly implemented based on agreed clear roles and responsibilities of both the MoPH and polio eradication partners. The NEAP implementation will be tracked and monitored by the core team at the National EOC towards achieving its main objectives, while exercising necessary accountability for responsibilities.

Costing

The GPEI in-country partners under the leadership of the National EOC are responsible for costing the NEAP interventions in consultation with the MoPH leadership and GPEI global partners. The Financial Resource Requirement/budget estimates for 2023 have already been submitted to GPEI.

Programme review and tracking progress of polio eradication at national and global level

National Level

- SIAs performance review after every campaign at the national and regional level
- Quarterly programme review by the National EOC's core team and subsequent briefing to the national authorities/leadership, as necessary

Global level

- Regular programme analyses/review by the GPEI HUB, with periodic briefs to the GPEI Strategy Committee
- Technical Advisory Group meeting: every 6 months
- Independent Monitoring Board meeting: Every 12 months
- Polio Oversight Board meeting: Every 6 months

5. Goals

- Stop transmission of wild poliovirus in the East by March 2023, consolidate and maintain poliovirus-free status of the country through end 2023.
- Prevent WPV-1 transmission elsewhere (outside the East) by building high population immunity and ensuring preparedness for timely, high quality outbreak response in case of any poliovirus detection, in line with national and international outbreak response SOPs.

6. Objectives

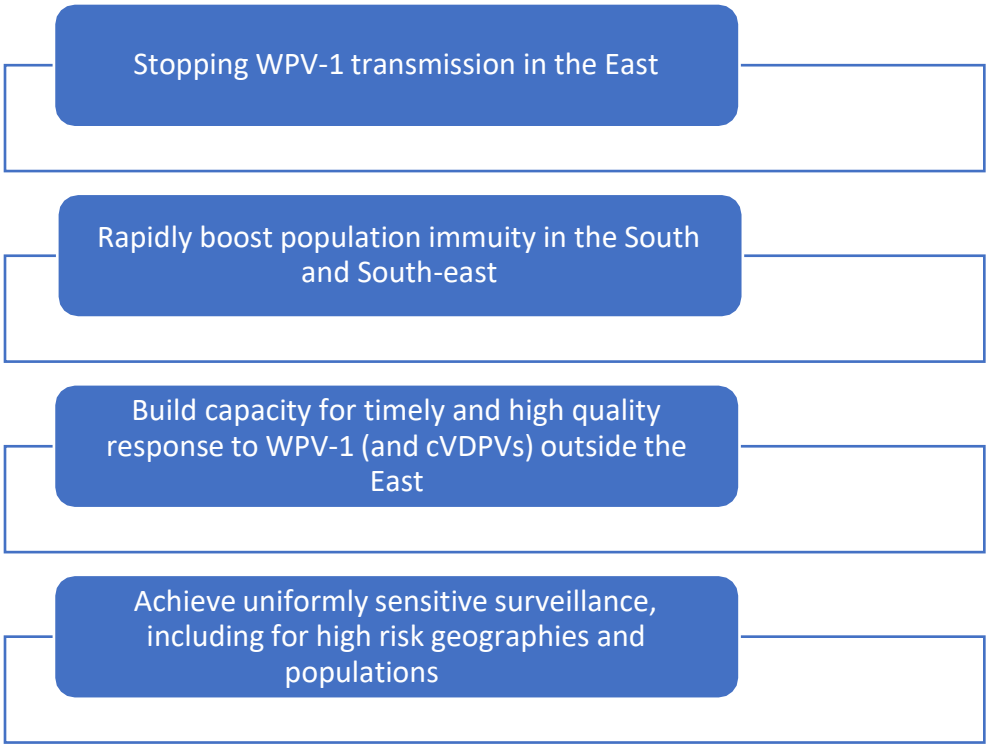
The NEAP 2023 has the following objectives:

- Urgently identify and address the remaining programme quality gaps in the East and ensure high-quality vaccination rounds and sensitive AFP surveillance.
- Enhance and sustain population immunity in the South and Northeast (Kunduz and Takhar) by resuming and maintaining house-to-house vaccination campaigns.
- Rapidly improve the quality of campaigns in house-to-house modality areas.
- Review and strengthen polio outbreak response capacity in all regions of Afghanistan.
- Engage community members and leaders to improve acceptance and demand for vaccination by addressing vaccine refusals through effective and locally appropriate communication and social mobilization strategies, with special focus on the East, South and South-east regions.
- Ensure safety and protection of polio health workers at the forefront from all forms of violence during the polio eradication activities.
- Promote gender equality at programme planning and implementation level, appropriate to Afghanistan context.
- Fully implement the prevention and response to sexual exploitation, abuse, and harassment (PRSEAH) at all levels of the programme.
- Identify and address remaining gaps in surveillance, aiming to achieve the certification level surveillance for polioviruses, including implementation of the recommendations of external surveillance review, possible expansion of environmental surveillance, as feasible, focusing on high-risk areas and populations.
- Promote integration of services in polio high risk areas (South and South-east regions) to strengthen EPI services and increase uptake of polio vaccinations between campaigns.
- Improve evidence generation on community perception, intent to vaccinate, and uptake of vaccines as well as barriers to vaccination through surveys, assessments, and other innovative approaches.

7. Strategic Interventions

Although access for polio vaccination campaigns improved during 2022, the reach for vaccination levels required for eradication could not be achieved. The current epidemiology (as of end-2022) seems very encouraging but given the inconsistent reach and quality of SIAs, the risks are paramount and, if high quality SIAs are not implemented during 2023, intense WPV-1 spread is imminent. There is also risk of cVDPV2 resurgence in the absence of uniform and consistent high-quality routine immunization.

The programme's overall strategic scheme for 2023 is:



In line with the above approach and prioritization, the key strategies to build upon progress made in 2022 and utilize the opportunity of current epidemiology are:

(I) Revised SIA schedule aiming at intensification of vaccination in the East, and rapidly improving immunity in the South and North-east as soon as house-to-house campaigns resume:

- The revised schedule retains the two NIDs and four SNIDs endorsed by the TAG.
- The TAG-endorsed scope of SNIDs is reduced with the exclusion of the North-east region. No WPV-1 case was reported from the North-east region in 2022. Historically, this region has not sustained poliovirus transmission for an extended period and importations have been rapidly contained without being a part of SNID.
- Three additional campaigns in the East (across all four provinces with a target of 1,144,312 children) to stop the only outbreak in the country.
- Additional campaigns planned for those areas of the South and the North-east without house-to-house to enable the programme to rapidly address immunity gaps once house-to-house campaigns are allowed.
- Since the intensity of WPV-1 transmission significantly decreased in 2022 and with no detection of cVDPV2, the programme will maintain a very aggressive stance for responding to new WPV-1 and cVDPV2 detected from any source. The aim will be to implement three bOPV vaccination rounds in sync with planned bOPV rounds, preferably within eight weeks of the onset of last WPV-1 case or collection of last WPV-1 environmental samples and

targeting at least one million children. For cVDPV2, two response rounds will be implemented using a type-2 containing vaccine, following the detection of a new cVDPV2 or cVDPV2 breakthrough transmission.

- The programme will maintain coordination with Pakistan to synchronize major SIAs, when feasible.

(II) Stopping transmission in the East through intensified vaccination campaigns and deployment of surge staff to support campaign preparation and monitoring.

(III) Provide additional opportunities in the South when house-to-house activities resume and respond to any WPV-1 incident in any part of the country.

(IV) Address population immunity gaps in large population centers of the South through EPI campaigns, and EPI strengthening in addition to polio campaigns:

- Involvement of the PEI team in microplanning, training, supervision, and monitoring of EPI, particularly in the South
- Provision of additional vaccinators in underserved and white areas to improve EPI reach
- Multi-antigen campaigns in large population centers of the South coupled with “Pluses”

(V) Improve campaign quality in house-to-house areas by building surge capacity, improving campaign basics, and strengthening review and correction mechanisms:

- Surge capacity: A Rapid Response Team will be trained to carry out epidemiological investigations, help local district and provincial teams to plan, implement, supervise, and monitor case responses, and identify and resolve management and technical issues in the field. This team will be deployed at the national level and in all high-risk regions.
- Surge support will be provided to areas of epidemiological concern by deploying staff from non-SNID campaign areas. The deployed staff will arrive in the districts and provinces before the preparatory phase, participate and evaluate frontline worker selection, conduct training, ensure adequate logistics and provide supervision and monitoring support.
- The programme will also invest further in streamlining and making programme reviews more effective for course correction and strategy development.
- The programme will focus on training and capacity building of programme staff and frontline workers.
    - Frontline workers: Apply learnings from various successful training modalities used by different countries and improve the training cascade mechanism making it less dependent on the cluster supervisor. Programme staff to conduct training in high-risk areas. Monitoring methodology for training will also be revised and utilized efficiently.
    - Regular training to effectively introduce new training modalities, data management systems such as APIMS, and other interventions.

Scenario -1a: Continuing endemic WPV-1 transmission in East Region with no geographic spread

- Continue with intensified SIAs schedule & ways to improving quality
- Maintain sensitive Surveillance
- Situational review in mid-2023

Scenario 1b: WPV1 transmission in the East Region curtailed/stopped

- Continue planned NIDs/SNIDs/East region SIAs during first half of 2023
- Review the situation and risk in mid-2023 and adjust the plans for Q3/Q4 – 2023
- Maintain sensitive surveillance and required enhancements as per the mid-2023 review

Scenario-2: WPV-1 detection in regions other than the East, representing geographical spread from the East Region or from Pakistan

- Aggressive immunization response i.e. two vaccination rounds within 56 days, and three vaccination rounds latest by 90 days - in conjunction with the planned rounds
- Maintain sensitive surveillance with necesary enhancements in the light of epdemiological investigation

Scenario 3: H2H campaigns become possible in South and/or Northeast regions

- Immediate steps to update/finalize micro-planning at the district level & implement 3 vaccination rounds within 60 days
- maintain, necessary communication and advocacy strategies

Scenario 4: cVDPV2 detection in Afghanistan

- Detailed epidemiological investigation/situational review
- If needed, vaccination response with appropriate OPV in consultation with the TAG; two vaccination rounds within 56 days
- Maintain sensitive surveillance with necessary reqired enhancements

(VI) Further enhance AFP surveillance and expand environmental surveillance sites:

- Regular follow up of action tracker developed based on the findings of the international surveillance review with support of EMRO/Hub
- Identification and inclusion of additional potential sites in the environmental surveillance network
- Establishing polio laboratory in Afghanistan

Complementary strategies include:

a) Review and update the epidemiological risk categorization and continue focus on identified high risk districts.

b) Implement tailored 3-year communication strategy, adapting to the evolving programmatic contexts, for strengthen influencers engagement, improved community knowledge, acceptances, and demand for polio vaccinations.
c) Facilitate engagement of female groups in programme design and improve females' participation in engagement activities through community led platforms and designed initiatives.
d) Ensure incorporation of gender-related analysis in all programme components, with focus on high-risk communities and localities. Sex disaggregation will be ensured in the data sets on SIAs and surveillance to generate evidence for planning and decision making at all levels. Ensure inclusion of clear parameters in the programme's human resources policy at all levels to ensure gender equality as well as ongoing supportive supervision of female staff.
e) Focus on enhancing women's inclusion in supervisory and mid-managerial positions, as feasible, to support further increase in women's participation in frontline staff.
f) Maintain accountabilities for all components of the programme in accordance with clear guidelines through a reward and sanction approach that identifies both good and under performance results applicable to both MoPH/DoPHs and partners.
g) Strengthen and improve EPI outcomes through implementation of integrated services in selected geographies and communities considered high risk for polio.
h) In line with the GPEI's zero tolerance for sexual misconduct in polio eradication operations, the polio eradication programme in Afghanistan will ensure protection of the beneficiary populations and of the personnel working for polio eradication from sexual exploitation, abuse, and harassment. This will include necessary training, screening of personnel, accessible mechanisms for reporting of potential allegations, and a victim centric approach in response to any sexual exploitation and abuse allegations while working in close collaboration with the UN mechanisms. Any allegations will be immediately reported through the appropriate organizational channels, investigated, and responded to accordingly.


7.1 Conduct supplementary immunization activities

The programme plans to implement two NIDs and four SNIDs in 2023 using bOPV, as endorsed by the TAG. Two of the four SNIDs and one NIDs are planned during the low transmission season of the first half of the year. In addition, there will be three intensified SIAs in the East to stop the ongoing transmission (see annex).

Additional campaigns are also planned for those areas of the South and North-east that do not implement house-to-house campaigns to enable the programme to rapidly address immunity gaps once house-to-house modality is allowed. bOPV may be appropriately replaced by tOPV in case some parts of the country affected by outbreaks of cVDPV2. The areas that can convert from mosque-to-mosque to house-to-house may be considered for additional OPV doses based on the risk assessment and local context.

As before, the programme will continue to ensure the safety of polio health workers at the forefront as well as communities and will ensure infection prevention and control measures for COVID-19 during SIAs planning and implementation.

7.2 Outbreak preparedness and response in non-endemic areas of the country

As only two vaccination opportunities are planned in the non-endemic areas of the country, the programme has developed a roadmap of constant preparedness and response to any wild or vaccine derived poliovirus event in these areas. Preparedness will include pre-positioned logistics, vaccines, and funding to rapidly mount a response if and when needed.

7.3 Focus on high-risk provinces and districts

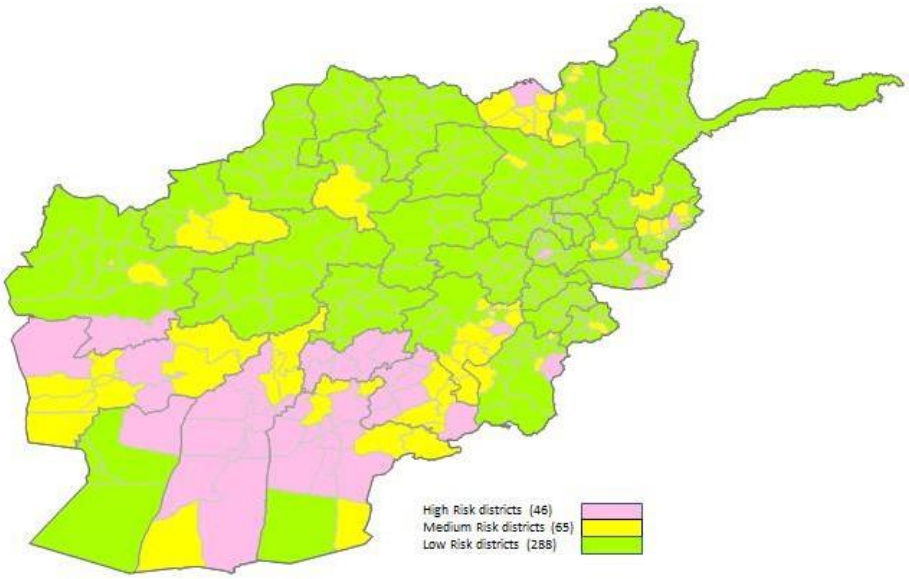
The risk categorization at district level has been revised following a multi variate risk assessment identifying 46 high risk, 65 medium risk and 288 low risk districts (see annex for risk categorization list).

During the process of risk categorization, significant weighting was given to polio epidemiology (frequency and duration of outbreaks in districts), SIA quality, and districts where the programme is not able to reach all children due to limitations in campaign modality amongst other factors. Based on the current categorization, 90% of Afghanistan's polio cases have been reported from medium and high risk districts while 72% have been reported from the 46 high risk districts alone. Seven provinces have been flagged as high risk: Kandahar, Helmand, and Uruzgan (South), Nangarhar and Kunar (East),

Paktika (South-east) and Farah (West). Together, these provinces account for more than 67% of Afghanistan's polio cases since 2017. The programme will continue to periodically review and adjust the risk categorization as per the evolving epidemiology.

The programme will place special focus on high risk districts as per the revised categorization in NEAP 2023, including adjustment of the SIAs schedule and scope, enhanced technical and programmatic support for operations and social mobilization, targeted supportive supervision, and monitoring from the provincial and national levels as well as support from Ministerial and higher levels on administrative and accountability related aspects.

Risk categorization 2023



Highest priority will be given to the East to stop the ongoing transmission at the earliest. Historically the East region has excelled in responding to polio outbreaks as a team, the recent example is the cVDPV2 outbreak. The current epidemiological situation is worrisome and requires a focused approach. Since early 2021 the region could not implement house-to-house campaigns because of several factors including targeted attacks against frontline workers. The region started house-to-house campaigns in May 2022 across all provinces but with a compromised quality amid significant interference in the selection of the frontline workers. With a focused intervention by the NEOC, the programme made some gains in recent campaigns, including involving more female frontline staff, reducing interference in the selection and the addition of surge support staff.

The best available polio staff from regions where campaigns are not planned will be mobilised to the East during campaigns. The deployed staff will primarily support in all preparatory activities and ensure that frontline worker selection, microplans and trainings are top quality. The East will also be supported with additional partner staff for improved programme management and monitoring. Every SIA in the East will be directly supervised from the national level, plans of actions will be prepared based on findings from all sources, and support provided to address issues identified.

7.4 Improving SIAs quality

The programme aims to continue and innovate targeted interventions to reduce and bring the proportion of missed children to 3% or less at district and cluster level in high risk areas and achieve the target of 90% passed LQAS lots at provincial level. The programme will continue to consider every LQAS lot below 90% threshold as failed.

Improving SIA quality in house-to-house areas will result in a reduction of unvaccinated children. In 2023, the programme will continue to focus on improving campaign basics: microplanning, selection, training, supervision, and monitoring. This will require extensive capacity building of programme staff and frontline workers, and the creation of a dedicated team to focus on these key priority aspects of the programme.

The programme will invest further in streamlining and making programme reviews more effective for course correction and strategy development. To that end, the programme will focus on two areas:

- Monitoring and evaluation: As APIMS is rolled out across the country, a data management and analysis tool developed with the support of the CDC, with better capacity to efficiently utilize this data will be required, a dedicated monitoring and evaluation unit with one international and one national professional staff will focus on this important field of work to enable the programme to make informed decisions and continuously improve.
- Internal and external programme review and technical support: As a part of strengthening monitoring and evaluation of the programme, an intense schedule of reviews will be planned at both field and Kabul level that will require staff to come to Kabul, and country office staff and staff from outside country to regularly visit the field.

The programme will take a focused and meticulous approach towards reaching missed children. Close supervision of vaccination teams during SIAs will immediately address any performance issues. In polio reservoirs and high risk areas, supervision and monitoring will be enhanced during SIAs from the regional and national levels. The reasons for missed children will be regularly disaggregated and investigated during and after each vaccination round, aiming to identify the root causes during the campaigns and/or in between the vaccination rounds. (Further details are outlined in Chapter 10: Monitoring)

The programme will review and adjust guidelines for recording various types of refusals in house-to-house areas for targeted interventions. The programme will plan for better understanding and disaggregating the recoverable children (who return to their houses during campaign) and non-recoverable absent children (children who do not return during campaign) to ensure every child available for vaccination is reached through appropriate approaches. Focus on recorded as “newborn, sick, sleeping” will be intensified to identify and address the core reasons for missing these children

with special attention to gender related barriers. Trainings and supervision will focus on reaching newborns as well as identifying and vaccinating guests, sick and sleeping children.

Reaching newborns also requires emphasis and monitoring during training and implementation of the EPI services as well as during house-to-house and transit points vaccinations, and appropriate communication strategies need to be designed and utilized, accordingly. Timely administration of OPV-0 through routine immunization will positively impact stopping transmission. Additionally, timely EPI vaccination with IPV will help reduce paralytic disease from WPV-1 and cVDPV2.

The programme will enhance focus on effectively reaching the newborns and infants during vaccination campaigns, including during revisit and catch-up phases. Recording of newborns and infants by community mobilizers in between campaigns will be further streamlined to support vaccination teams on reaching such children. Full-time mobilizers and communication supervisors will prioritize community engagement and communication work during and between campaigns. These cadres will dedicate 10-15% of their time to support monitoring of routine EPI at health facilities and during outreach activities.

High risk areas will be prioritized for efforts to increase female participation as vaccinators, supervisors, and monitors to reach young children more effectively. Women's participation will also be considered for the long-term engagement activities at the district level to support the campaign activities and engage families for positive perception toward the vaccine. Transit vaccination teams including the cross-border teams will also be specifically trained on appropriately approaching families and vaccinate newborns and infants. The programme will work towards strengthening referral mechanisms to enroll and follow up newborns for immunization and other essential health services to gain trust of communities in the programme. The programme will continue to strive towards supporting the identification of white and underserved areas and coordinating for inclusion in the outreach schedules.

A "No Tolerance Policy" for campaign quality gaps will be adopted, utilizing the programme accountability mechanisms at all levels. Any quality gap will be treated as priority for analysis and addressing the reasons. Appropriate steps will be initiated as per the accountability mechanism, aimed at improving programme implementation quality. The programme will consult with the community about the service quality and share their feedback beyond the programme to improve programme results. The National EOC will ensure transparent data/information reporting, with zero

tolerance for misreporting. The persistence of any issues in resolving quality gaps will be immediately taken up by the National EOC until appropriate steps are taken at the national level. The programme will focus on improving the basics that constitute the fundamental elements of campaigns-microplanning, selection of polio health workers at the forefront, trainings, monitoring and supervision, locally appropriate social mobilization activities, and data quality and utilization.

7.4.1 Polio health workers at the forefront

Unbiased selection of appropriate frontline workers will be ensured for all campaigns and other complementary vaccination activities. There will be no tolerance for any favoritism or nepotism related to the selection process and appropriate steps will be taken about any such reports. Close monitoring from national level will be done for frontline worker selection through the following interventions:

- Close monitoring and support from the National EOC on selection of polio frontline workers and empowering the selection processes to function effectively and transparently, without any interference. Heads of all selection committees will have direct access to the National EOC to report any undue influence on the selection of polio health workers.
- Ensure functional, impartial, and well-balanced district selection committees in coordination with the relevant health shuras, particularly in high risk provinces.
- National monitors will review frontline worker selection during their campaign monitoring visits. Any deviation from selection guidelines or influence on selection will immediately be brought to the attention of the National EOC for appropriate action. When required, chronic interference and nepotism will be brought to the attention at Ministerial level for support and rectification.
- Selection committees will make transparent and active efforts to engage more women as frontline workers including as vaccinators, supervisors, mobilisers, and monitors. The percentage of female staff particularly in urban areas, will be tracked over the rounds to monitor progress.
- Selection committees in high risk provinces will have at least one female member to facilitate and promote the recruitment of female frontline workers and monitors.
- The National EOC will continue to directly monitor and support the engagement of women frontline workers and mid-level managers. The National EOC will also ensure an enabling environment at all levels for recruiting and sustaining women workers at all levels. The National EOC, in coordination with provincial EOCs, will continue to monitor the risks (including cultural barriers and workplace and environment related challenges) for engagement and sustainment of female frontline workers, monitors and mid-level managers, and address those risks in a timely and efficient manner.
- The programme will review and strengthen accountability of frontline workers and track the implementation including removals based on objective documented criteria.

- The programme will recognize the best performing personnel and reward the best performing frontline staff with non-monetary incentives to maintain their motivation.

The following measures will be taken to sustain motivation:

- Timely payments of frontline staff will be ensured: 90% of payments to be made before the next planned campaign in SNIDs areas and within one month in non-SNID areas. This will be tracked at the national level.
- The Direct Disbursement Mechanism will be periodically reviewed by the national programme supported by global experts, aiming to identify and address any systemic challenges and impediments in timely payments to the polio health workers at the forefront as well as any potential gender incentive gap.

7.4.2 Training and mentorship

The programme will focus on training and capacity building of programme staff and frontline workers. A dedicated training unit will be set up to appropriately train frontline staff to improve the quality of campaign implementation. The training unit will look at all training content and basic interpersonal communication skills, gender awareness and community engagement will be streamlined.

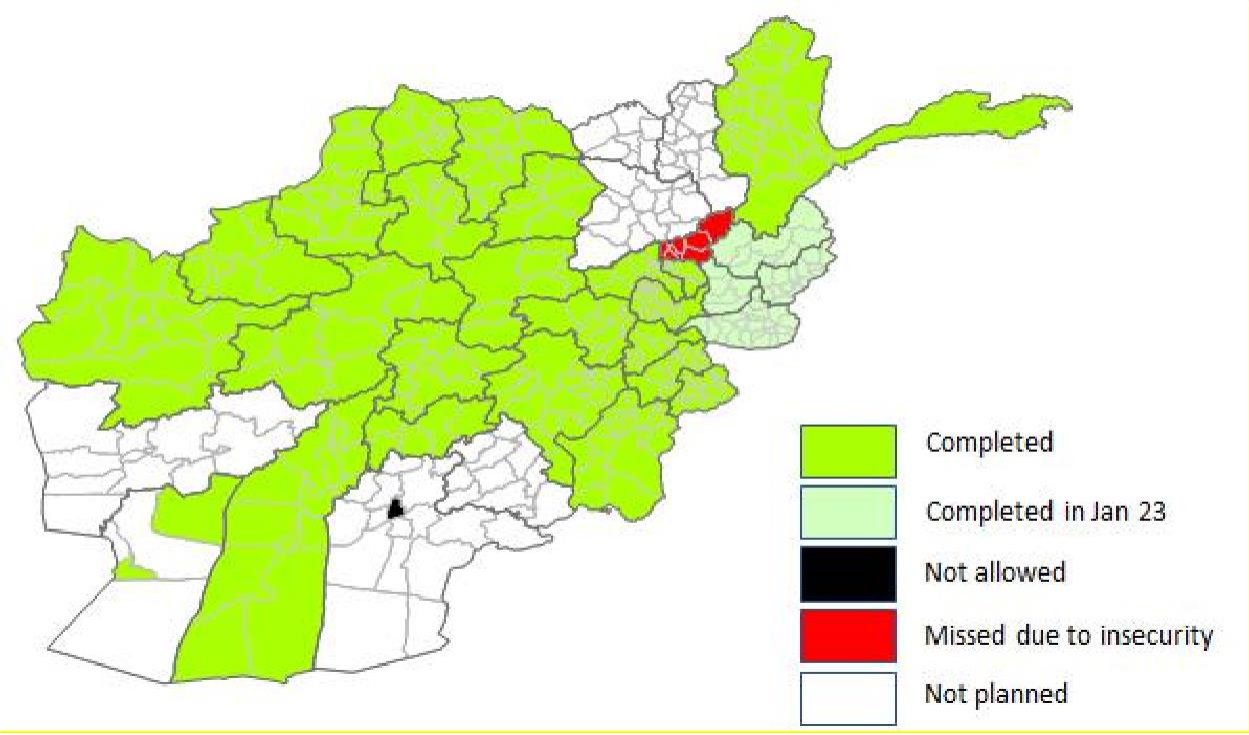
- The training unit will review the existing training manual during the first quarter of 2023, tease out the lessons learnt and accordingly take measures to improve training quality. Any required revisions will be made in the training manual by the end of May 2023. Emphasis will be to ensure simplicity in the trainings with focus on identification and recording of all eligible children, ensuring vaccination of newborns, sick, sleeping and guest children, and recovering missed children by the end of the campaign. Trainings will also focus on interpersonal communication skills, community engagement and communication strategies at the household level as well as on gender-related barriers, to ensure high quality vaccination during house-to-house campaigns. The trainings will also include building the basic skills on field problem solving, refusal recording and reporting at household and community level.
- Pictorial messages will be developed to simplify learning and understanding of frontline staff in areas where the literacy rate is very low.
- Trainings in high-risk districts will be conducted by senior programme staff themselves, rather than team supervisors.
- Effective use of training monitoring data to take corrective measures.
- Direct oversight on the functioning of training committees in high risk provinces and ensuring their effectiveness.
- On-the-job training will be introduced to assist frontline staff in improving the quality of their work.

7.4.3 Microplanning

With more and more areas implementing house-to-house campaigns, the programme will ensure review, revision and updating of microplans before each campaign. Mechanisms to monitor the revision of microplans by each supervisor will be ensured with special focus on high risk provinces and districts. In addition, key components of microplanning such as team, supervisor or coordinator workload and team composition will be tracked for each campaign.

Field validation of microplans was undertaken in 2022 in areas where at least three campaigns have been implemented implementing house-to-house modality. This exercise could not be done in the East region in 2022 owing to case response campaigns and supplementary immunization activities as per the SIA calendar, and was completed in January 2023. The exercise is planned to be completed in Farah and Baghlan provinces in April 2023 and the remaining areas in 2023 as soon as the criteria of implementing at least three house-to-house campaigns has been fulfilled.

The below map shows the status of microplan field validation exercise.



7.4.4 Revisit/catch up vaccination of missed children

To effectively address the two major reasons for missed children - absence and refusals - the programme will carry out the following key interventions:

- The daily revisit strategy will be strengthened by enhancing and improving the quality of supervision by first level supervisors of the vaccination teams and as well as monitoring by higher levels. After finishing the day's assigned area, vaccination teams will revisit households with missed children on the same day. The missed children catch up through daily revisits will continue during the three days of the campaign, as operationally feasible in areas with house-to-house campaigns. Children not reached during the three days of the campaign will be followed up on the fourth/revisit day(s).
- The revisit strategy will be flexible for high risk areas, and decisions can be taken locally to perform revisit of missed children for two days by splitting the vaccinations teams, if operationally feasible (no additional resources allocated for such adjustment).
- The National and Regional EOCs will continue to monitor and make necessary required changes for timing of revisits the better to recover the missed children. The communication workers to focus on vaccine promotion and community engagement rather recovery and vaccination of missed children.
- The programme will establish refusal committees at subnational level to engage with the regional and National EOCs, as appropriate, and continue developing and fine tuning of strategies/actions to address issues of refusals and make recommendations to campaign teams before, during, and after every campaign.

7.5 EPI strengthening through integration of services targeting high risk areas of the South-East and South Regions

In the South, children living in areas out of coverage of health facilities chronically miss polio vaccinations conducted through campaigns or routine services. In 2019 and 2020, over 75% of all polio cases nationally were reported from Helmand, Kandahar and Uruzgan provinces which have consistently reported low routine immunization coverage with high number of zero-dose children and high rates of malnutrition.

Integration of polio and routine EPI in these provinces is priority for MoPH to enhance synergy between the two programmes so that EPI coverage is boosted together with immunity in high-risk and underserved communities.

In 2022, WHO and UNICEF oversaw the delivery of BPHS. In 2023 UNICEF will lead the delivery of BPHS under the Humanitarian Emergency Response project.

To mitigate the risk of poliovirus transmission in these areas, the programme will use an integrated approach to bring basic health services including polio vaccinations to vulnerable communities in the South, South-East, and East regions.

This approach will leverage nutrition, WASH, and broader health services delivery platforms and is both cost effective in enhancing and sustaining polio vaccinations and strengthening EPI, particularly in areas at high risk of polio virus re-emergence and transmission.

Specific objectives:

- Strengthen EPI services to increase opportunities for delivery of polio vaccines particularly among youngest and most vulnerable children in endemic and white areas.
- Strengthen and promote community engagement activities to increase participation and demand for EPI services.
- Promote investment in other critical health, nutrition, and humanitarian programmes including water, sanitation, and hygiene promotion in priority areas to address inherent vulnerabilities for poliovirus transmission.

Key interventions

The polio programme will contribute to the objective of improving immunization outcomes by:

- Dedicating proportion of polio staff time to strengthen EPI, including monitoring of EPI fixed and outreach sessions, supporting EPI microplan updates, and conducting training sessions.
- Provision of additional basic health services such as nutrition screening and referral, provision of nutritional supplements, as part of EPI fixed and outreach services.
- Provision of promotion items such as soaps, baby blankets, clean delivery kits and hygiene kits, as incentive to promoting polio, routine EPI and institutional deliveries

- Advocacy with health and humanitarian partners to increase investments, for example, WASH, in the South and Southeast regions.

BPHS+ Project:

- In late 2019, the NEOC supported the launch of the BPHS+ programme in Helmand, Kandahar and Uruzgan through partnering with local NGOs. Under this programme, 86 sub health centres and 14 basic health centres were established in white areas of the three provinces following BPHS guidelines in order to address the major gaps in basic health services across Helmand and Kandahar, boost EPI coverage in poor performing areas, and deliver polio vaccine in areas where polio campaigns were not allowed. In addition to support for health facilities, partners implemented an intensified monitoring system whereby each health facility would be monitored every month.
- Through this project, 25,000 children were vaccinated with Penta3 in 2021, 10,000 deliveries occurred, and more than 300,000 children received OPV. Additionally, monitoring and field reports indicate these health facilities as exceptionally well-performing in very difficult conditions, largely staffed up, well supplied, and conducting activities in line with plans.
- In February 2023, all BPHS+ facilities were successfully transitioned to the Health and Emergency Response project to ensure consistency and coordination across basic health delivery in the South as well as the sustainability of these critical health facilities. These facilities will continue to play a key role in meeting basic health needs including in response to the ongoing humanitarian crisis, save lives through EPI strengthening and contribute the eradication of polio in Afghanistan.

EPI coverage survey:

- With a strong routine immunization programme key to eradicating polio, it is imperative to continuously strengthen the EPI programme, particularly in areas at high risk of wild poliovirus circulation.
- The last household immunization survey - the Afghan Health Survey, 2018 - indicated Penta 3 coverage in Helmand was 17.4%, Kandahar 29.6%, and Uruzgan 3.1%. Recent administrative data, however, indicates coverage in Helmand is 55%, Kandahar 68%, and Uruzgan 55%.
- While these are encouraging improvements, it is difficult to ensure the accuracy of this information. To better understand the changes in immunization rates in the South, two household immunization surveys are planned for 2023, and will be coordinated through the ISD working group at NEOC.

Health

Working closely with stakeholders at regional and provincial level, the programme will seek to increase access to health services and improve uptake of EPI services by implementing the following:

- Support to the operations of 50 mobile health and nutrition teams and 16 health camps in polio high risk areas to increase access to EPI services and improve immunity gap including for polio.
- Improve utilization of health and immunization services through provision of pluses such as soaps, clean delivery kits, and baby blankets at health facilities to increase and sustain uptake of vaccinations.
- Improved routine immunization coverage through deployment of additional technical staff and outreach vaccinators and materials such as solar fridges in polio high-risk areas.
- Strengthened capacity of existing health facilities, through training, technical and financial support inclusive of training of new vaccinators for underserved and white areas.
- Strengthen community engagement and mobilization to engender participation and increase demand of vaccinations and other health services.

Nutrition

The following nutrition services will be integrated at all levels in consultation with service providers and communities:

- Integrate nutrition services into mobile health teams as well as at Comprehensive Health Centres and Basic Health Centres in polio high-risk areas
- Provide de-worming tablets to children aged 24-59 months
- Provide therapeutic food for treatment of children 6-59 months with Severe Acute Malnutrition and provide Ready to Use Supplementary Feeding to Moderate Acute Malnutrition
- Distribute Vitamin A and Albendazole to children during national polio campaigns, as per the age policy in the national SIAs guidelines.
- Integrate the polio vaccine messages and information into infant and young child education sessions for caregivers.

WASH

The polio programme will work with WASH teams to improve access to clean and safe water and good sanitation in polio high risk areas. The following WASH interventions are proposed in 2023:

- Establish 20 WASH facilities in health facilities
- Establish 20 WASH facilities in schools
- Establish 20 WASH facilities in polio high risk communities

Provision of polio promotional items

The programme will use promotional items to increase uptake and reduce dropout of children for polio and routine vaccinations. These promotional items will be distributed through health facilities,

mobile health teams and, where applicable, multi-antigen campaigns. The following promotional items will be bundled with vaccinations:

- Soap for zero-dose children identified for vaccinations and followed through completion of vaccinations and for missed or refusal children.
- Baby blankets for newborns in maternity facilities or communities as identified by community health workers with preference to deliver through facilities so as not to encourage homebased deliveries.
- Hygiene kits and clean delivery kits through clinics and gender safe spaces to pregnant women.
- Scholastic materials for children such as crayons, exercise books, pencils, picture books
- Solar radios to engage the community in discussions about polio and answer relevant questions.

Humanitarian engagement

- Reaching additional children especially in high risk, underserved areas is an important factor in getting the job done. Humanitarian organizations have stood up large humanitarian response programmes across Afghanistan, including in polio priority areas. Given the depth and breadth of this response, the polio programme is collaborating with these humanitarian organizations to support their activities and leverage their response efforts to reach additional children with polio vaccine. The objectives of this collaboration are to contribute to lifesaving humanitarian assistance while identifying ways to expand the reach of polio vaccination and routine immunization in polio priority areas of Afghanistan particularly underserved areas of the South.
- The outputs of this collaboration, which include expanded humanitarian response activities and increased polio vaccination coverage in polio priority areas, will be rigorously measured. The programme has worked with each of the humanitarian organizations to identify specific villages where the humanitarian organizations will focus their activities. Targets have been assigned and will be measured based on the number of missed children from polio campaigns that humanitarian organizations are able to reach. These targets will be refined on an ongoing basis based on campaign data as well as feedback from the field. Humanitarian organizations will report on children reached with polio vaccine on a monthly basis and other indicators (e.g., EPI coverage, nutrition, etc.) on a quarterly basis.
- The main objective of this initiative is to improve the quality of polio eradication efforts in Afghanistan, with a particular focus on previously missed ("polio zero dose") or under-immunized children. To measure its effectiveness, impact indicators were chosen utilizing the existing GAVI framework for zero-dose children and missed communities[1] as well as GPEI polio programme indicators.

[1] *Guidance on Use of Gavi Support to Reach Zero Dose Children and Missed Communities – Gavi, Aug 2021*

7.6 Advocacy, Communication, Community Engagement and Social Mobilization

Responding to the challenges of missed children and silent and chronic refusals requires strategic focus on community engagement, the involvement of new actors, and reliable evidence to drive decisions.

The programme will build its community engagement activities through:

- Enhanced capacity of Immunization Communications Network and partners (INGOs, community-based organizations, universities, and local media) to engage with communities to improve knowledge and increase awareness and trust of vaccines.
- Increased accountability of religious leaders, teachers, medical professionals, and women groups through sustained and systematic community engagement.
- Improved integration of community networks through messaging, training packages and tools through the 'One FLW' and community engagement approach and strengthened partnerships.
- Improved evidence generation on community perception and intent to vaccinate as well as barriers to vaccination through innovation.
- Increased female participation in immunization activities to improve vaccine uptake.

7.6.1 Pillars for community engagement and social mobilization

The programme will focus on four pillars that will sustain and strengthen its capacity to maintain high polio knowledge and awareness, bolster capacity for mobilisation and community engagement, establish a strong network of agencies and NGOs working as partners with the programme, and gather the data needed to guide and monitor success.

Pillar 1: Enhanced two-way knowledge and awareness raising

Knowledge and awareness raising is a two-way communication. It involves disseminating accurate knowledge and motivational messaging to caregivers and frontline workers to reinforce or change attitudes and perceptions that impact the decision to vaccinate.

Activities under this pillar will include:

- Support dialogue and community engagement to increase community knowledge and change its perception towards the vaccine
- Enhance social listening and increase misinformation management activities at all programme levels to address refusal and respond to rumours
- Increase integration and partnership with local and international NGOs, including integrating polio awareness and knowledge within other related knowledge such as routine immunization, maternal health or nutrition in messaging and materials and other frontline tools used for mobilisation and engagement
- Position the polio programme and campaigns as part of a wider set of health initiatives that respond to the realities of life in Afghanistan
- Reduce hesitancy and create increased support for and involvement in polio campaigns and increase caregiver's willingness to vaccinate their children.

Pillar 2: Women and community engagement

Building trust and responding to the significant challenges facing the programme is core to sustaining the engagement of the community and women through the following:

- Sustain systematic approach to community engagement, outreach and mobilisation interventions with caregivers and carefully planned work with influencers and community leaders.
- Listen and respond to community concerns, gathering insights into perceptions, and creating spaces where communities can be involved in co-creation of solutions to issues affecting vaccination.
- Increased levels of trust and ownership of the polio programme and develop community relationships in which the programme is seen as a resource for more than just administering polio drops.

Pillar 3: Substantive integration and partnership building

The polio programme will build networks of partners that provide other related services and are responding to Afghanistan's growing humanitarian needs. Closer links will be explored with humanitarian agencies working at scale to ensure that polio vaccination is part of the services and information they provide. This will enable the programme to extend its reach and integrate its work with a basket of services in high demand by communities and will focus on achieving the following:

- Reinforce the message that the polio programme contributes to a much wider set of community needs.
- Provide a stronger base for responding to community concerns by creating partnerships that allow for linking communities to other services and knowledge
- Develop educational materials that incorporate polio knowledge and information with that of partners on high priority community health concerns such as routine immunization and maternal health.

Pillar 4: Improve evidence generation and knowledge management

This entails re-establishing or improving the quality of priority core methods of data gathering and analysis and, in some cases, new approaches to gathering evidence in those areas where restrictions make it impossible to gather evidence using extant methods on how communities perceive the polio programme, their intent to vaccinate, the barriers they confront, the social norms that influence their actions, and the impact of the various activities and initiatives the programme is engaged in. The evidence framework will focus on the following activities:

1. Establish and streamline monitoring system to systematically collect evidence to inform programme design and course correction
2. Capacity building of UNICEF and partner staff on evidence generation and use of evidence
3. Conduct caregiver survey (baseline, mid-term, and end)
4. Conduct ongoing rapid assessments using proven social science methods

Gender and Women's Participation

The role of women in the polio programme is critical to increase access to households, identify and vaccinate newborns and infants, and mobilise women in communities. To increase the level of participation of women in the programme, this strategy will embrace a range of initiatives designed to maximise coverage in contexts where women's roles have been reduced together with advocacy to rebuild and sustain the engagement of women at every level from community focal points to frontline workers and influencers and in supervisory and management roles.

The 2023 NEAP and the *Adopting a Gender Lens to Improve and Sustain Polio Vaccine Uptake in Afghanistan: Topline Final Report* make the following recommendations for improving gender participation*:*

1. Training on gender related barriers and gender activities among all the partners
2. Messages and activities to promote the role of women and men in eradicating polio in Afghanistan
3. Follow-up research focusing on social norms analysis
4. Improving gender mainstreaming in communications and community engagement through training, data collection, materials and messages, gender-sensitive messaging, gender indicators.

5. Strengthening women's participation in the polio programme through leadership driven, gender-sensitive Terms of Reference and job advertisements, strategy for the prevention of and response to sexual exploitation, abuse and harassment functioning at community level
6. Improving gender and security factors affecting women's participation including for mosque-to-mosque campaigns through mobilising support from both male and female community members using gender-sensitive and appropriate approaches, working with larger numbers of older women, and advocating continuously for greater female involvement.

Innovation

In consultation with community groups and polio health workers at the forefront , and based upon an understanding of the local norms, community initiatives will be supported to create innovative interventions. The initiatives aim to address the lack of motivation and polio eradication activities fatigue. These initiatives are designed to make any polio outbreak visible and a national concern:

- Radio drama series focusing on polio prevention in the context of daily life in communities and families
- Define a national/local model to promote polio messages at household and community level
- Promote UNICEF's Aisha character as a sample for fighting the poliovirus in Afghanistan.

7.6.2 Communication and Advocacy Strategies

The programme will implement the 2023-2025 communication strategy and develop context-specific national and subnational communication action plans with participations of all stakeholders.

7.6.2.1 Mass Media Engagement

Polio awareness is critical to the successful implementation of campaigns across the country. Engagement of local mass media will adapt to the current context with its contracted media landscape and economic hardships. The following actions will be taken.

- Regularly map media to establish functional channels for media engagement and monitoring to ensure consistency in creating polio awareness at national and community level.
- Revise TV and radio engagement plan and incorporate mapped, functional channels or mass broadcasts of polio messages for nationwide and subnational campaigns. Targeted channels will be selected for case response initiatives.
- Maintain media monitoring mechanisms to ensure timely broadcast placement and reduction of broadcast drops.
- Media roundtable discussions and debates at provincial, district and village level are intensified during campaigns and outside of campaign period to engage and increase

community participation in discussions regarding their children's health and polio immunization concerns

- Key panelists involved in media round table discussions will be composed of influencers, including religious leaders, community leaders and medical experts to drive these discussions in addressing issues around polio and routine immunization.
- Implement media impact assessments for better analysis and planning to achieve the required results.
- Maintain the production of high-quality multimedia materials to increase polio knowledge and awareness and address programme challenges including missed children, refusals, rumours and misinformation, and other priorities to influence behavior change towards vaccine uptake.

7.6.2.2 Digital Media engagement and other Innovations

Social media engagement plays a critical role in creating polio awareness as well as informing and educating communities on the importance of vaccination children against polio. Strategic digital media engagement actions will include:

- Developing a social media strategy and action plan to strengthen digital approaches to increase engagement across all platforms to amplify vaccine acceptance.
- Target specific regions, especially outbreak areas and high-risk polio circulation provinces and districts with consistent messaging and engagement to increase awareness.

- Utilize various mechanisms and tools for social listening, analyze social media trends, track rumours and misinformation and design appropriate messages to counter them.
- Build the capacity of the social media cell at the National EOC and other members of Communication Working Group on better and innovative ways to increase awareness and engagement reach while at the time countering polio rumours and misinformation.
- Link social media platforms and audiences with U-Report, platform and provide a toll-free number that relays key polio messages.
- Use social media engagement to drive traffic on polio free website as the key reference point for all polio programme information and increase knowledge on polio and routine immunization.
- Maintain and regularly update polio website with information and updates, eradication strategies, success stories, achievements, challenges, and other relevant information.
- Localize website content and ensure all information is to be easily accessible in the local languages Pashto and Dari.

7.6.2.3 Crisis Communication

With poliovirus circulation in the East and the related threat of further outbreaks, crisis communication remains key. Support will continue to be provided to Regional EOCs to ensure a crisis communication response protocol is developed and implemented.

7.6.2.4 Partnerships and Advocacy Interventions

- Continue to build capacity of journalists to better understand polio and vaccines through media training and enhance their reporting skills on polio and health related issues through strengthening existing partnerships with Radio Azadi and VOA and build new partnerships with sports associations and other influential organizations to play a critical role in vaccine acceptance.
- Maintain advocacy with key decision-makers and leadership at national and provincial level and involve high level religious scholars and Islamic institutions.
- Continue to motivate dedicated journalists to produce polio stories addressing vaccine uptake issues and maintain polio eradication at the top of the news agenda.

7.6.2.5 Cross-border communication interventions

Cross-border communication initiatives with Pakistan remain critical and require strengthening to address high risk mobile population moving between the two countries. This will mainly entail coordination with the Pakistan programme along several areas:

- Synchronized communication materials for border crossing points
- Mapping and engaging media channels along the border to create polio awareness

- Use well known influencers and humanitarian actors on both sides of the border to engage mobile populations and influence towards vaccine acceptance
- Initiate social listening along the border to understand rumours and misinformation circulating and prepare for appropriate response.
- Coordinate with humanitarian actors providing essential services at the border to integrate polio information packages

7.6.3 Islamic Advisory Group (IAG) initiatives

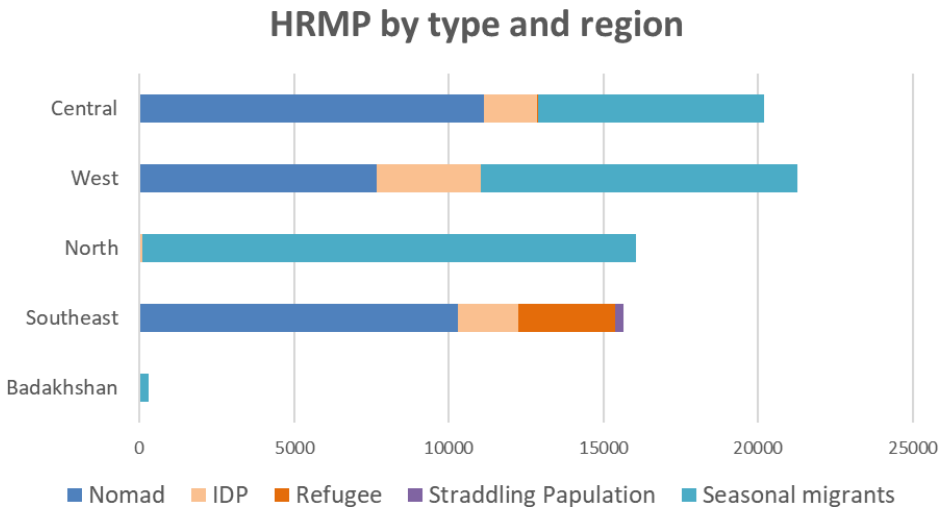
The Communication Working Group will continue to work with IAG members, religious influencers through capacity building and knowledge sharing regarding polio vaccination, routine immunization, and child health in Islam. The following interventions will be pursued:

- Continue advocacy meetings with religious leaders, scholars, and mosque imams to advocate for polio eradication, routine immunizations, and child health, raise community awareness, create demand for vaccination, and tackle refusals based on religious misconceptions.
- Work with community influencers to support SIAs and facilitate access for campaigns to reach all target children through house-to-house vaccination strategy.
- Visits to madrasas to highlight importance of vaccination and immunizations in Islamic Shariah and ensure support for polio vaccination campaigns.
- Build the capacity of National IAG provincial focal points and religious scholars on vaccination, routine immunization, and mother and child health from Islamic perspective.
- Religious scholars training on interpersonal communication skills to advocate for polio eradication and routine immunization, raise community awareness, create demand for vaccination and tackle refusals based on religious misconceptions.
- Ensure accountability and impact for religious leaders trained and engaged in the communities to influence and convert vaccine refusals
- Fatwa book will be revised, under the leadership of Islamic Emirate of Afghanistan, and will be certified by the Ministry of Haj Awqaf.
- Training of frontline workers on the Fatwa book content for informed discussions during household visits and community meetings.
- Coordination with Ministry of Religious Affairs and Ministry of Education and Higher Education
- Orientation of 2022 Sharia Faculties on polio, routine immunization and mother and child health; maintaining a data base of trained student for their further engagement to support immunization and other public health interventions,
- Dissemination of messages on importance of vaccinations, and mother and child health from Islamic perspective through information and educational communications materials and social media

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

Despite the low level of WPV-1 transmission in 2022, there is continued transmission between Afghanistan and Pakistan, evidenced by the epidemiology and genetic analysis of the isolated viruses. This highlights the continued significance of mobile populations travelling across the border and within both countries in sustaining and spreading poliovirus transmission.

Movement patterns for nomads and seasonal migrants were revalidated and mapped during the field validation of microplans carried out in some parts of the country in 2022. In total, 29,109 nomad settlements, 33,793 seasonal migrants, 3,142 refugee settlements, 7,075 IDPs were identified. The below graph provides the finding of the validation exercise:



Under the NEAP 2023, the mapping and vaccination activities for these mobile populations will the further strengthened, and National and provincial EOCs will follow the implementation of agreed strategies related to high-risk mobile populations.

In addition:

- The programme will continue to collaborate with other UN agencies, organizations, and line departments for detailed information about IDPs and will immediately plan vaccination activities in response to any significant development in dynamics of IDPs. The programme will also focus on effectively reaching IDPs during the NIDs and SNIDs and ensure that they are included in microplans and during intra-campaign supervision and monitoring.
- SNIDs will continue to include settlements of high-risk mobile populations in non-endemic and high-risk areas.

- Continuous mapping and cross border information sharing about movements of nomads will be carried out with vaccination strategies including a nomad specific campaign in the South-east and special transit teams along nomad movement routes in the South, South-east, and West.
- Cross border:
    - The programme will continue to vaccinate travelers of all age groups at Torkham cross border point with Pakistan. The programme will consider strengthening all age vaccination on at Boldak cross point at Friendship Gate.
    - Regular assessment of informal crossing points will continue at the least at quarterly frequency, and cross border vaccination teams rationalized accordingly.
    - The programme will continue vaccination at all cross-border points and international airports
    - Regular coordination with the Pakistan programme for mutual information sharing on any major population movement including returnees and refugees, and ensure preparation for vaccination on such instances
    - Vaccination of travelers as per International Health Regulations will continue for all age groups
- Returnees:
    - Through regular coordination with UNHCR, IOM and the Department of Returnees and Repatriation, the programme will monitor the flow of returnees to Afghanistan and adjust vaccination teams in UNHCR repatriation centres and IOM centres as required
    - All major congregations of returnees will be identified, and special vaccination opportunities will be provided
    - The programme will exercise all possible flexibilities while endeavoring to reach cross border resettling families during and outside the campaigns with the core aim of consistently reaching and vaccinating the children in such families.

7.8 Maintaining sensitive surveillance

Afghanistan has a well-functioning, responsive and resilient polio surveillance system with both national and local surveillance indicators consistently above global standards. In 2022, both an independent surveillance review and meeting of the Technical Advisory Group on polio eradication in Afghanistan affirmed the efficiency and sensitivity of the system. The system is comprised of health facility-based surveillance for reporting and investigating AFP cases that is supported by large-scale community-based surveillance and complemented by a network of environmental surveillance sites in epidemiologically or demographically priority areas.

The system regularly collects aggregate data for priority vaccines preventable diseases such as measles and neonatal tetanus, in line with principle of integration and eventual transition, and regularly coordinates its activities with the Pakistan polio eradication programme because of the shared epidemiological block and the testing of specimens at the polio laboratory in Pakistan.

The system's internal monitoring ensures continuous review and, where necessary, the expansion of the network including in health facilities, among community-based volunteers, and the network of environmental surveillance sites. As a result, the number of health facilities in the system increased from 3,040 in 2021 to 3,058 in 2022, and active surveillance sites increased from 1,827 to 1,844. The AFP network expanded from 45,066 volunteers in 2021 to 45,994 in 2022. Following the independent international surveillance review, the number of environmental surveillance sites increased from 26 in 2021 to 32 in 2022 including six new ad hoc sites. Sample collection frequency continued bimonthly in 2022, with the aim of increasing isolation of the virus in the environment.

The Afghanistan programme continues to implement the recommendations of the surveillance review. The recommendations are structured in a quantitative manner for uniformity of tracking. The programme continues to conduct internal surveillance reviews on an annual basis targeting high-risk regions and provinces.

Strategic Priorities in 2023

The programme has identified the key priority areas for surveillance and will develop its surveillance strategy in accordance with the 2022 international surveillance review ad TAG recommendations. To sustain and further improve surveillance sensitivity and quality, the programme will:

1. Continued, comprehensive review of existing environmental surveillance and expansion in consultation with Hub, EMRO.
2. Strengthen cross border coordination with Pakistan on surveillance activities, particularly the timely measures of cross notified AFP cases.

3. Modify surveillance guidelines, tools, and databases in consultation with Hub and EMRO to further improve efficiency and sensitivity of the system.
4. Enhance capacity building, improve knowledge and skills of all surveillance officers, supervisors, and AFP focal points.
5. Prioritize expansion of reporting sites both in public and private sectors and review of reporting volunteers. The analysis will be based on patients' health seeking behavior, patient turn over, newly opened health facilities and the past trends of contacts missing cases.
6. Establish sentinel site for provision of nerve conduction study machine to government tertiary care facility. The programme will seek guidance on this from National Expert Review Committee.
7. Development of risk assessment tool by the revitalized Rapid Response Team with triangulation of SIA and EPI data.
8. Continued special focus on gender balance in surveillance team.

7.9 Re-establishment of NEOC Call Centre

The call centre at the NEOC will be re-established to facilitate community listening, feedback, community education and awareness. The center will provide the platform for telephonic queries and complaints about polio eradication to be addressed in a timely manner. Likewise, it will deliver accurate information about the benefits of vaccines for polio and other vaccine-preventable diseases to target audiences through telephone conversations, text and voice messages to promote vaccine

acceptance in the community. The centre will focus on low performing areas or communities, and conduct remote monitoring of SIA activities in pre, intra and post campaign phases with frontline staff as well as with community members. Data will be analysed and reported to all stakeholders for followup and recommendations.

The NEOC call centre will work closely with the Ministry of Communication, Information and Technology/ATRA to activate a toll-free short code number or hotline accessible to subscribers of all telecommunication companies. In addition, an MOU between MoPH/NEOC and MCIT/ ATRA will be signed so that active phone numbers of communities residing in target areas should be provide to the call centres.

The call centre will be managed by the Call Center Supervisor who will oversee an initial team comprising of one Islamic scholar, five male and five female agents, as well as one national data analyst. The initial team of 11 staff will be expanded to 13 once the centre is established. Staff will be recruited through an open competitive process.

8. Enhancing EPI/PEI convergence in high-risk districts

The programme will continue to mutually collaborate with EPI in the areas at high risk of vaccine preventable disease transmission. The approaches initiated in 2020 and continued over the following years will be further enhanced in 2023 to promote the EPI – PEI convergence, mainly focusing on high risk and difficult to reach areas and populations.

Under Gavi HSS4, the programme will collaborate with EPI in the following ways:

- the polio team will support EPI with data management during SIAs, whereas the EPI team will share data on EPI administrative coverage,
- subnational polio officers will support provincial and health facility officers to better monitor the daily work of EPI and to strengthen microplanning,
- polio staff will increase the breadth of monitoring routine immunization at health facilities by reviewing cold chain records, vaccine safety and waste disposal and implementation of outreach sessions
- the AFP surveillance system will support strengthening AFR surveillance to ensure more complete detection and investigation of cases including sample collection and transport to laboratory.

In 150 priority districts three Multi Antigen Acceleration Campaigns will be conducted to provide a quick catchup. These vulnerable districts, many of them in previously insecure areas will require longer term investment and are also targeted for additional vaccinators and facility upgrades.

In 2023, the National EPI plans to continue enhancing routine and polio immunization coverage among children through focused strategies and interventions. The National EPI and Polio EOC will jointly plan and implement the following:

- Multiantigen acceleration campaigns focused on high-risk districts based on an EPI gap analysis that is heavily weighted for polio risk. Districts targeted include those around Kandahar city.
- Overall acceleration of routine immunization in all areas of the country, with emphasis on areas and populations having a high number of children who have not yet received the first Penta dose
- Continued PEI-EPI collaboration and field convergence to support the monitoring of routine immunization in the health facilities and outreach
- Monthly reporting, referral, and follow-up of zero-dose children between PEI and EPI across the country
- Use polio resources including the surveillance network for other vaccine preventable disease surveillance specially to strengthen the Acute Fever Rash surveillance to detect measles cases
- Develop aligned communication strategy that cover PEI and EPI services to enhance demand creation for all vaccines offered by the Afghanistan National EPI.

The key objective include:

- Providing all routine immunization vaccines to unvaccinated children aged less than 24 months
- Providing measles vaccine to children aged 9-59 months and OPV to children aged 0-59 months during required SIAs
- Ensure that zero dose children are reached in under-performing districts in 2023
- Ensure vaccine, immunization, and injection safety
- Improve and strengthen vaccine-management systems
- Expand vaccination beyond the traditional target groups, based on risk and considering operational feasibility.
- Increase community demand for immunization and provide integrated service delivery with information, education, communication, and social mobilization.
- Evaluate special immunization activities and strengthen national immunization programmes.

Continuation of supply and monitoring of OPV vaccine for children under 5 years in 34 provinces

The National EPI will continue supplying OPV for children aged less than five years nationally across all health facilities in 2023. This is expected to help boosting the population immunity against polio.

The current polio support to EPI will be maintained by WHO and UNICEF polio staff, spending 20% of their time supporting EPI.

There will be further focus on strengthening:

- Supportive supervision and monitoring of EPI with focus on outreach and mobile sessions
- Support in improving of EPI microplans
- Collated findings with basic analysis of polio staff monitoring, including zero dose AFP cases data, will be regularly shared with the National EPI as well as with NGOs, Grant and Service Contracts Management Unit and Programme Management Unit for planning and intervention (see annex).
- BPHS NGOs and PEMTs are expected to share information on actions taken for issues identified by the polio program.
- Systematic engagement of Immunization and Communication Network in creating demand for vaccination,

Coordination between BPHS NGOs, polio eradication partners and PEMT/REMTs will be enhanced using the EOCs.

9. Effective vaccine management and cold chain operations for PEI

In 2022, the programme ensured 100% availability of all polio vaccines for polio eradication activities, using bOPV for all nine SIAs. Vaccine wastage rate was on average 13.4% during the year.

In 2023, the programme will prioritize the following interventions:

- On quarterly basis review and update vaccine forecasting in accordance with recommendations and schedules of SIAs. This will be implemented in staggered manner to avoid overstocking and manage vaccine storage space availability.
- Ensure timely supply of vaccine to support SIA schedule and all other activities including outbreak response and integrated services.

- Facilitate timely delivery of offshore vaccines and in-country distribution to the regional cold chain hubs, in coordination with supply division, national and provincial EPI teams.
- Ensure basic vaccine and cold chain management trainings at all levels and regular monitoring of stocks.
- Strengthen and facilitate vaccine management at subnational cold chain stores and regular and timely reports on vaccine utilization and leftovers.
- Ensure accountability for non-routine vaccines (mOPV2, nOPV2, and tOPV) if used in a timely manner. This will include implementation of standard operation procedures related to safe storage, disposal, and accountability.
- Facilitate introduction of nOPV2 by providing necessary logistics management tools, procedures, terms of reference, guidelines and appropriate training on vaccine handling, management, and accountability.
- Ensure quarterly update of active and passive cold chain equipment and monthly vaccine stock inventories.

10. Monitoring

The NEAP 2023 will regularly assess implementation of strategies and take immediate corrective measures, identifying challenges and bottlenecks, facilitating resolution of the same so that the programme leadership and the other oversight bodies are given an early indication of the progress or gaps in achievement of the programme objectives. The National EOC will ensure systematic use of key performance indicators to inform strategic and operational interventions respectively.

The key areas that will be prioritized for the ongoing monitoring of actions in the plan include:

Ensuring every child under the age of 5 years is reached with OPV every time with zero tolerance for poor performance

- Selection of appropriate polio health workers at the forefront as per approved guidelines and training as per the revised training module
- Revising and updating micro plans and conducting both desk and field validation prior to each campaign
- Conducting intra-campaign monitoring with focus on expeditious resolution of identified issues
- Emphasis on monitoring revisits by vaccination teams
- The GPEI considers LQAS as the gold standard for assessing the quality of SIAs and track trends in SIA quality hence LQAS will be conducted in all areas irrespective of campaign modality
- Investigating all LQAS failed lots and ensuring corrective actions and remedial measures

Detecting every poliovirus transmission chain in a timely manner through

- Weekly data review at national and sub-national levels

- Maintain the high standards of both AFP and environmental surveillance
- Expand the environmental surveillance sites where possible
- Conduct annual refresher training for provincial and district polio officers as well as sensitization of the reporting network
- Enhance surveillance supportive supervisory visits by national, regional, and provincial levels
- Conduct internal AFP surveillance reviews on a regular basis
- Using the new web-based Information for Action system for surveillance data management and use

Improving data processes and systems

- Credible and timely SIA data (sex disaggregated) is essential for assessing risks and guiding improvements in the programme. Existing deficiencies greatly impede the ability to improve quality. Increase accountability at all levels to ensure that all SIA data shared is valid, timely and complete (e.g., timely sharing of administrative data).
- Conduct rigorous and regular data audits - both internal and external - to ensure programme data is reliable and decisions based on this data are objective

Ensuring that communication and community engagement strategies are yielding impactful results

- Ensure shifts in communication strategies result in improvement of community mobilization and trust in the areas where house to house strategy is implemented
- Assess the impact of the revamped communication and community engagement strategies on the refusal situation in the South, South-east and East regions
- Document the effectiveness and utilization of mass media and social media – in addressing emerging issues from messages circulating in mass and social media
- Ensure the program is developing context specific and evidence-based communication approaches and information and educational communications materials

Providing support to and improving the coordination with EPI program

- Joint planning and implementation of routine immunization outreach sessions
- Supportive supervision and monitoring of Routine Immunization sessions at fixed, and outreach sites, mobile teams by EPI and PEI staff both jointly and independently. Rapid coverage assessments in the catchment areas of fixed and outreach sites are also done by the PEI field staff.
- Sharing the line list of all Routine Immunization zero-dose children identified through AFP surveillance on weekly basis with the EPI team
- Sharing of monitoring report and feedback with PEMTs, relevant NGO and National EPI in a timely manner

10.1 SIAs monitoring

- Monitoring of SIA informs the programme on the quality of campaign and identifies gaps in management, service delivery and training that should be corrected immediately and plan interventions for future rounds. Special focus will be to understand the reasons for missing recoverable absent children during revisits, and reasons for underperformance of vaccination teams.
- An important approach among the several mechanisms of campaign monitoring is to continue deployment of national monitors to support the SIA activities in high-risk districts and provinces during every campaign in all three phases (pre, intra and post). National monitors complement the regional and provincial level monitoring activities in addition to providing capacity building and providing national level oversight in all phases of campaign implementation.
- Monitoring SIA activities helps in generating quality data which is used at local and national levels for taking rapid corrective action and planning future remedial measures.
- Sharing data on daily basis is very important and critical to enable programmes make decisions based on evidence and on time

Pre-campaign phase

- Frontline worker selection as per the SIA guideline criteria
- All efforts to ensure that team composition is as per SIA minimum standards and both vaccination team members are local and trained, at least one team member is literate, and female.
- The programme will strengthen accountability of frontline staff through regular performance-based review and will take necessary actions which will include removals based on objective documented criteria
- The programme will endeavor to increase the proportion of female supervisors, vaccinators, social mobilizer, monitors and mid-level managers. The National EOC will also ensure an enabling environment for recruiting and sustaining women workers at all levels. This activity will be closely monitored, and the progress tracked
- Training frontline staff using the standard training curriculum
- Monitoring of training of frontline staff will be conducted to improve the quality of the training and ensure that participants have received the necessary knowledge and skills
- National EOC will provide direct oversight on the functioning of training committees in high-risk provinces and ensuring their effectiveness

- Provincial and regional team members (program staff) to facilitate the training of frontline staff in all high-risk districts.
- All (100%) cluster supervisors and volunteers' training sessions should be monitored in high-risk districts. Volunteer's trainings in medium risk (60%) and low risk districts (25%) (SIA minimum standards) should be monitored by district, provincial, regional, and national PEI team members.
- Training monitoring data should be effectively used to take corrective actions.
- Successful implementation of SIAs requires meticulous microplanning at district, cluster, and team levels.
    - Revision and updating microplans to be ensured before each campaign through field validation exercise by all district coordinators and cluster supervisors and this should be ensured during the monitoring visits by national team
    - National, regional, and provincial programme staff will validate the micro plans through desk review and field validation particularly in high-risk districts based on SoPs for microplan validation. For instance, during field validation, the monitor will verify the start and end points of a team's daily work plan, inclusion of kindergartens, primary schools, madrassah, mosques, important landmarks, boundaries, fixed vaccination site and transit points etc.
    - In addition, key components of microplanning such as team, supervisor and coordinator workload will be tracked for each campaign.

- Key components in the micro plan that need to be examined include the following:
  - ✓ List of all villages and settlements including target population
  - ✓ High risk mobile population such as nomads, IDPs, returnee refugees, and straddling population
  - ✓ Team and supervisor maps and itineraries (with clear description of day wise area to be covered and route maps with clearly defined boundaries with adjacent team and supervisor areas)
  - ✓ List of high-risk areas (for example, where WPV-1, cVDPV2 cases have been reported, areas with positive environmental samples)
  - ✓ A list of special sites (for example: brick kilns, hotels, kindergartens, madrassah) and plans to cover them
  - ✓ Cold Chain, vaccine, logistics distribution plan
  - ✓ Social data (for example: C4D data) and findings of gender analysis
  - ✓ Social Mobilization and communication plan

Intra-campaign phase

- Good quality monitoring should be able to locate unvaccinated children for follow-up and identify management and operational issues that need immediate correction.
- The intra campaign monitoring will aim to provide real-time information and opportunities for local corrections.
- Intra campaign monitoring will assess whether areas are properly covered, identify missed children (if any) and the reasons for the same, supervisor and team performance, FLW workload of frontline staff, quality of daily and 5th day revisits, cold chain, and vaccine management; take immediate corrective actions.
- Intra campaign monitoring will ensure that their findings are shared during evening meetings and poorly covered and missed areas identified are recovered the next day.

Post campaign phase

- The outcome monitoring following SIA campaign includes post campaign monitoring, Lots Quality Assurance Survey (LQAS) and out-of-house finger mark survey conducted to assess the coverage and quality of the vaccination activity, to identify missed or poorly covered areas, reasons for missed children, and take immediate and future corrective actions (for example: recovering missed area; vaccinating missed children; improving microplanning for the next round, particularly missed areas; replacing inappropriately selected teams and supervisors).
- LQAS will be conducted in all areas of the country irrespective of the modality of campaigns as it is increasingly important to assess the quality of campaigns and effectively address the same. Following the TAG in October 2022 the scope of LQAS was expanded to include all districts in the country.

- To improve the reliability of post campaign monitoring and LQAS the program will continue to validate the monitoring and LQAS for data quality assurance and to identify poor performing clusters and lots for corrective interventions.
- The program will continue to conduct joint investigation of the failed lots by a team comprising representatives from WHO, MoPH, UNICEF and other partner organizations at the provincial level. The investigation aims to identify the root causes of missing children, act by recovering the area and planning remedial action. The national team will investigate lots that fail more than two times in successive campaigns.
- Financial accountability will be exercised with zero tolerance for any misappropriation.

Third party monitoring

Campaign monitoring is subject to bias if conducted by supervisors and other people directly involved in the campaign. Monitoring is less biased when performed by independent and third party monitors. They provide an objective independent source of timely and reliable quantitative data for each campaign:

- to identify why children are missed to guide future action
- to spot problems with implementation and guide corrective measures

In LQAS and post campaign monitoring, third party monitors chiefly deployed include university students, teachers, NGO staff or private sector health workers who are not directly involved in the implementation of polio campaign. It should be ensured that the monitors speak the language of the community and have been properly trained.

- In all areas of the country, post campaign monitoring will be conducted house-to-house irrespective of the modality of campaign as it precisely identifies missed children and direct teams to missed houses and areas; documents information on reasons for missed children and refusals; and reduces bias by random selection of areas.

10.2. Improving data systems

Afghanistan Polio Information Management System (APIMS), an online data collection, collation and analysis tool including polio dashboards has been developed to improve the efficiency of data management and utilization in the country. It is estimated that the APIMS development will be completed and implemented in the East by the end of March 2023 and then rolled out across the country.

In addition to speeding up data compilation and analysis, the system will also simplify and standardize data collection and collation processes at various levels. Once APIMS is fully functional, the programme anticipates several data related issues will be resolved including timeliness and utilization of data.

The programme will conduct capacity building exercises for regional and provincial data staff but will continue to implement validation mechanisms to ensure data quality and completeness. The programme will have no tolerance for any negligence or falsification of data.

10.3. NEAP monitoring

The Core Group at the National EOC will be overall responsible for implementation of NEAP. Technical working groups will conduct a quarterly review of NEAP workplan implementation status and report to the Core Group for any course correction or strategy modification. The review process will particularly focus on:

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

A similar review mechanism will also be adopted at sub-national level EOCs and at provincial headquarters. National EOC will continue to participate in reviews carried out in East, South and other regions, and provinces.

Given the high risk of reinfection and importation of polioviruses in the South and regions, the National, Regional and Provincial EOCs will jointly monitor the progress in the region, preferably each month. The regional EOC will regularly share the status of progress and their findings with the working groups of National EOC.

A regular review of the NEAP implementation status and effectiveness of strategies will be carried, and necessary corrections and adjustments will be made, as needed.

10.4 Monitoring and Evaluation of communication and ISD activities

The overall guiding principles for monitoring and evaluation of planned immunization and surveillance activities for polio eradication include improved quality of all polio eradication activities including campaigns, AFP Surveillance, communication, community engagement, and routine immunization.

- improved quality of all polio eradication activities including campaigns, AFP surveillance, communication, community engagement, and routine immunization
- Increased programmatic access and reach with a focus on continuously missed children in high-risk areas

- Provision of timely and quality information, including spatial analysis, for decision making.
- Documentation of the polio eradication activities and lesson learnt
- To determine if the interventions were effective and improved the situation, conduct effectiveness evaluations and studies

Priority activities to improve quality of immunization services particularly scheduled SIA activities, communication and social mobilization, and special rounds targeting cVDPV2 outbreaks will be monitored or evaluated as follows:

For Communication and community engagement

- Analysis and feedback from local assessments and exit interviews.
- Trend of reported and converted refusals by SIAs implemented during 2023.
- Supportive supervision, including concurrent monitoring, using real time data collection on the Open Data Kit platform.
- KAP surveys and mapping of community influencers
- Solicit feedback via tools including in-person questionnaires at service points, group discussions, telephone surveys from caregivers and polio health workers at the forefront on the reach and uptake of polio vaccinations.
- Media monitoring
- Collect data on communication and community engagement on monthly basis using standard template to enable programs understand the situation and make evidence-based decisions.

For Vaccine management and cold chain operations

- Vaccination utilization including wastage rate.
- Monitoring of vaccine and cold chain management

For Integrated services

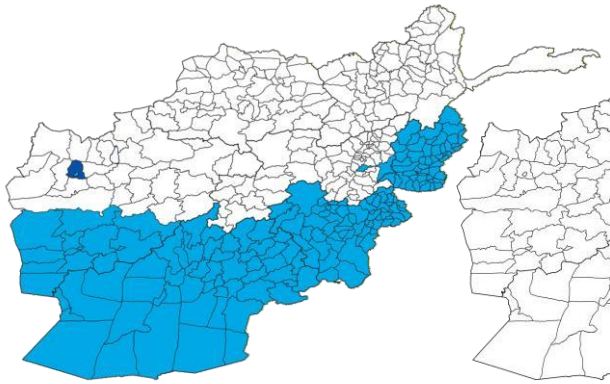
- Spot checks
- Supportive supervision and monitoring of routine immunization services by PEI staff.

11. Annexures

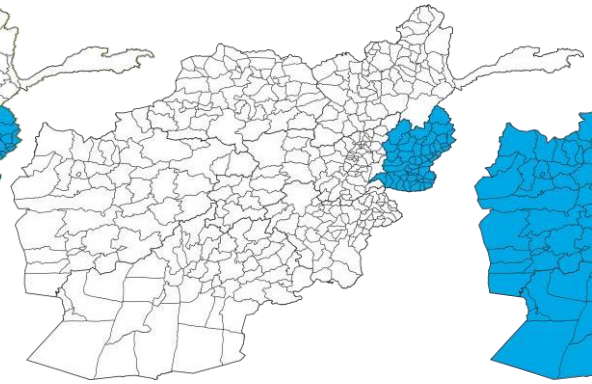
Annexure I:	NEAP 2023 work-plan *(to be finalized after NEAP finalization)*
Annexure II:	SIAs plan 2023
Annexure III:	List of High, Medium, and Low risk districts (Risk Categorization)
Annexure IV:	Minimum standards for SIAs
Annexure V:	Integrated services plan review, 2023
Annexure VI:	SOPs – Support of PEI staff on monitoring of routine immunization
Annexure VI:	Strategy document: Reaching Zero Polio in Afghanistan

Proposed SIA calendar for 2023

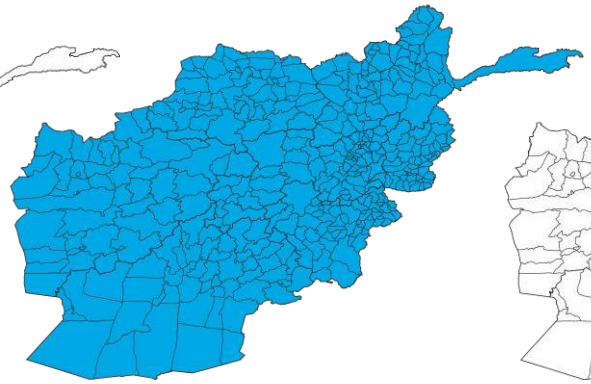
23-26 Jan SNID



20-23 Feb East intensification



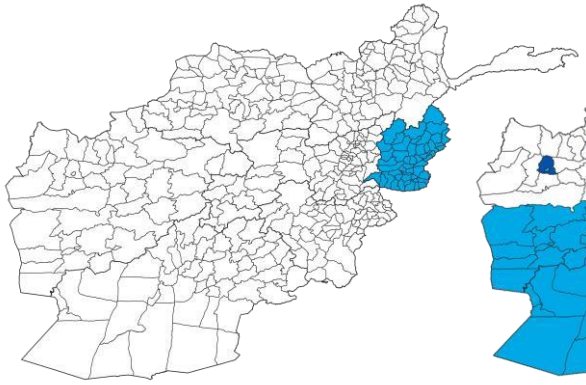
13-15 Mar NID



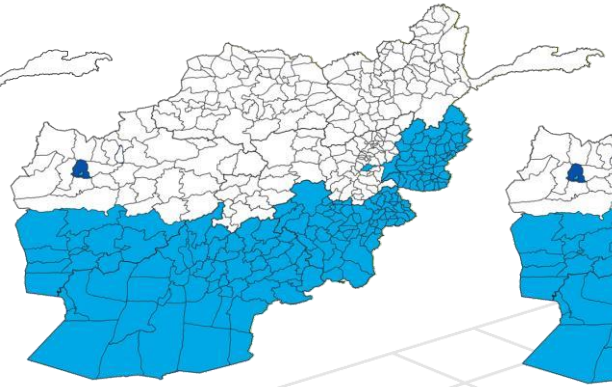
(TBD) Apr East intensification

15-18 May SNID

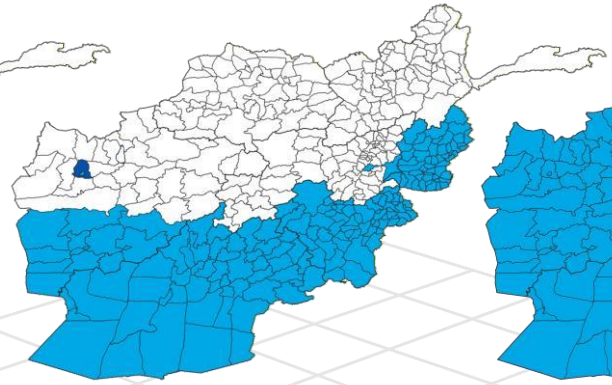
12-15 Jun East intensification



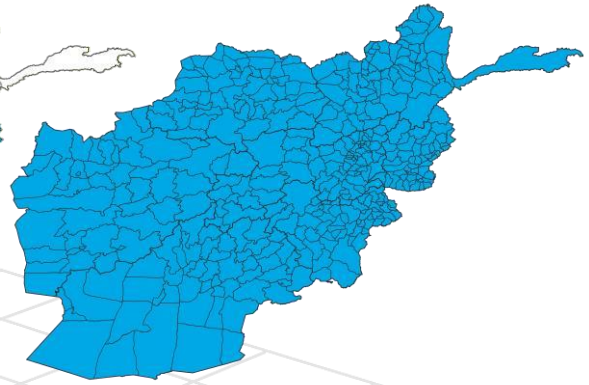
Jul SNID



Oct SNID



Nov NID



Full district | Partial district (IDP/HRMP)

bOPV SIAs schedule for second half of 2023 will be reviewed in end-May/early June 2023, for necessary adjustments as per the epidemiology

Case response strategy will be implemented in conjunction with SIAs schedule. Changes to vaccine type may be done in case type 2 incident is reported.

Annex II: List of high-risk, medium-risk and low-risk districts

REGION	PROVINCE	DISTRICT	Dcode	Risk Categorization 2023
Central	KABUL	KABUL	101	High
East	KUNAR	SHIGAL WA SHELTAN	1306	High
East	KUNAR	ASADABAD	1301	High
East	NANGARHAR	JALALABAD	601	High
East	NANGARHAR	ACHIN	617	High
East	NANGARHAR	MUHMAND DARA	619	High
East	NANGARHAR	BEHSUD	602	High
East	NANGARHAR	BATIKOT	615	High
Northeast	KUNDUZ	EMAMSAHEB	1702	High
South	HILMAND	NAWZAD	3207	High
South	HILMAND	NAWA-E-BARAKZAIY	3204	High
South	HILMAND	SANGIN	3205	High
South	HILMAND	LASHKARGAH	3201	High
South	HILMAND	WASHER	3208	High
South	HILMAND	NAHR-E-SARAJ	3202	High
South	HILMAND	REG	3212	High
South	HILMAND	NAD-E-ALI	3203	High
South	HILMAND	GARMSER	3209	High
South	KANDAHAR	SHAHWALIKOT	3306	High
South	KANDAHAR	ARGHANDAB (K)	3302	High
South	KANDAHAR	GHORAK	3315	High
South	KANDAHAR	ZHERAY	3303	High
South	KANDAHAR	DAMAN	3305	High
South	KANDAHAR	PANJWAYI	3304	High
South	KANDAHAR	MAYWAND	3308	High
South	KANDAHAR	KANDAHAR	3301	High
South	KANDAHAR	SPINBOLDAK	3311	High
South	NIMROZ	KHASHROD	3405	High
South	URUZGAN	KHASURUZGAN	2305	High
South	URUZGAN	SHAHID-E-HASSAS	2303	High
South	URUZGAN	CHORA	2302	High
South	URUZGAN	DEHRAWUD	2304	High
South	URUZGAN	TIRINKOT	2301	High
South	ZABUL	DAYCHOPAN	2408	High
South	ZABUL	SHOMULZAY	2410	High
South	ZABUL	KAKAR	2407	High
South	ZABUL	ARGHANDAB (Z)	2402	High
South	ZABUL	MIZAN	2403	High
South	ZABUL	TARNAK WA JALDAK	2404	High
South	ZABUL	QALAT	2401	High
Southeast	GHAZNI	ANDAR	1105	High
Southeast	PAKTIKA	BERMEL	2515	High

West	FARAH	BALABULUK	3103	High
West	FARAH	BAKWA	3102	High
West	FARAH	ANARDARA	3111	High
West	HIRAT	SHINDAND	3015	High

REGION	PROVINCE	DISTRICT	Dcode	Risk Categorization 2023
East	KUNAR	GHAZIABAD	1312	Medium
East	KUNAR	BARKUNAR	1311	Medium
East	KUNAR	WATAPUR	1302	Medium
East	KUNAR	DARA-E-PECH	1307	Medium
East	KUNAR	CHAPADARA	1313	Medium
East	KUNAR	NARANG	1303	Medium
East	LAGHMAN	MEHTARLAM	701	Medium
East	NANGARHAR	LALPUR	620	Medium
East	NURISTAN	PORUNS	1401	Medium
North	SAR-E-PUL	KOHESTANAT	2003	Medium
Northeast	BAGHLAN	PUL-E- KHUMRI	901	Medium
Northeast	KUNDUZ	ALIABAD	1705	Medium
Northeast	KUNDUZ	KUNDUZ	1701	Medium
Northeast	KUNDUZ	DASHT-E-ARCHI	1707	Medium
Northeast	KUNDUZ	QALA-E-ZAL	1703	Medium
Northeast	KUNDUZ	CHARDARAH	1704	Medium
Northeast	KUNDUZ	KHANABAD	1706	Medium
Northeast	TAKHAR	YANGI QALA	1611	Medium
Northeast	TAKHAR	TALOQAN	1601	Medium
Northeast	TAKHAR	KHWAJABAHAWUDDIN	1612	Medium
Northeast	TAKHAR	KHWAJAGHAR	1614	Medium
Northeast	TAKHAR	ESHKASHEM	1615	Medium
Northeast	TAKHAR	FARKHAR	1607	Medium
South	HILMAND	BAGHRAN	3211	Medium
South	HILMAND	MUSAQALAH	3206	Medium
South	HILMAND	DEH-E-SHU	3213	Medium
South	HILMAND	KAJAKI	3210	Medium
South	KANDAHAR	KHAKREZ	3307	Medium
South	KANDAHAR	NESH	3314	Medium
South	KANDAHAR	MIYANSHIN	3313	Medium
South	KANDAHAR	SHORABAK	3310	Medium
South	KANDAHAR	MARUF	3316	Medium
South	KANDAHAR	ARGHESTAN	3312	Medium
South	ZABUL	NAWBAHAR	2411	Medium
South	ZABUL	SHINKAY	2405	Medium
South	ZABUL	SHAHJOY	2406	Medium
South	ZABUL	ATGHAR	2409	Medium
Southeast	GHAZNI	DEHYAK	1106	Medium
Southeast	GHAZNI	NAWA	1119	Medium

Southeast	GHAZNI	ZANAKHAN	1107	Medium
Southeast	GHAZNI	RASHIDAN	1108	Medium
Southeast	GHAZNI	WALIMUHAMMAD-E- SHAH	1103	Medium
Southeast	GHAZNI	WAGHAZ	1104	Medium
Southeast	GHAZNI	QARABAGH	1110	Medium
Southeast	GHAZNI	GIRO	1111	Medium
Southeast	GHAZNI	MUQUR	1114	Medium
Southeast	GHAZNI	GELAN	1118	Medium
Southeast	GHAZNI	ABBAND	1115	Medium
Southeast	GHAZNI	KHWAJAUMARI	1102	Medium
Southeast	KHOST	KHOST(MATUN)	2601	Medium
Southeast	PAKTIKA	SAROBI	2509	Medium
Southeast	PAKTIKA	DILA	2518	Medium
Southeast	PAKTIKA	NAKA	2511	Medium
West	BADGHIS	JAWAND	2905	Medium
West	BADGHIS	QADIS	2904	Medium
West	FARAH	PURCHAMAN	3110	Medium
West	FARAH	GULESTAN	3109	Medium
West	FARAH	PUSHTROD	3105	Medium
West	FARAH	SHIBKOH	3107	Medium
West	FARAH	FARAH	3101	Medium
West	FARAH	QALA-E-KAH	3106	Medium
West	FARAH	KHAK-E-SAFED	3104	Medium
West	FARAH	LASH-E-JUWAYN	3108	Medium
West	HIRAT	HERAT	3001	Medium
West	HIRAT	PASHTUNZARGHUN	3006	Medium

REGION	PROVINCE	DISTRICT	Dcode	Risk Categorization 2023
Badakhshan	BADAKHSHAN	KOFAB	1516	Low
Badakhshan	BADAKHSHAN	WAKHAN	1528	Low
Badakhshan	BADAKHSHAN	ESHKMESH	1523	Low
Badakhshan	BADAKHSHAN	TAGAB	1519	Low
Badakhshan	BADAKHSHAN	KESHEM	1518	Low
Badakhshan	BADAKHSHAN	YAMGAN	1520	Low
Badakhshan	BADAKHSHAN	KORAN WA MONJAN	1526	Low
Badakhshan	BADAKHSHAN	SHAHR-E-BUZORG	1508	Low
Badakhshan	BADAKHSHAN	YAWAN	1507	Low
Badakhshan	BADAKHSHAN	KHWAHAN	1517	Low
Badakhshan	BADAKHSHAN	YAFTAL-E-SUFLA	1502	Low
Badakhshan	BADAKHSHAN	KOHESTAN	1505	Low
Badakhshan	BADAKHSHAN	SHAKI	1525	Low
Badakhshan	BADAKHSHAN	DARWAZ	1524	Low
Badakhshan	BADAKHSHAN	BAHARAK	1512	Low
Badakhshan	BADAKHSHAN	ZEBAK	1527	Low
Badakhshan	BADAKHSHAN	JORM	1521	Low

Badakhshan	BADAKHSHAN	RAGHESTAN	1506	Low
Badakhshan	BADAKHSHAN	WARDUJ	1522	Low
Badakhshan	BADAKHSHAN	DARWAZ-E-BALLA	1515	Low
Badakhshan	BADAKHSHAN	TESHKAN	1509	Low
Badakhshan	BADAKHSHAN	DARAYEM	1510	Low
Badakhshan	BADAKHSHAN	ARGHANJKHWA	1504	Low
Badakhshan	BADAKHSHAN	SHIGHNAN	1514	Low
Badakhshan	BADAKHSHAN	ARGO	1503	Low
Badakhshan	BADAKHSHAN	FAYZABAD	1501	Low
Badakhshan	BADAKHSHAN	SHUHADA	1513	Low
Badakhshan	BADAKHSHAN	KHASH	1511	Low
Central	BAMYAN	KAHMARD	1006	Low
Central	BAMYAN	YAKAWLANG	1003	Low
Central	BAMYAN	SAYGHAN	1002	Low
Central	BAMYAN	BAMYAN	1001	Low
Central	BAMYAN	PANJAB	1004	Low
Central	BAMYAN	WARAS	1007	Low
Central	BAMYAN	SHIBAR	1005	Low
Central	DAYKUNDI	MIRAMOR	2209	Low
Central	DAYKUNDI	SHAHRESTAN	2206	Low
Central	DAYKUNDI	SANG-E-TAKHT	2207	Low
Central	DAYKUNDI	KAJRAN	2208	Low
Central	DAYKUNDI	KITI	2204	Low
Central	DAYKUNDI	KHADIR	2203	Low
Central	DAYKUNDI	GIZAB	2205	Low
Central	DAYKUNDI	ASHTARLAY	2202	Low
Central	DAYKUNDI	NILI	2201	Low
Central	KABUL	ESTALEF	114	Low
Central	KABUL	QARABAGH	108	Low
Central	KABUL	FARZA	115	Low
Central	KABUL	GULDARA	111	Low
Central	KABUL	SHAKARDARA	103	Low
Central	KABUL	MIRBACHAKOT	110	Low
Central	KABUL	KALAKAN	109	Low
Central	KABUL	DEHSABZ	102	Low
Central	KABUL	BAGRAMI	107	Low
Central	KABUL	MUSAYI	106	Low
Central	KABUL	CHAHARASYAB	105	Low
Central	KABUL	PAGHMAN	104	Low
Central	KABUL	SUROBI	113	Low
Central	KABUL	KHAK-E- JABBAR	112	Low
Central	KAPISA	NEJRAB	202	Low
Central	KAPISA	TAGAB	205	Low
Central	KAPISA	KOHBAND	203	Low
Central	KAPISA	MAHMUD-E- RAQI	201	Low
Central	KAPISA	HISA-E- AWAL-E- KOHE	207	Low
Central	KAPISA	HISA-E- DUWUM-E- KOH	204	Low

Central	KAPISA	ALASAY	206	Low
Central	LOGAR	BARAKIBARAK	504	Low
Central	LOGAR	CHARKH	505	Low
Central	LOGAR	KHOSHI	502	Low
Central	LOGAR	AZRA	507	Low
Central	LOGAR	KHARWAR	506	Low
Central	LOGAR	MOHAMMADAGHA	503	Low
Central	LOGAR	PUL-E- ALAM	501	Low
Central	PANJSHER	RUKHA	803	Low
Central	PANJSHER	KHENJ (HES-E- AWAL)	805	Low
Central	PANJSHER	PARYAN	807	Low
Central	PANJSHER	SHUTUL	802	Low
Central	PANJSHER	DARA	804	Low
Central	PANJSHER	ONABA(ANAWA)	806	Low
Central	PANJSHER	BAZARAK	801	Low
Central	PARWAN	JABALUSSARAJ	302	Low
Central	PARWAN	SAYDKHEL	305	Low
Central	PARWAN	BAGRAM	304	Low
Central	PARWAN	KOH-E- SAFI	308	Low
Central	PARWAN	CHARIKAR	301	Low
Central	PARWAN	SURKH-E- PARSA	310	Low
Central	PARWAN	SALANG	306	Low
Central	PARWAN	SHINWARI	303	Low
Central	PARWAN	SHEKHALI	309	Low
Central	PARWAN	GHORBAND	307	Low
Central	WARDAK	SAYDABAD	407	Low
Central	WARDAK	HESA-E- AWAL-E- BEHS	404	Low
Central	WARDAK	NERKH	403	Low
Central	WARDAK	DAYMIRDAD	405	Low
Central	WARDAK	MARKAZ-E-BEHSUD	408	Low
Central	WARDAK	JAGHATU	409	Low
Central	WARDAK	JALREZ	402	Low
Central	WARDAK	MAYDANSHAHR	401	Low
Central	WARDAK	CHAK	406	Low
East	KUNAR	DANGAM	1310	Low
East	KUNAR	MARAWARA	1305	Low
East	KUNAR	CHAWKAY	1308	Low
East	KUNAR	SARKANI	1304	Low
East	KUNAR	KHASKUNAR	1309	Low
East	KUNAR	NURGAL	1314	Low
East	KUNAR	NARI	1315	Low
East	LAGHMAN	ALISHANG	702	Low
East	LAGHMAN	ALINGAR	704	Low
East	LAGHMAN	DAWLATSHAH	705	Low
East	LAGHMAN	QARGHAYI	703	Low
East	NANGARHAR	SHINWAR	618	Low
East	NANGARHAR	KUZKUNAR	608	Low

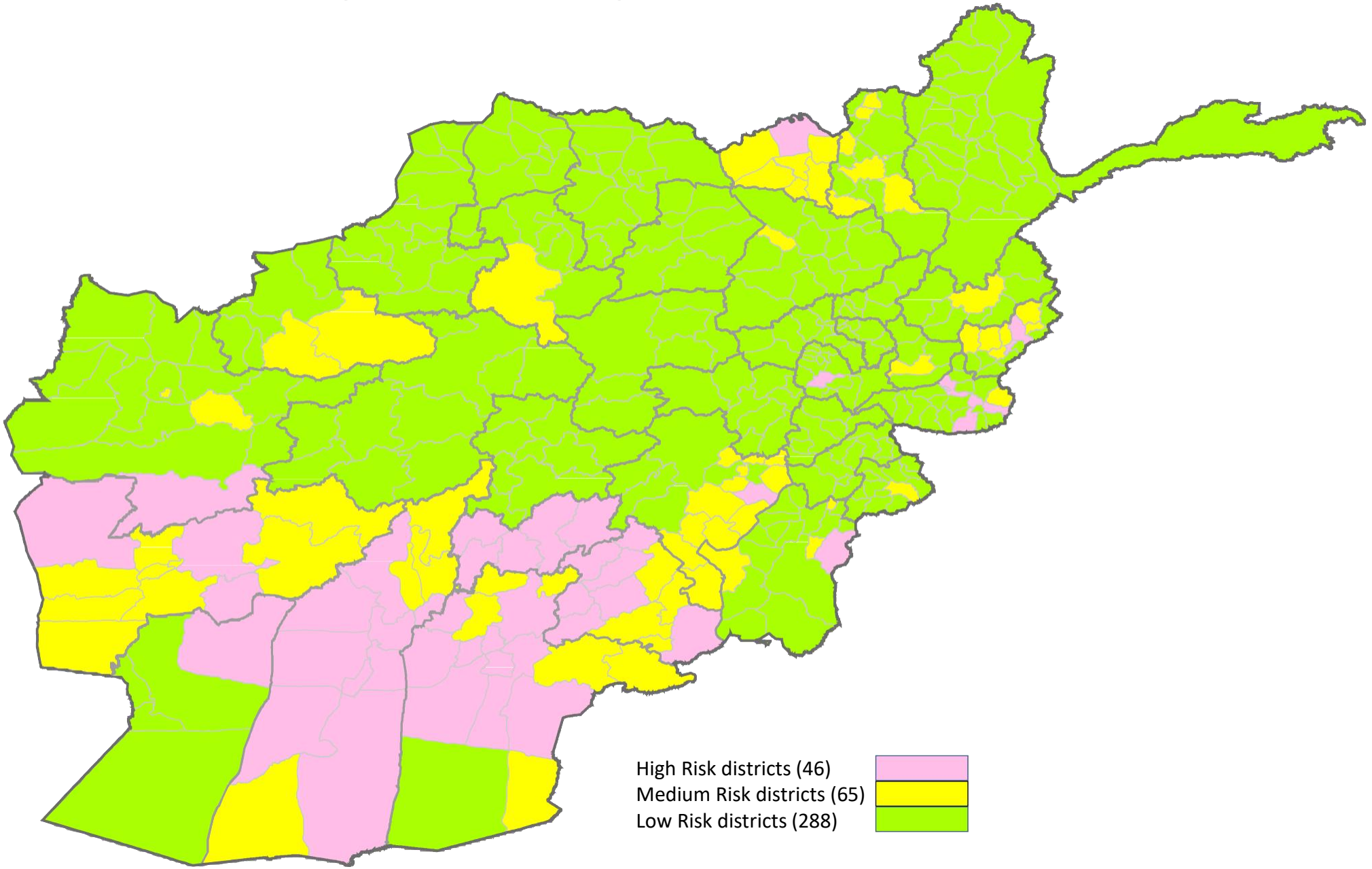
East	NANGARHAR	SHERZAD	611	Low
East	NANGARHAR	DEHBALA	613	Low
East	NANGARHAR	CHAPARHAR	605	Low
East	NANGARHAR	SURKHROD	603	Low
East	NANGARHAR	PACHIERAGAM	612	Low
East	NANGARHAR	NAZYAN	621	Low
East	NANGARHAR	HESARAK	610	Low
East	NANGARHAR	RODAT	606	Low
East	NANGARHAR	DURBABA	622	Low
East	NANGARHAR	GOSHTA	616	Low
East	NANGARHAR	KAMA	607	Low
East	NANGARHAR	DARA-E-NUR	609	Low
East	NANGARHAR	KOT	614	Low
East	NANGARHAR	KHOGYANI	604	Low
East	NURISTAN	WAMA	1405	Low
East	NURISTAN	NURGERAM	1404	Low
East	NURISTAN	WAYGAL	1406	Low
East	NURISTAN	KAMDESH	1407	Low
East	NURISTAN	DUAB	1403	Low
East	NURISTAN	BARG-E- MATAL	1408	Low
East	NURISTAN	MANDOL	1402	Low
North	BALKH	SHOLGAREH	1814	Low
North	BALKH	CHARBULAK	1812	Low
North	BALKH	CHEMTAL	1813	Low
North	BALKH	MAZAR-E-SHARIF	1801	Low
North	BALKH	NAHR-E- SHAHI	1802	Low
North	BALKH	KESHENDEH	1815	Low
North	BALKH	SHARAK-E-HAYRATAN	1811	Low
North	BALKH	SHORTEPA	1803	Low
North	BALKH	ZARI	1816	Low
North	BALKH	CHARKENT	1807	Low
North	BALKH	DAWLATABAD	1804	Low
North	BALKH	MARMUL	1808	Low
North	BALKH	KALDAR	1810	Low
North	BALKH	BALKH	1805	Low
North	BALKH	KHULM	1809	Low
North	BALKH	DEHDADI	1806	Low
North	FARYAB	KOHESTAN	2807	Low
North	FARYAB	QAYSAR	2806	Low
North	FARYAB	QORGHAN	2814	Low
North	FARYAB	QARAMQOL	2812	Low
North	FARYAB	DAWLATABAD	2810	Low
North	FARYAB	ALMAR	2805	Low
North	FARYAB	KHAN-E-CHAR BAGH	2813	Low
North	FARYAB	KHWAJASABZPOSH	2802	Low
North	FARYAB	ANDKHOY	2811	Low
North	FARYAB	MAYMANA	2801	Low

North	FARYAB	BILCHERAGH	2809	Low
North	FARYAB	SHIRINTAGAB	2804	Low
North	FARYAB	PASHTUNKOT	2803	Low
North	FARYAB	GARZIWAN	2808	Low
North	JAWZJAN	AQCHA	2707	Low
North	JAWZJAN	MINGAJIK	2702	Low
North	JAWZJAN	KHAMYAB	2710	Low
North	JAWZJAN	FAYZABAD	2705	Low
North	JAWZJAN	MARDYAN	2708	Low
North	JAWZJAN	QARQIN	2709	Low
North	JAWZJAN	DARZAB	2711	Low
North	JAWZJAN	KHANAQA	2706	Low
North	JAWZJAN	KHWAJADUKOH	2703	Low
North	JAWZJAN	QUSHTEPA	2704	Low
North	JAWZJAN	SHIBERGHAN	2701	Low
North	SAMANGAN	HAZRAT-E- SULTAN	1902	Low
North	SAMANGAN	RUY-E-DUAB	1907	Low
North	SAMANGAN	DARA-E SUF-E-BALA	1905	Low
North	SAMANGAN	KHURAM WA SARBAGH	1906	Low
North	SAMANGAN	FEROZNAKHCHIR	1903	Low
North	SAMANGAN	AYBAK	1901	Low
North	SAMANGAN	DARA-E- SUF-E- PAYIN	1904	Low
North	SAR-E-PUL	SAR-E-PUL	2001	Low
North	SAR-E-PUL	SOZMAQALA	2004	Low
North	SAR-E-PUL	SAYAD	2002	Low
North	SAR-E-PUL	BALKHAB	2006	Low
North	SAR-E-PUL	GOSFANDI	2005	Low
North	SAR-E-PUL	SANCHARAK(SANGCHARK)	2007	Low
Northeast	BAGHLAN	DOSHI	904	Low
Northeast	BAGHLAN	DAHANA-E-GHORI	903	Low
Northeast	BAGHLAN	NAHRIN	905	Low
Northeast	BAGHLAN	KHWAJAHEJRAN	909	Low
Northeast	BAGHLAN	ANDARAB	908	Low
Northeast	BAGHLAN	KHENJAN	907	Low
Northeast	BAGHLAN	TALA WA BARFAK	906	Low
Northeast	BAGHLAN	GUZARGAH-E- NUR	914	Low
Northeast	BAGHLAN	FERENG WA GHARU	915	Low
Northeast	BAGHLAN	DEHSALAH	912	Low
Northeast	BAGHLAN	BURKA	910	Low
Northeast	BAGHLAN	BAGHLAN-E-JADID	902	Low
Northeast	BAGHLAN	PUL-E-HESAR	911	Low
Northeast	BAGHLAN	KHOST WA FERENG	913	Low
Northeast	TAKHAR	DASHT-E- QALA	1613	Low
Northeast	TAKHAR	DARQAD	1617	Low
Northeast	TAKHAR	CHAHAB	1610	Low
Northeast	TAKHAR	CHAL	1605	Low
Northeast	TAKHAR	NAMAKAB	1606	Low

Northeast	TAKHAR	BANGI	1604	Low
Northeast	TAKHAR	BAHARAK	1603	Low
Northeast	TAKHAR	HAZARSUMUCH	1602	Low
Northeast	TAKHAR	KALAFGAN	1608	Low
Northeast	TAKHAR	ROSTAQ	1609	Low
Northeast	TAKHAR	WARSAJ	1616	Low
South	KANDAHAR	REG	3309	Low
South	NIMROZ	ZARANJ	3401	Low
South	NIMROZ	KANG	3402	Low
South	NIMROZ	CHAKHANSUR	3404	Low
South	NIMROZ	CHARBURJAK	3403	Low
Southeast	GHAZNI	AJRESTAN	1116	Low
Southeast	GHAZNI	GHAZNI	1101	Low
Southeast	GHAZNI	NAWUR	1112	Low
Southeast	GHAZNI	JAGHURI	1113	Low
Southeast	GHAZNI	MALESTAN	1117	Low
Southeast	GHAZNI	JAGHATU	1109	Low
Southeast	KHOST	TEREZAYI	2608	Low
Southeast	KHOST	SPERA	2611	Low
Southeast	KHOST	TANI	2606	Low
Southeast	KHOST	SHAMAL	2610	Low
Southeast	KHOST	GURBUZ	2607	Low
Southeast	KHOST	NADIRSHAHKOT	2604	Low
Southeast	KHOST	BAK	2612	Low
Southeast	KHOST	JAJIMAYDAN	2613	Low
Southeast	KHOST	SABARI	2602	Low
Southeast	KHOST	QALANDAR	2609	Low
Southeast	KHOST	MUSAKHEL	2603	Low
Southeast	KHOST	MANDOZAYI	2605	Low
Southeast	PAKTIKA	YOSUFKHEL	2503	Low
Southeast	PAKTIKA	ZIRUK	2517	Low
Southeast	PAKTIKA	MATAKHAN	2502	Low
Southeast	PAKTIKA	SHARAN	2501	Low
Southeast	PAKTIKA	GOMAL	2508	Low
Southeast	PAKTIKA	WAZAKHAH	2513	Low
Southeast	PAKTIKA	SARRAWZAH(SARHAWZAH)	2504	Low
Southeast	PAKTIKA	TURWO (TARWE)	2519	Low
Southeast	PAKTIKA	WORMAMAY	2514	Low
Southeast	PAKTIKA	ZARGHUNSHAHR	2505	Low
Southeast	PAKTIKA	JANIKHEL	2512	Low
Southeast	PAKTIKA	OMNA	2507	Low
Southeast	PAKTIKA	GYAN	2516	Low
Southeast	PAKTIKA	URGUN	2510	Low
Southeast	PAKTIKA	YAHYAKHEL	2506	Low
Southeast	PAKTYA	JANIKHEL	1209	Low
Southeast	PAKTYA	CHAMKANI	1210	Low
Southeast	PAKTYA	DAND WA PATAN	1211	Low

Southeast	PAKTYA	LIJA AHMAD KHEL	1207	Low
Southeast	PAKTYA	AHMADABA	1203	Low
Southeast	PAKTYA	GARDEZ	1201	Low
Southeast	PAKTYA	ZURMAT	1204	Low
Southeast	PAKTYA	ZADRAN	1206	Low
Southeast	PAKTYA	SHAWAK	1205	Low
Southeast	PAKTYA	ALIKHEL (JAJI)	1208	Low
Southeast	PAKTYA	SAYEDKARAM	1202	Low
West	BADGHIS	ABKAMARI	2903	Low
West	BADGHIS	BALAMURGHAB	2906	Low
West	BADGHIS	MUQUR	2902	Low
West	BADGHIS	QALA-E-NAW	2901	Low
West	FARYAB	GHORMACH	2907	Low
West	GHOR	LAL WA SARJANGAL	2108	Low
West	GHOR	TAYWARAH	2106	Low
West	GHOR	PASABAND	2107	Low
West	GHOR	TOLAK	2109	Low
West	GHOR	SHAHRAK	2105	Low
West	GHOR	DOLAYNA	2103	Low
West	GHOR	CHARSADRA	2102	Low
West	GHOR	CHAGHCHARAN	2101	Low
West	GHOR	DAWLATYAR	2104	Low
West	GHOR	SAGHAR	2110	Low
West	HIRAT	ZINDAJAN	3004	Low
West	HIRAT	GHORYAN	3009	Low
West	HIRAT	KUSHK-E-KOHNA	3013	Low
West	HIRAT	KUSHK	3003	Low
West	HIRAT	KOHSAN	3014	Low
West	HIRAT	ADRASKAN	3010	Low
West	HIRAT	GUZARA	3005	Low
West	HIRAT	INJIL	3002	Low
West	HIRAT	KARUKH	3007	Low
West	HIRAT	CHISHT-E-SHARIF	3016	Low
West	HIRAT	OBE	3012	Low
West	HIRAT	FARSI	3011	Low
West	HIRAT	GULRAN	3008	Low

Risk categorization, Afghanistan PEI, 2023



Annex IV: SIAs Minimum Standards

Component	Indicator
Vaccinator selection	Both vaccinators in each team are local and resident of the area as in the team microplan The vaccinator is literate - at least 7th standard or equivalent (enough to write and read) Increment in number of female vaccinators selected
Social Mobilizer selection	Social mobilizer is local (resident in area of work and accepted by community) Completed 7 years of basic education or completed high school and able to read and write in local language Age > 25 years Preference in selection of females as much as possible
Supervisor selection	At least 80% members of selection committee are in agreement with selection 100% supervisors are local from the same cluster 100% supervisors are literate - at least 12th standard (enough to understand/use all SIA forms and to compile reports) Increment in number of female supervisors selected
District coordinator selection	All members of selection committee are in agreement with selection 100% coordinators are local for the district 100% coordinators are literate - at least 12th standard (enough to understand/use all SIA forms and to compile reports)
Trainings	ToT organized for trainers before each campaign At least 95% training attendance in vaccinator trainings 100% attendance in supervisor and district coordinator trainings 100% sessions monitored in high-risk districts, 60% in medium-risk districts and 25% in low-risk districts 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 High-risk districts >95% missed children found by ICM recorded on the back of tally sheet in all clusters PCM conducted in 100% clusters in high-risk districts, 50% in medium and low-risk districts PCM coverage should be >95% in all monitored clusters Out of house survey should be >95% in all monitored clusters Proportion of passed LQAS @ 90% should be above 90%
Data validation and use	5% ICM, 5% PCM and 10% lots validated ICM, PCM, LQAS, out of house finger mark coverage, reported coverage data compiled, verified for accuracy and the complete data should be submitted timely (within 10 days of completion of campaign) All data streams - ICM, PCM, LQAS and reported coverage analysis used in post campaign review

Annexe V: Integrated services update

IMB report 2018

Communities in polio high-risk areas lack access to food, water, sanitation and basic health services. The resulting frustration leads to refusals & absent children among key populations. Eradication will be hard to achieve without effective advocacy & coordination to help ensure basic needs of at-risk communities are met.

TAG March 2021

TAG appreciates MoPH policy to deliver OPV to all children under 5 years at all health facilities, and also acknowledges the work done to improve oversight and monitoring of immunization and PHC services. BPHS-Plus has demonstrated the value of monitoring and accountability towards better service provision.

Progress to date (south region)

Program Area	Plan activities	What was accomplished (May 2021- August 2022)
Service Delivery	• Establishment of 115 BPHS Plus health facilities (HF)* in Southern region	• 100 HFs established (50 in Kandahar, 42 in Helmand and 8 in Urozgan)
	• Deploy 72 mobile health and nutrition teams	• 76 teams established (53 in South and 23 in Southeast)
	• Establish policy to vaccinate all children <5 with OPV who come to HFs	• Policy established and implemented (Particularly in 3 provinces of south) • Every child under 5 years receives polio vaccine at every visit
Demand Generation	• Baby blankets and soap bars for EPI visits across all 200 HFs (36 months)	• 109,353 children received baby blankets (till Sept 2022) • 133,920 children received baby blankets
	• Nutrition services available at all HFs in south	• Services available at 231 HFs (66%)
Community Engagement	• Solar powered pumps/wells in the community	• 6,685 targeted population got access to safe drinking water
	• WASH at community centers	• 6,765 latrine (71 communities at ODF)
	• WASH at schools and health facilities (South)	• WASH in 22 schools (56,492 students) • WASH in 9 HFs (409,700)
	• Increase access and utilization of community schools	• Enhanced access to 680 community schools

*BPHS+ health facilities are equivalent of SHCs with (nurse, midwife, 2 vaccinators and nutrition counselor)

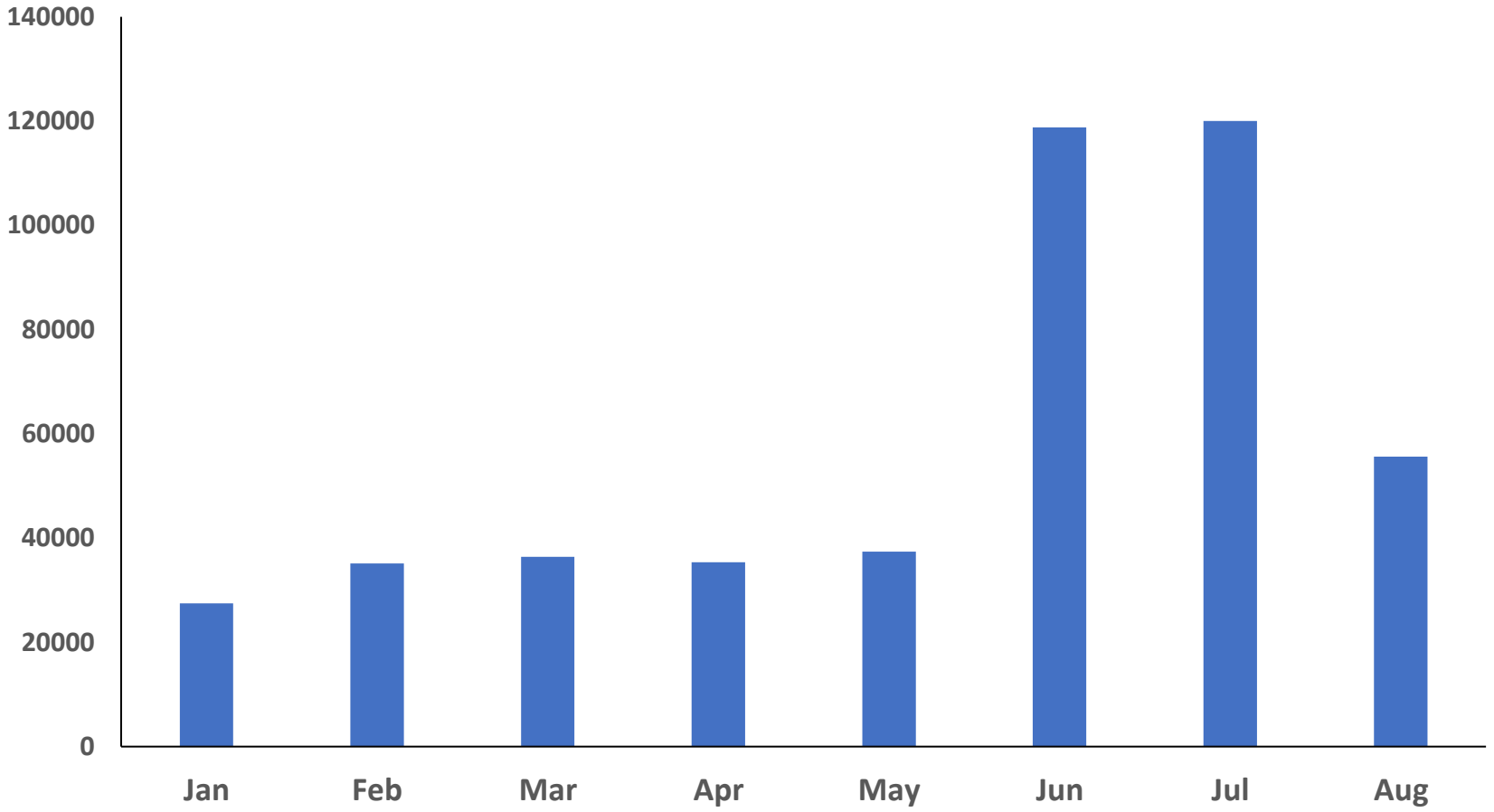
These HFs are established in rented houses and in white areas

Progress:

420,736 children <5 years received polio vaccine in the high-risk areas of Southern region

*Increase in June/Jul due to new MHNTs on board

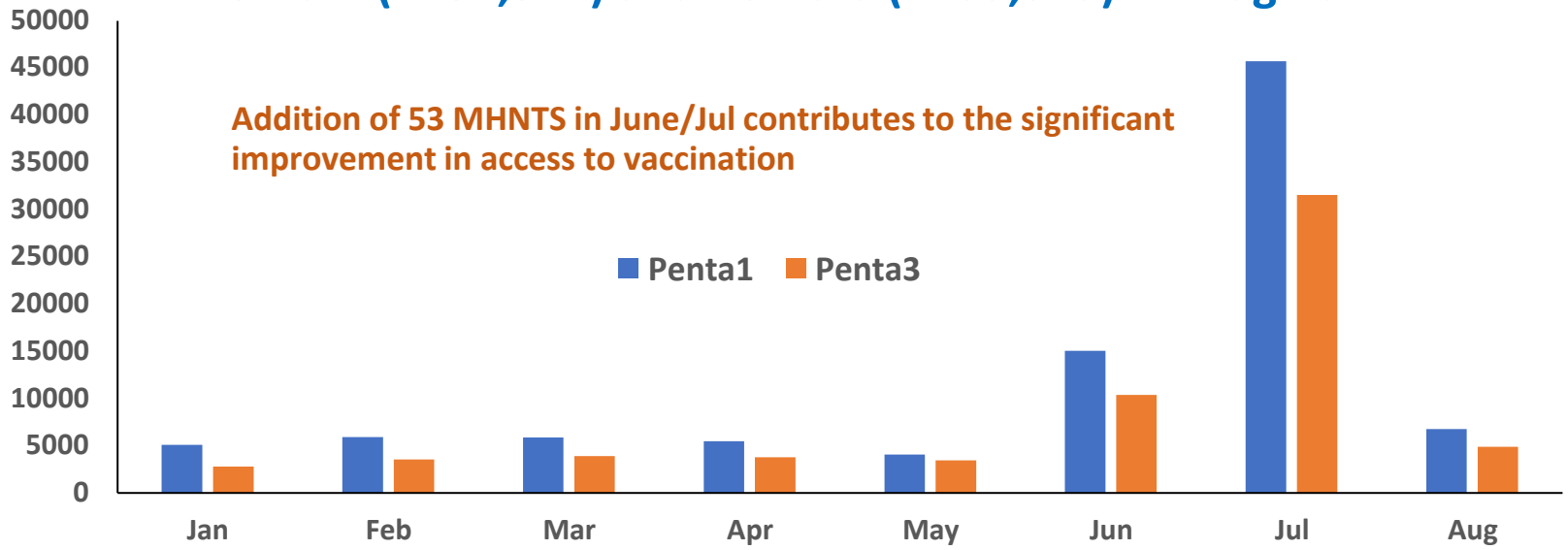
Children <5 years vaccinated at BPHS plus and MHNT clinics in Southern Region, 2022 (n=420,736)



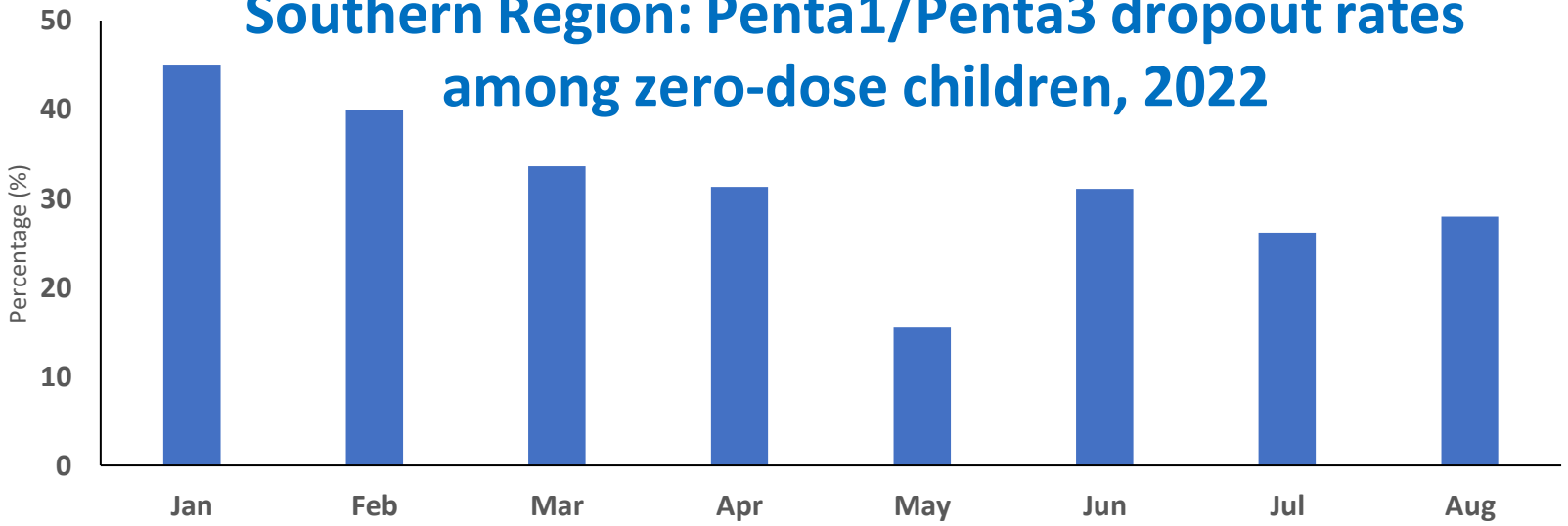
Zero-dose children in polio high-risk areas receiving routine vaccinations.

However, dropout rates from Penta-1 to Panta-3 still high.

Southern Region: Zero-dose children <2 years received Penta-1 (n=57,574) and Penta-3 (n=39,579) till Aug 2022



Southern Region: Penta1/Penta3 dropout rates among zero-dose children, 2022



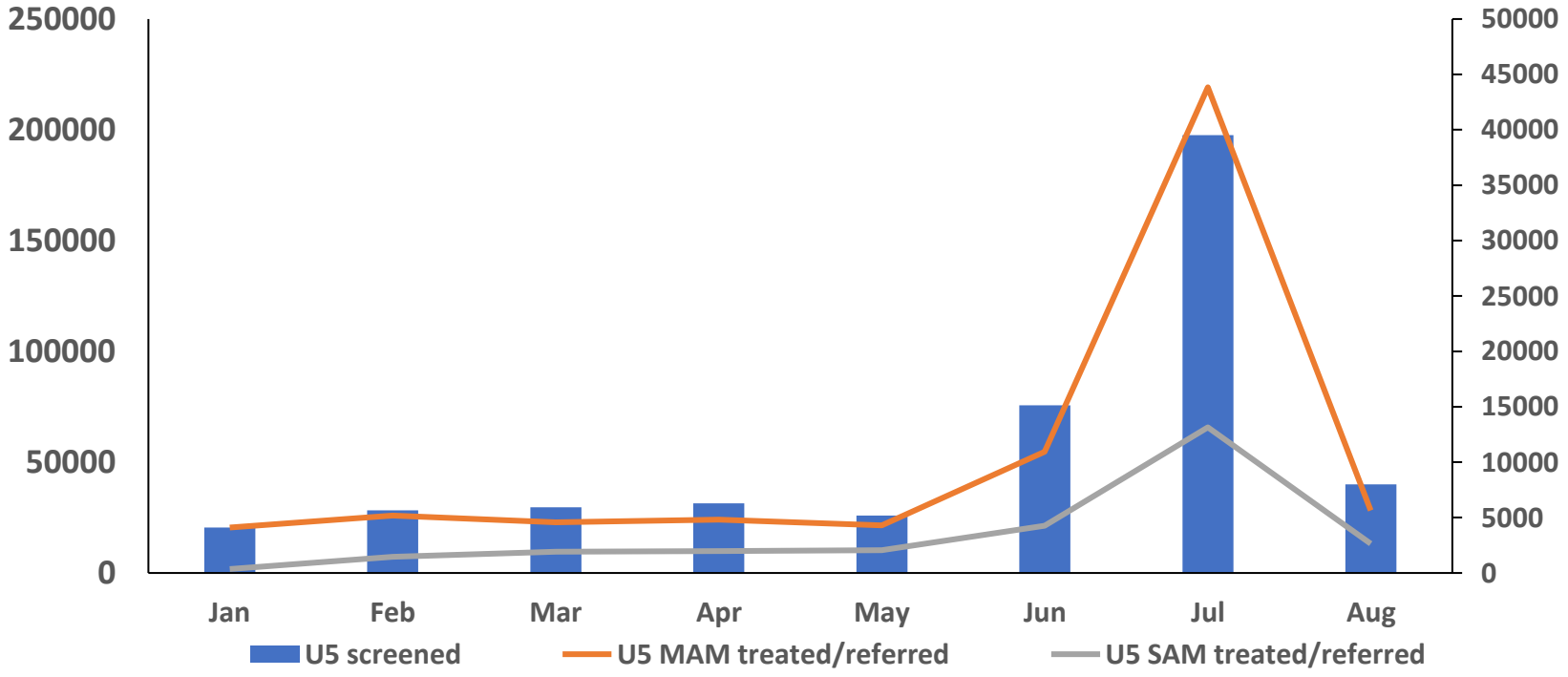
314,233 U5 yrs. children in polio high-risk areas screened for nutritional status as GAM rates among screened children is very high (21%)

Children with MAM and SAM treated/referred accordingly

All the screened children targeted for polio vaccination

*Increase in June/Jul due to new MHNTs on board

Children U5 Screened and treated/referred for malnutrition correction (n=314,233) in 2022



WASH approaches to improve access to clean and safe water in polio high-risk area in southern region

- Community WASH
- Institutional WASH (Health facilities and Schools)

Construction of adequate and segregated sanitary toilets and handwashing facilities completed in 22 schools in 4 provinces. Beneficiaries: 56,492 (students and teachers)
9 communities reaching +/- 13,000 people; 100% of which are gravity-fed solar powered piped systems and house to house connection implemented in 3 provinces covering 7 districts. Completed provincial hospital water treatment in Uruzgan, serving clean and safe water to over 200,000 caregivers and children
9 Health Facilities in Kandahar (Shahwalikot, Arghistan, Spinboldak, Dand, Kandahar City) targeting 409,700 indirect beneficiaries – catchment population.
A water solar system installed in Sourkhmorghab CHC, Dehrawood DH and Khas Uruzgan HF, delivering clean water to over 400,000 population

EPI Outreach Achievement

- Total 134 CHWs, 3 CHSs and 7 outreach vaccinators has been engaged to strengthen outreach vaccination.
- Over 390 outreach vaccination sessions conducted by vaccinators and community health workers
- Coverage:

Penta1	Penta3	Dropout	OPV1	OPV3	Measles1	TT1	TT3
767	655	15%	943	797	799	832	360

- Soap has been distributed to vaccinated children and women to promote hygiene and encourage families to bring children for subsequent doses of vaccines

Way forward

1. Expand health facilities in white areas to serve deprived communities
    - Establish 3 BHCs, 15 SHCs, 5 MHTs and 28 additional outreach vaccinators in Paktika
    - Continue use of MHTs in southern region to deliver basic package of health and nutrition services
2. Establish 25 WASH facilities in selected health facilities and communities in polio high-risk areas in Southeast region
3. Continue provision of nutrition services (screening, supplementation, treatment/referral) including appropriate supplies
4. Provide polio promotional items (soap, family hygiene kits, baby blankets, and clean delivery kits) to boost uptake of polio/routine vaccinations and built community trust
5. Implement integrated community awareness messaging to improve health seeking and promote hygiene and sanitation practices
6. Conduct mapping exercise in remaining 3 provinces of SER, and in Uruzgan and Zabul provinces

Annex VI
Standard Operating Procedures for Polio Staff to Support Routine Immunization

One of the key activities of National emergency action plan (NEAP) for 2020 relates to PEI support to EPI. The program is trying to ensure that polio field staff spends at least 20% of their time on supporting the Routine Immunization (RI) by monitoring the RI activities at fixed sites / health facilities and outreach sessions as well as by participating in the training of health workers and mobilization.

PEI to EPI support working group under Emergency Operation Center (EOC) umbrella developed three checklists / formats for monitoring of the routine immunization activities, i.e. one checklist each for fixed centers, outreach/mobile sessions and for assessing community coverage.

The objective of these SOPs is to outline the procedures for monitoring of routine immunization services by polio staff that will be engaged as follows:

1. Each Polio Provincial Officer (PPO) and District Polio Officers (DPO) should prepare monthly plan for monitoring the routine immunization sessions. One working day a week is an approximate equivalent of 20% of time; therefore, the monthly plan should include 4 visits to the immunization sessions (twice a month to the fixed centers and one each to the outreach/mobile activities combining these where possible with active AFP surveillance visits). Copy of plan should be shared with Provincial Health Coordination Committee (PHCC)/PEMT and BPHS partners.

2. During each monitoring visit of fixed, outreach or mobile session, PPO/DPO should conduct community coverage survey by visiting 10 households in the area selected at random and filling in the relevant checklist.

3. The observations and findings will be recorded in the supervisory checklists; feed-back should be provided to the vaccinators at the time of visit and completed check-lists should be shared with the WHO Offices, EOCs (where exist), PEMT, PHCC as well as relevant BPHS partner.

4. At each RI session (fixed, outreach or mobile), PPO should spend at least one hour to observe the vaccination practices, complete the checklist and possibly address the identified gaps in knowledge of vaccinators.

5. Subsequent visit to the same center should occur in the next 2 or 3 months depending on the number of RI facilities in the PPOs area of assignment; PPO/DPO should follow up on his/her findings in the subsequent visits to the facility.

6. EOC and WHO Country Office will be tracking completeness and timeliness of the report's submission at the dedicated dashboard and providing feed-back on these indicators.

7. Copies of the supervisory checklists should be sent to WHO Country Office for compilation and analysis, while another copy should be kept in office for records. The WHO country office will share the compiled reports with the Polio National EOC and the National EPI.

REACHING ZERO POLIO IN AFGHANISTAN

Intensifying polio eradication efforts in 2023

The National Emergency Action Plan for Polio Eradication in Afghanistan is the overall guiding document for all polio eradication interventions for 2023. This document compliments the NEAP and outlines additional strategies to intensify programme implementation with an aim to reach ZERO POLIO by the end of 2023. The strategies outlined here include a revised SIA schedule based on current epidemiology, and case response scenarios in various possible eventualities. Improving the basic principles of preparedness, surge capacity and capacity building, intensive review mechanisms and improving data utilization will be the center of focus for improving SIA quality. Additional strategies are included to address immunity gaps in areas with limitations to implementing house-to-house (H2H) SIAs.

OVERVIEW

Revised strategy to achieve eradication: revised SIA schedule, actions to improve campaigns, and address population immunity gaps in non-H2H areas.

With two polio cases reported in 2022, Afghanistan is closer to achieving eradication than ever before. However, the opportunity comes with unparalleled challenges due to limitations for H2H campaigns in most vulnerable areas, and the risk of the current outbreak in the East region sustaining and spreading to other parts of the country and internationally. The programme has developed an intensified strategy aligned with available resources to secure the current gains, and to finally stop transmission by the end of 2023.

The Objective

- To stop transmission in the East through intensified immunization strategy by Q1 2023
- Rapidly improve the quality of campaigns in H2H modality areas
- Continue efforts to revert to house-to-house campaigns in the remaining areas
- Close the population immunity gap in non-H2H modality areas in the South to prevent reestablishment of poliovirus circulation
- Ensure, resource and operational preparedness to timely response to any poliovirus detection outside the East Region
- Improve ability to early detection of poliovirus transmission, generally across the country and especially focusing the high-risk areas/populations

The Challenge

- Continued transmission in the East Region
- Restrictions on H2H campaigns in most vulnerable areas of the country – the South, and the Northeast regions
- Gaps in campaign quality resulting in compromised immunity levels in H2H areas
- Volatile security situation in Northern and Eastern parts of the country

Strategic priorities and adjustments

- Revised SIA schedule to intensify vaccination in the East, provide additional opportunities in the South when H2H resumes, and respond to any WPV1 incident in any part of the country
- Address population immunity gaps in large population centers of the South region through EPI campaigns, and EPI strengthening in addition to polio campaigns
- Improving campaign quality in H2H areas by building surge capacity, improve basics, strengthen review and correction mechanisms
- Further enhancing AFP surveillance and expanding environmental surveillance

(I) STOPPING TRANSMISSION IN EAST – INTENSIFIED SUPPORT

East region will be the focus of the programme in first half of 2023. The only focus of transmission will be addressed immediately.

Historically the East region have exceled in responding to polio outbreaks as a team, the recent example is the cVDPV2 outbreak. The current epidemiological situation is though worrisome and requires a focused approach. After the transition in the government the region could not start house-to-house campaign because of several factors, one of which was the targeted attacks against the front-line workers. The region started house-to-house campaigns in May 2022 all over the region but with a compromised quality amid huge interference in the selection of the front-line workers. The program has made some gains in the recent campaigns, involving more female FLWs, reduction in the interference in the selection and surge support staff. Issues identified are mainly in the selection, training, community reluctance to vaccination and follow up actions.

Additional campaigns in East region, and SNIDs will give an opportunity to mobilize best available polio staff from other regions where campaigns are not planned to East region. The deployed staff will primarily support in all preparatory activities and ensure that frontline worker selection, microplans and trainings are of top quality. Their role will not be limited to monitoring during the preparatory phase. In addition, East region will be supported with additional DPOs and PPOs for better programme management and monitoring. Every SIA in east will be directly supervised from the national level, plan of actions prepared based on the findings from all sources, and support provided to address the issues identified.

With the staff surge provided to East region in the last campaign, several issues have been identified with an action plan prepared. Issues are predominantly related to inappropriate team composition or selection and gaps in quality of trainings; and are being addressed at all levels.

Cross border coordination: East region shares a long border with Khyber Pakhtunkhwa province of Pakistan, there is good coordination mechanism between East region and Khyber Pakhtunkhwa province. The program will further enhance the established coordination in areas of communication, AFP surveillance, synchronization of SIAs and sharing of best practices. A schedule of monthly virtual and quarterly face-to-face cross border meetings will be ensured.

(II) REVISED SIA SCHEDULE

Revised SIA schedule aims to intensify vaccination in the East, rapidly improve population immunity in the South and Northeast as soon as H2H campaigns resume and establishes a plan to respond to a WPV1 detection in any part of the country.

The Technical Advisory Group for PEI in Afghanistan in its recent meeting in October 2022 endorsed two NIDs (target 9,999,227 children each) and four SNIDs (target 6,973,272 children each) during 2023. For the most impactful use of resources, the programme has appropriated the scope of SNIDs in the light of current epidemiology as well as the outcomes of the TAG meeting in October 2022, prioritizing the key endemic areas and populations in the country, and plans additional campaigns with the rational described below.

Interventions and rationale

- The revised schedule retains the number of NIDs (2) and SNIDs (4) endorsed by the TAG.
- The TAG-endorsed scope of SNIDs reduced, Northeast region excluded: Northeast historically has not sustained poliovirus transmission for an extended period and the importations were rapidly contained without being a part of SNID. No poliovirus was reported from the Northeast region in 2022. The saved funds will be more effectively utilized for contingency planning for any WPV1 emergency in non-SNID areas including the Northeast region, and for intensification in the East.
- Three additional campaigns in the East regions (all four provinces with a target of 1,144,312 children) are planned to stop the only outbreak in the country. This will close the time gaps between campaigns in the TAG-endorsed schedule in the East region.
- Additional campaigns are planned for non-H2H areas of the South and the Northeast to enable the programme to rapidly address immunity gaps once H2H campaigns are allowed.
- Resources are set aside to address any event of WPV1 detection in non-SNID and/or SNID areas. Case response vaccination will be done (at least 3 opportunities) in sync with the planned calendar targeting at least 1 million children.

Execution Strategy

The TAG-endorsed schedule along with additional campaigns in the East region will be implemented as per the plan laid out below in the table. In addition to the planned campaigns, case response campaigns are provisioned and will be implemented as per need to carry out at least three case responses within 2-3 months of the onset of the index case. The need of additional case response will vary based on planned campaigns at the time of outbreak and will cover ~1 million children. The plan also provisions a rapid population immunity build up in non-H2H areas once access to H2H modality is gained.

The programme will review the SIA schedule and contingency plan mid-2023 and make necessary changes according to the prevailing epidemiology.

Operational and Financial Panning for the Revised SIAs Strategy/Schedule

For operational and financial planning purposes, the programme is considering possible scenarios during the next 6 to 12 months and will work towards ensuring preparedness for timely responding to any epidemiological and programmatic evolutions during the course 2023.

Below is a precis of possible scenarios and general programme response scheme to key anticipated scenarios. Polio NEAP remains the overarching guidance for details on operational and communication strategies for each of these scenarios.

Scenario -1a: Continuing endemic WPV-1 transmission in East Region with no geographic spread

- Continue with intensified SIAs schedule & ways to improving quality
- Maintain sensitive Surveillance
- Situational review in mid-2023

Scenario 1b: WPV1 transmission in the East Region curtailed/stopped

- Continue planned NIDs/SNIDs/East region SIAs during first half of 2023
- Review the situation and risk in mid-2023 and adjust the plans for Q3/Q4 – 2023
- Maintain sensitive surveillance and required enhancements as per the mid-2023 review

Scenario-2: WPV-1 detection in regions other than the East, representing geographical spread from the East Region or from Pakistan

- Aggressive immunization response i.e. two vaccination rounds within 56 days, and three vaccination rounds latest by 90 days - in conjunction with the planned rounds
- Maintain sensitive surveillance with necesary enhancements in the light of epdemiological investigation

Scenario 3: H2H campaigns become possible in South and/or Northeast regions

- Immediate steps to update/finalize micro-planning at the district level & implement 3 vaccination rounds within 60 days
- maintain, necessary communication and advocacy strategies

Scenario 4: cVDPV2 detection in Afghanistan

- Detailed epidemiological investigation/situational review
- If needed, vaccination response with appropriate OPV in consultation with the TAG; two vaccination rounds within 56 days
- Maintain sensitive surveillance with necessary reqired enhancements

From financial perspective, the SIAs schedule will require USD26.675 million which is within the approved operations budget. It is to be noted that out of the total of USD26.675 million, USD22.475 million will cover planned campaigns that will be implemented in all scenarios, and USD4.2 million is allocated as contingency for case response.

Month		TAG endorsed SIA schedule	Intensification in East to stop transmission	Detection of poliovirus in non-SNID area	Detection of poliovirus in SNID area
January	Target	5,248,473		Three short interval case response campaigns targeting 1 million each Budget = 600,000 USD each	Additional case response in case of outbreak, and additional opportunities in South when H2H resumes targeting 1 million each. (3 campaign opportunities are planned for this purpose to fill into non-campaign months) Budget = 600,000 USD each
	Budget	$2,800,000.00			
February	Target		1,144,312		
	Budget		$625,000.00		
March	Target	9,999,227			
	Budget	$4,700,000.00			
April	Target		1,144,312		
	Budget		$625,000.00		
May	Target	5,248,473			
	Budget	$2,800,000.00			
June	Target		1,144,312		
	Budget		$625,000.00		
July	Target	5,248,473			
	Budget	$2,800,000.00			
August	Target				
	Budget				
September	Target				
	Budget				
October	Target	5,248,473			
	Budget	$2,800,000.00			
November	Target	9,999,227			
	Budget	$4,700,000.00			
December	Target				
	Budget				
Target		**40,992,346**	**3,432,936**	**3,000,000**	**4,000,000**
Budget		**$20,600,000.00**	**$1,875,000.00**	**$1,800,000.00**	**$2,400,000.00**
Total budget:					**$26,675,000.00**

(III) EPI STRENGTHENING/SIAs IN NON-H2H ENDEMIC AREAS

Sustaining adequate population immunity in non-H2H areas is essential to eradicating polio. Along with the intensive involvement of the PEI team to improve EPI, additional vaccinators will be provided for white areas, and multi-antigen campaigns coupled with "Pluses" are planned in large population centers of the South to sustain current gains.

The polio programme in 2023 will use the EPI platform to build and sustain population immunity against poliovirus particularly in areas where H2H campaigns are not being implemented. In addition, any other opportunity to deliver polio vaccine, such as measles campaigns, will also be utilized. Following are the interventions planned to harmonize EPI and PEI for achieving polio eradication.

Interventions and rationale

- Involvement of the PEI team in microplanning, training, supervision, and monitoring of EPI, particularly in the South region
- Provision of additional vaccinators in underserved/white areas to improve EPI reach
- Multi-antigen campaigns in large population centers of the South region coupled with "Pluses"

Execution Strategy

With an enhanced coordination of all implementing partners, the programme will plan and implement the listed interventions with clearly defined roles and responsibilities of all stakeholders. A quarterly review of the joint workplan will be carried out for impact assessment and course correction.

Finances

The planned activities will have no financial requirement from the polio programme as the activities will be funded by the available GAVI resources.

(IV) IMPROVING CAMPAIGN QUALITY IN H2H AREAS

Improving H2H campaigns will significantly result in reducing the number of unvaccinated children. In 2023, the programme will focus on improving basics – microplanning, selection, training, supervision and monitoring. This will require extensive capacity building of programme staff and frontline workers, and the creation of dedicated teams to focus on these often out of top priority aspects of the programme.

Polio campaigns have various critical components that need to be monitored closely for a desirable quality. Selection of frontline workers, and training of polio staff and frontline workers are two of the most important components that impact programme quality and outcome. The programme will also invest further in streamlining and making programme reviews more effective for course correction and strategy development. The plan is laid out in detail below.

Interventions and rationale

- Surge capacity: A surge team – “Rapid Response Team (RRT)” - trained to carry out epidemiological investigations, help local district and provincial teams to plan, implement, supervise, and monitor case responses; and identify/resolve management and technical issues in the field will be deployed at the national level and in all high-risk regions. The RRT will also be provided with resources to immediately deploy mobile medical teams in the infected and surrounding villages/areas providing camp-based curative services, vaccination, and Polio Pulses as a “zero case response.”
- In addition to RRTs, surge support will also be provided to areas of epidemiological concern by deploying staff from non-SNID/campaign areas. These deployed staff will arrive in the districts/provinces before the preparatory phase, participate and evaluate frontline worker selection, conduct trainings, ensure adequate logistics and provide supervision and monitoring support.
- Training unit: The programme will focus on training and capacity building of programme staff and frontline workers. This will require a dedicated training unit with the following expectations:
    - Frontline workers: Apply learnings from various successful training modalities used by different countries and improving the training cascade mechanism making it less dependent on the cluster supervisor level. Trainings in high-risk areas will be delivered directly by programme staff. Monitoring methodology for trainings will also be revised and utilized efficiently.
    - Programme staff: Capacity building of the programme staff in relevant technical areas, management, humanitarian negotiations, etc. will be a priority during 2023 to enable best staff performance. Regular upgrade trainings for staff will also be required to effectively introduce new training modalities, data management systems such as APMIS, and other interventions.
- Monitoring and evaluation unit: As the APMIS is rolled out across the country, a data management and analysis system developed with the support of CDC Atlanta, better capacity on efficiently utilizing this data will be required. A dedicated monitoring and evaluation unit with one international and one national professional staff will focus on this important field of work to enable the programme to make informed decisions and continuously improve.

- Internal and external programme review/technical support: As a part of strengthening monitoring and evaluation of the programme, an intense schedule of reviews are planned at both field and Kabul level that will require staff to come to Kabul, and country office staff and staff from outside country to regularly visit the field. One of the limiting factors of having regular programme reviews in Kabul both with sub-national staff and for inviting surge support as well as expertise from outside the country is the lack of available security-cleared accommodation in Kabul. Currently the WHO country office is finalizing the reconstruction of WHO accommodation to cater to the increased staff needs of the Emergency and Polio programme which requires programme contribution for additional accommodations.

Execution Strategy

Surge guidelines will be developed both for RRT and campaign surge to assist the national EOC in taking immediate steps for case investigation and response with defined timelines aiming to mobilize as much support as possible to the incident area in the shortest possible time, with a pre-defined action matrix involving all partners.

Training and M&E units will consist of one international staff with experience of polio eradication in other countries and one national staff with experience in Afghanistan. Both these units will work closely with the national EOC, with national staff embedded part time in the national EOC facilitating synergy and catering to the requests of additional staff at the national EOC.

The polio contribution (nearly one third of the total requirement) towards reconstruction of the WHO guest house will double the occupancy capacity in the UNOCA compound. Designing, contracting, supervision will be done by the WHO country office supported by EMRO engineers.

Finances

Case response and surge support funding will be done through contingency budget allocated for case response.

Additional funding requirement for two international professional staff is added to the FRR (USD 435,750 – covering 9 months).

The national professional staff will be funded though the existing activity workplan. Polio programme contribution to guest house restructuring/expansion will be USD 600,000.

(V) FURTHER ENHANCING AFP SURVEILLANCE AND EXPANDING ENVIRONMENTAL SURVEILLANCE

Implementation of international surveillance review recommendation, and expansion of environmental surveillance will be the priority during 2023.

The prime focus of the surveillance unit will be to fully implement the recommendations of the international surveillance review, simplify surveillance processes and expand both AFP and environmental surveillance infrastructure.

Interventions and rationale

- Regular follow up of action tracker developed based on the findings of the international surveillance review with support of EMRO/HUB

- Identification and inclusion of additional potential sites in the ES network
- Establishing polio laboratory in Afghanistan

Execution Strategy

The programme has restructured the national surveillance unit in line with the recommendations of the international surveillance review and has developed a matrix to implement and track the recommendations. Surveillance unit will intensify the capacity building of program staff, restructure the standard operating procedures with modification of the AFP surveillance tools, and revamping the data compilation and analysis processes. Providing the evidence-based information for absence of virus in Southeast and South regions and establishing the epidemiological linkages of virus circulation in Northeast & East, will be a priority during 2023.

Finances

Implementation of the recommendations of the international surveillance review and expansion of ES infrastructure will be done within the available funding for surveillance under FRR.

Financial requirements for polio laboratory in Afghanistan should be outside FRR and managed by EMRO/HUB.