

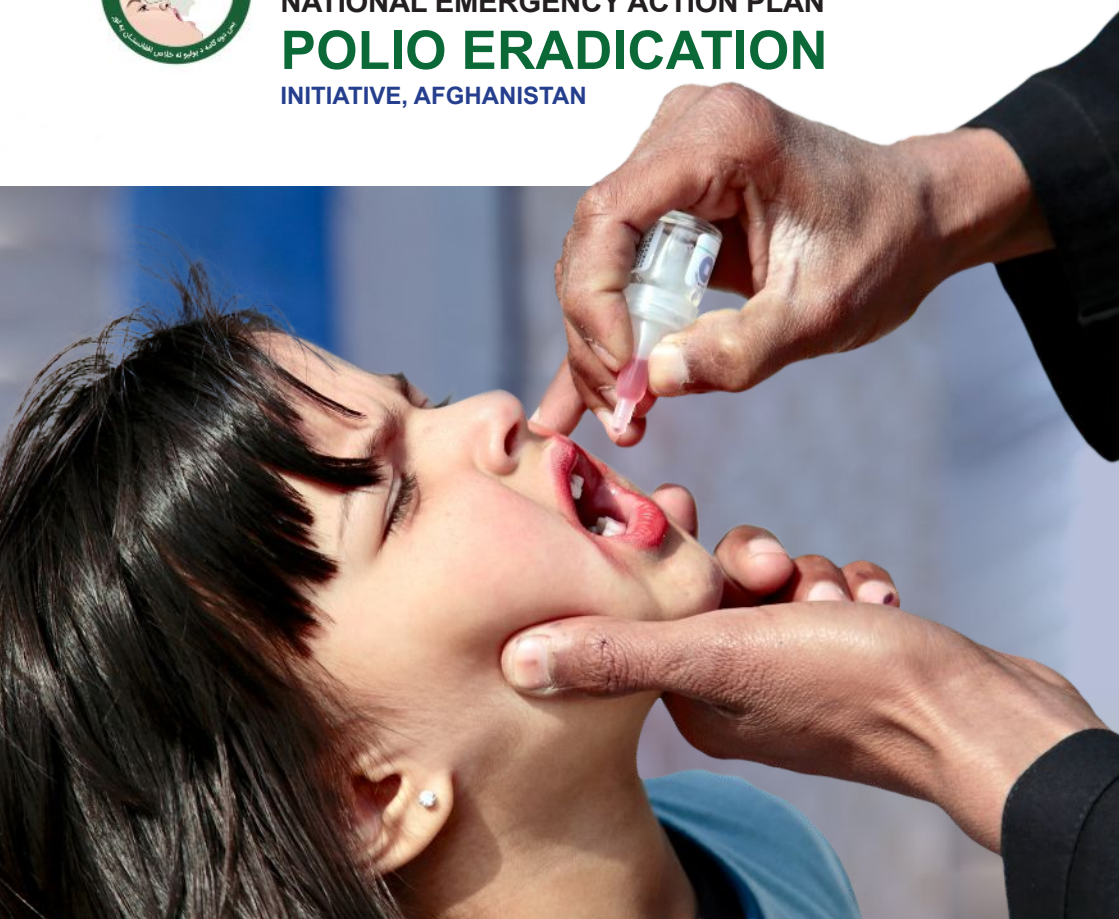


2020

NATIONAL EMERGENCY ACTION PLAN

POLIO ERADICATION

INITIATIVE, AFGHANISTAN



List of acronyms

AFP	Acute flaccid paralysis
AGE	Anti-government elements
AHS	Afghanistan Health Survey
ARCS	Afghan Red Crescent Society
BPHS	Basic package of health services
CCE	Cold Chain Equipment
CWG	Communication working group
CDC	Centre for Disease Control
DDM	Direct Disbursement Mechanism
DoRR	Department of Refugees and Repatriation
GCMU	Grant and Service Contracts Management Unit
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunization
FD	Focus district
FGD	Focus group discussions
FLW	Front-line worker
GPEI	Global Polio Eradication Initiative
HRD	High risk district
HRMP	High risk mobile population
HR	High risk
H2H	House to House
IAG	Islamic Advisory Group
ICM	Intra-campaign monitor/monitoring
ICN	Immunization and Communication Network
IOM	International Organization for Migration
IPC	Inter-personal communication
ICN	Immunization communication network
IEC	Information, Education, Communication
IHR	International Health Regulation
IPV	Inactivated polio vaccine
KP	Khyber Pakhtunkhwa
LQAS	Lot Quality Assurance Sampling
MNCH	Maternal New-born and Child Health
MoU	Memorandum of Understanding
MHT	Mobile health team

List of acronyms

NEOC	National Emergency Operations Centre
NGO	Non-governmental organization
NEAP	National Emergency Action Plan
NID	National Immunization Days
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
PTT	Permanent Transit Team
REOC	Regional Emergency Operations Centre
RI	Routine Immunization
REMT	Regional EPI Management team
SIA	Supplementary immunization activity
SNID	Subnational Immunization Days
SOP	Standard operating procedure
SIADS	Short Interval Additional Dose Strategy
SWG	Strategy Working Group
S2S	Site to Site
TAG	Technical Advisory Group
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VHRD	Very high-risk district
IMB	Independent Monitoring Board
IFA	Information for Action
PHC	Primary Health Care
PMU	Program Management Unit
POB	Polio Oversight Board
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
WASH	Water Sanitation Hygiene
WHO	World Health Organization
WPV	Wild poliovirus

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Section 1:

Epidemiology and Situational Overview

Most of Afghanistan is polio free but pockets still struggle to end transmission

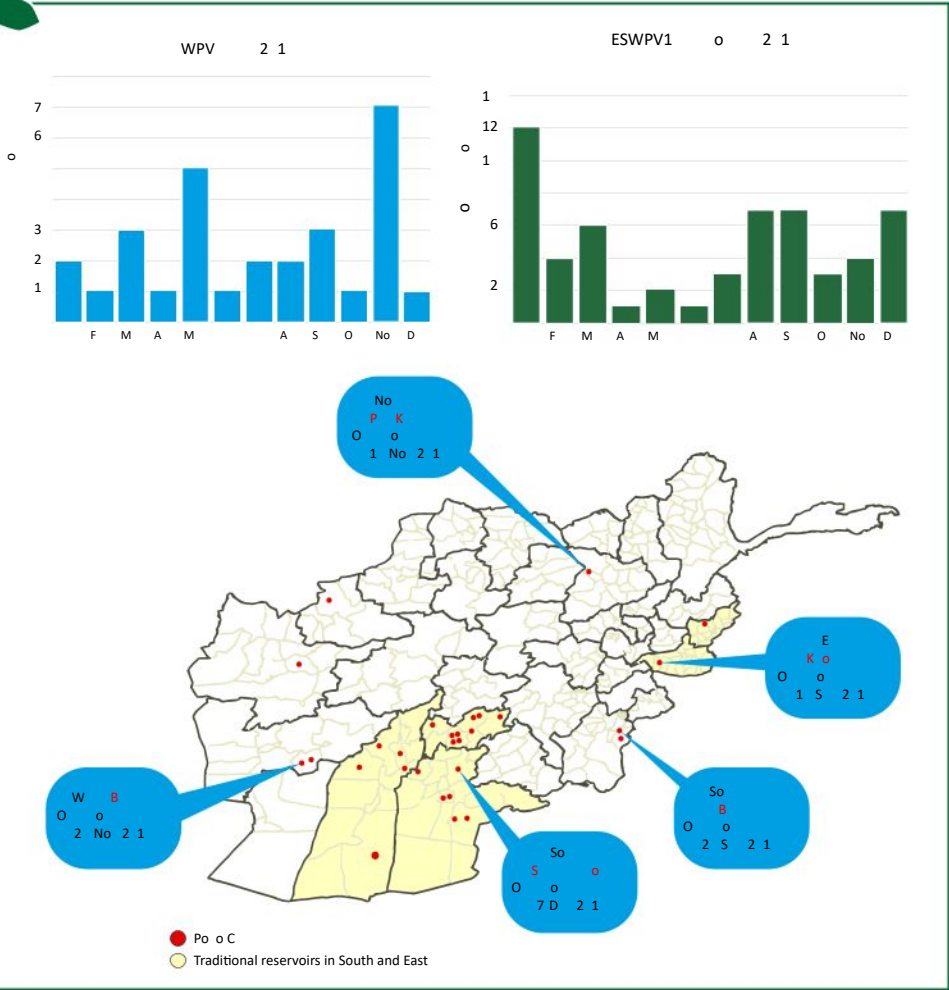
Afghanistan's Polio eradication program in 2019 was challenged with consistent inaccessibility to all the children in the country hindered by reasons beyond the program's control. The ban on house to house vaccination imposed since May 2018 became more stringent in April 2019 with its imposition everywhere. This led to the suspension of campaigns from April to July 2019. The number of cases and infected districts has been on the increase since 2017. The number of infected districts based on polio cases reporting increased from 4 in 2016 to 9 in 2017, 14 in 2018 and 20 in 2019. Similarly, the number of cases also increased from 13 in 2016 to 14 in 2017, 21 in 2018 and 29 in 2019. Regarding environmental samples, after a steady rise in the positive samples from 2016 to 2018 (41 in 2016, 42 in 2017 and 83 in 2018), the number of positive environmental samples decreased in 2019 to 56 primarily due to decrease in the eastern region. It is important to note that in 2019, wild poliovirus transmission in Afghanistan mostly remained restricted to Southern and Eastern regions, during the first half of the year. Ongoing transmission in the Southern region is due to indigenous local transmission. During the



second half, WPV-1 transmission started to appear outside these regions and polio cases were reported from the South East (2), West (4) and North East (1). Eighty-three per cent of the polio cases in 2019 were reported from the areas where house to house vaccination was banned since May 2018. The rate of infection was lower in the East region in 2019 (two polio cases & 13 positive environmental samples compared to 6 and 24 in 2018 respectively) where access for house to house vaccination was relatively better. The Eastern region is part of the Northern cross border axis corridor areas of Afghanistan and Pakistan.

There is a growing risk of cDVPV2 importation to Afghanistan in view of ongoing population movement with the areas that reported cDVPV2 outbreak in Pakistan. At the time this document is being written, cDVPV2 was isolated in environmental samples collected from the East region, genetically linked to the cDVPV2 circulation in Pakistan.

Figure 1: Situation Summary, 2019





Southern region

In 2019, 20 polio cases were reported from the region, including 9 from Uruzgan, 6 from Kandahar and 5 from Helmand province. There were four infected districts in Kandahar province (Kandahar, Spinboldak, Ghorak, Shahwalikot), five in Helmand (Sangin, Washer, Nawzad, Musaqalah, Garmser) and four in Uruzgan province (Shahid-e-Hassas, Chora, Tirinkot, Khas Uruzgan). The local transmission in Kandahar city continued during 2019, evidenced by the persistent positive environmental samples, while one polio case was reported with onset of paralysis in November 2019. It is noted that 17 (85%) of the 20 cases were reported from the areas with no house to house vaccination since May 2018. Persistent positive environmental samples were reported from Helmand (mainly Lashkargah) during 2019 representing local transmission in the province.

Eastern region

In 2019, two polio cases were reported from the region, one each from Kunar and Nangarhar provinces (Watapur and Khogyani districts respectively). The case in Kunar was reported from an area inaccessible for polio campaigns. The intensity of WPV-1 transmission seemingly declined in the East region during 2019; as indicated by the lower number of polio cases compared to 2018 (6 in 2018, 2 in 2019) and positive environmental samples 24 in 2018, 13 in 2019). However, detection of few long chain viruses in 2019 indicate potential populations somewhere

across the northern corridor (Nangarhar/Kunar – Great Peshawar/KP) that are not consistently reached by the program. It is pertinent to mention that eastern region could do house to house vaccination in majority of the areas during the second half of 2019. Recently, cVDPV2 was detected in environmental samples collected from Jalalabad during early January 2020, genetically linked to cVDPV2 transmission in Pakistan. In 2020, 3 cases have so far been registered in the South.

Outside endemic zones

No polio cases were reported from outside the traditional reservoirs until September 2019. From September to December 2019, two polio cases were reported from the South East region (September), four from the West region (October/November) and one from North East region (November). All the polio cases in these regions represent new viral introductions from the endemic areas. WPV-1 was not detected in the environmental samples collected from outside the South and East Regions during 2019.

It is important to mention that persistent inability to implement house to house campaigns in a significant part of the country (around 45% of the target population) is leading to substantial decline in the population immunity. Polio cases from non-reservoir areas of the country during the last quarter of 2019, represent the risk of further geographical spread of WPV-1 transmission over the coming months.

Section 2:

Progress on NEAP 2019

The program made progress on objectives but was not able to stop transmission

In 2019, Afghanistan polio program had to handle continuously evolving situation and adapt the operations according to varying state of security and access. The program placed extensive efforts to improve the SIAs quality in the accessible areas, while maintaining access dialogue at all levels. In general, three out of the eight objectives set in the NEAP 2019 were met, two were partially met and three including the main objective to stop transmission were not met.

Access to vaccination remained continuously hampered during the year 2019. The AGE's ban on vaccination was mostly limited to high risk provinces of the South region (with active polio transmission) in 2018. As a measure to cope, the program implemented three campaigns using the site to site modality from January to March 2019 to reach as many children as possible in these areas.

Since the beginning of 2019 the ban gradually expanded, initially to other parts of the South region, then to South East region and finally everywhere in April 2019. In fact, polio vaccination campaigns were completely stopped in the country from April to July 2019.

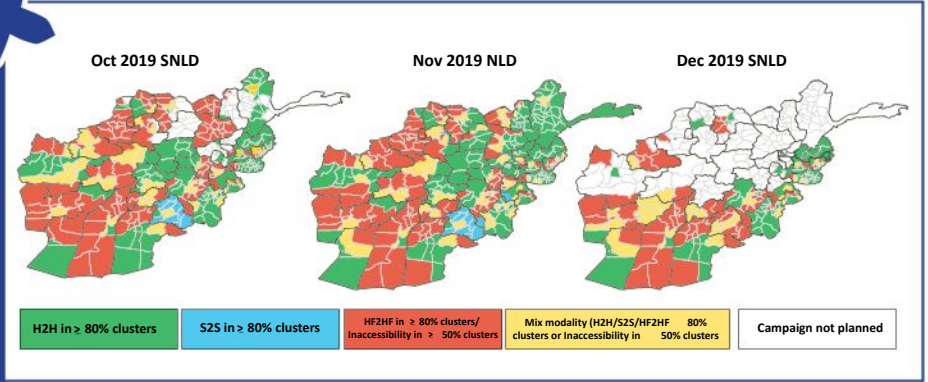


No ban	H2H ban in high risk provinces 2018						Complete Ban 2019	HF2HF permitted
Jan Feb Mar Apr	May Jun Jul Aug Sep Oct Nov Dec	Jan Feb Mar Apr	May Jun Jul Aug Sep	Oct Nov Dec				

Despite the complete ban, vaccination rounds were implemented in August and September 2019 following a careful assessment of the security situation and taking all the necessary measures to ensure the security of the frontline workers. These campaigns were implemented in an environment of fear and threat due to ongoing ban from the AGE leading to sub-optimal implementation and monitoring in both rounds 49% and 43% children were inaccessible respectively.

On 25 September 2019, the AGEs lifted the ban on polio campaigns. However, house to house campaigns were not allowed in the AGE areas and only health facility-based vaccination was allowed. Following this development, the program intensified access dialogue at the provincial and sub-provincial levels. Three campaigns were implemented during the last quarter of 2019, including one nationwide and two sub-national rounds. The proportion of targeted children (aged less than five years) that could be reached by house to house strategy was 57% in October, 64% in November and 68% in December 2019. This proportion, however, was quite variable at the subnational, with about 90% target children in the East region and less than 50% in the South region reached by house to house strategy. It is important to note that the areas in the South region with ongoing intense WPV-1 transmission could not implement house to house campaigns. As per the reported administrative data, the health facility-based campaigns could reach a maximum of 20% of targeted children (the least being 3% in some high-risk areas of south region). This low coverage is mainly due to challenges like very few health facilities in some districts, difficult terrain, long distances and lack of motivation among communities to walk long for only polio vaccination.

Figure 2



% of target population covered by H2H/S2S and Inaccessible

Region	%H2H			%S2S			%HF2HF/Inaccessible		
	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
Badakhshan	91			9			0		
Central	85	85	100	0	0	0	15	15	0
East	90	86	90	0	1	1	10	13	10
North	20	44	22	0	0	0	80	56	78
Northeast	3	67		0	1		97	33	
South	46	46	47	7	7	0	47	47	53
Southeast	66	61	65	0	5	1	34	34	34
West	47	50	40	4	2	0	49	48	60
AFG	57	64	68	2	2	0	41	34	32

The program maintained a scenario-based approach in 2019, to be able to adapt to the evolving access and security situations. This approach was endorsed by the TAG, under which different strategies and interventions are appropriately devised according to their weightage in given access / security scenario (please see the matrix below).

Adjusting NEAP Implementation as per Access - Scenario Based Planning

+ sign indicates program focus on an activity in the given scenario

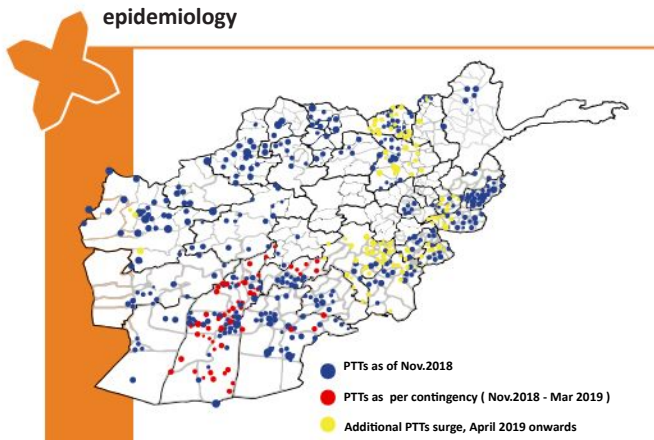
Strategies	Scenario-1; H2H ban Lifts	Scenario-2; Sit to site/ health facility Strategy	Scenario-3; Ban Persists
OPV SIAs	+++	+++	
IPV/OPV SIAs	+	+	+
Permanent transit teams (PTTs)*	+	++	+++
Enhanced EPI in HR areas + expanded age group for IPV/OPV + Integrated outreach	+	++	+++
Multi antigen EPI campaign including IPV/ OPV	++	++	+++
Polio Plus / incentivized community engagement	+	++	+++
Boosting Surveillance	+++	+++	+++

During 2019, the program continued to address vaccine acceptance issues through wide variety of communication and social mobilization activities. Focus was paid to pockets of vaccine refusal especially in south and south east. The average vaccine refusal rate in South and South East regions is 2.4% per coverage data of 2019. Dedicated regional plans and communication products, partnerships with the local authorities were developed and external community engagement review took place. Further details are available in the Communication Chapter.

During 2019, the program carried out several interventions, on one hand to improve the quality of vaccination campaigns in the accessible areas and on the other hand to maximize the reach to children in the inaccessible areas (with no house to house campaign). The interventions in the accessible areas include microplanning validation, revision of training guidelines, monitoring of training sessions, and direct oversight of the National EOC monitors. Of note is the special focus on Kandahar city (flagged as engine of transmission by the technical advisory group) after the ban was lifted. A special micro plan validation and exercise was carried out led by the national EOC; followed by prompt actions to fix the identified gaps.

The program continues to maintain dialogue process with AGEs at local, provincial and higher levels to ensure program neutrality for polio eradication and supporting humanitarian activities. Resultantly, the program was able to perform house-to-house vaccination in majority areas of the East region and some high-risk areas of the South East. The program calls upon all polio eradication and international partners to play their part to improve access for house to house polio vaccination campaigns everywhere in the country.

Figure 3: Increase in PTTs as per the evolving epidemiology



In addition to the ongoing dialogue on access, the program continues to implement contingency measures to reach as many children as possible from the areas with no house to house vaccination, including:

- The number of permanent transit teams were increase by more than two-fold (reach up to a maximum 1,234), strategically deployed to vaccinate the children from inaccessible areas

- Site-to-site vaccination implemented in the South region during January to March 2019 IPV+OPV SIAs

- A state of preparedness is being maintained to implement 3 consecutive H2H SIAs as soon as access gained

- Establishment of 53 new health facilities in white areas with capacity of cold chain and vaccinators for fixed and outreach in Kandahar and Helmand provinces



Afghanistan maintains a sensitive surveillance system irrespective of access for SIAs. The number of zero reporting sites (routine reporting) was expanded from 2,510 in 2018 to 2,730 in 2019, active surveillance sites from 1,492 to 1,611 and reporting volunteers from 34,548 in 2018 to 36,323 in 2019 across the country. The indicators of Non-polio AFP rate and percent AFP cases with adequate stool specimens were maintained above the target benchmarks set by the program. Currently, Afghanistan is collecting environmental samples from 21 sites located in 12 major population centers of 9 provinces of the country. Internal surveillance review was conducted in 2019 in the South and South East regions, while the same is planned for East region during the first half of 2020. It is important to note that internal surveillance reviews are done on annual basis targeting the high-risk regions and provinces. A total of 327 stool samples from healthy children residing in chronically inaccessible areas were tested; WPV-1 was isolated in the stool sample of three healthy children from Chapadara district of Kunar province in the East region. There was an important development in the surveillance data management of Afghanistan; with the initiation of Web - Information for Action (Web - IFA) use in December 2019. The Web-IFA is currently being piloted in the

Central region and will be fully rolled out in the entire country during 2020.

Afghanistan and Pakistan are considered as one epidemiological block for polio eradication, since there is ongoing significant population movement between the two countries, especially in the bordering districts / areas. Afghanistan program maintains close coordination with Pakistan polio program at the national and provincial levels focusing on synchronized program implementation in three common corridors i.e. northern corridor (East Region / Nangarhar – Great Peshawar / Khyber Pakhtunkhwa), Southern corridor (South Region – Quetta Block) and central corridor (South East Region – South KP). Joint corridor action plans were developed and are being implemented for all three corridors. The key focus is to ensure that all types of high risk mobile populations (HRMP) are identified and specific strategies are in place to reach and vaccinate the target children amongst them. The key identified HRMP include the long-distance travelers within the corridors, the nomads, the straddling populations and the returnees / refugees. Formal and informal border crossing points between Afghanistan and Pakistan have been mapped and vaccination teams are deployed. Currently, a total of 47 cross border vaccination teams are functioning on 17 border crossing

points. Mandatory all age vaccination is being performed at the Torkham border in the northern corridor while children less than 10 years of age are targeted at the Friendship gate in the Southern corridor. Reportedly, more than 1.6 million doses of OPV were delivered by the cross-border vaccination teams in 2019.

There is close coordination at the national and regional level on operational and technical aspects, including information sharing on surveillance, communication, population movement, SIAs as well as coordinated response to poliovirus detection. Under the supervision of National and Regional EOCs, the teams of bordering provinces and district are maintaining coordination with the bordering areas' teams of Pakistan; focusing on joint microplanning and information sharing on population movement. A total of 30 AFP cases were cross notified in 2019 among the two countries.

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

In addition, to ensure appropriate coverage, polio eradication field staff and National EOC staff support implementation of existing plans through direct support in updating and validating micro plans, adjusting team workload, monitoring and social mobilization which will be further strengthened. Kandahar specific microplanning is being started.

NEAP 2019; Summary Progress by objective

#	Goal/Objective in NEAP 2019	Status
Objective 1	To stop ongoing transmission in the Southern and Eastern regions	Not achieved
Objective 2	To achieve and maintain high population immunity in the rest of VHRDs and HRDs, ensuring no secondary cases following possible importation	Achieved outside core reservoirs
Objective 3	To gain and maintain access through flexible approaches	Partially achieved
Objective 4	To rapidly and effectively respond to any importation of WPV1 and/or emergence of any VDPV (and in particular the VDPV type 2) into polio free areas of Afghanistan	Achieved
Objective 5	To achieve and maintain high population immunity among HRMPs	Partially achieved
Objective 6	To enhance program quality with focus on high risk provinces/districts to reduce missed children to less than 5%	Not uniformly achieved
Objective 7	To improve vaccine acceptance contributing to a reduction in refusals	Not uniformly achieved
Objective 8	To maintain high levels of surveillance quality across the country with surveillance quality indicators meeting the global standards in all provinces	Achieved

Section 3

Key Challenges and Risks

Reaching all children, improving quality, and RI integration are 2019 focuses

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

1. Inaccessibility and inability to perform house to house campaigns
2. Sub optimal campaign quality
3. Refusals
4. High Population Mobility
5. Chronically low Routine Immunization coverage in the polio high risk provinces

1. Inaccessibility / Inability to perform house to house vaccination

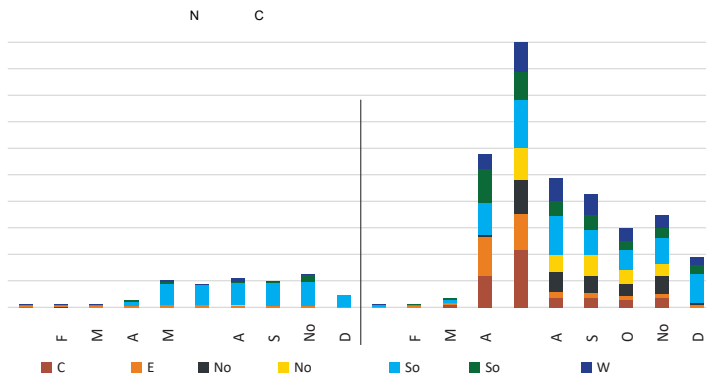
Since May 2018, the number of inaccessible children continued to increase significantly. This has been due to continued ban on the house-to-house strategy in most parts of the Southern region due to security concerns of the AGE. During early 2019, the program implemented site to site campaigns in the Southern Region. However, the ban on vaccination was imposed everywhere in April 2019 that continued until September 2019, suspending one nationwide and two sub-national campaigns. Moreover, the campaigns implemented in August and September could not reach more than 50% of the national target.

Despite lifting the ban on polio eradication activities in September 2019, the restriction on house to house campaigns is continuing in some areas, leading to persistent missing of a significant proportion of target children for a substantial period. This challenge has been the most significant in the South region where a house to house campaigns have not been implemented for more than 20 months in the AGE areas.

Though the program is maintaining dialogue at local, regional and global levels, there is immense need to intensify neutral negotiations with AGEs at all these levels and exploring possible additional channels for this purpose.



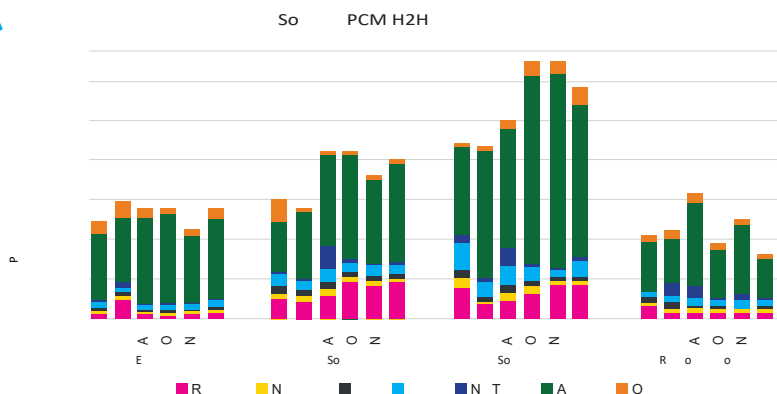
Figure 4: Inaccessibility for House to House Campaign: 2018-2019



2. Sub-optimal campaign quality

The program continues to face the challenge of compromised quality SIAs (both in accessible and AGE controlled areas) due largely to management and accountability issues. Although the overall campaign quality in accessible areas looks fine; however in-depth data analysis indicates that the quality of SIAs is not uniform at the sub-district level. Improving program quality is one of the top priorities to eradicate polio which is prioritized and will be followed in the NEAP 2020. In accessible areas, the Program quality as an overarching factor contributes to about 3% to 5% missed children, with absence and refusal being the primary reasons, along with children missed as newborn, sick or sleeping.

Figure 5: Missed children by Reasons & Regions - 2019



Reports from the field indicate problems in selection of frontline workers and other staff, lack of female vaccinators, training, supervision, capacity building, timely payment, monitoring, sub-optimal accountability, limited data use, gaps in follow up actions in between SIAs, failed LQAS lots with lack of investigation and correction measures, poor implementation of revisit strategy and

appropriate micro-plans implementation. In most of AGE areas, national monitors are not allowed to monitor the campaigns. Of note is the finding that there is interference in selection of frontline workers / staff from many sources (in the accessible and AGE controlled areas). Selection committees are either not sufficiently empowered or influenced or lack commitment to follow the guidelines.

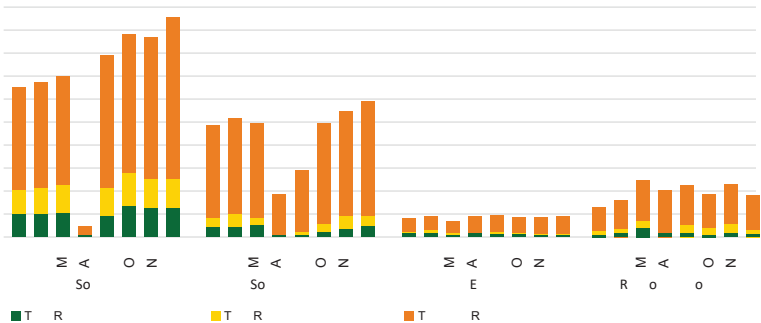
Field missions from the national levels noted that in some areas, the time during the training sessions is not well utilized to focus on the core SIAs activities and many less relevant topics are given more time. The training manual was reviewed and revised during the last quarter of 2019 in consultation with the regional and provincial teams; and is currently being implemented.

3. Clusters of refusals , particularly in and around Kandahar (South Region) as well as in the South East region. The refusal size in general is not very high; however, there is persisting high number of refusing families in the South and South East region, with the highest concentration in the Kandahar city and surrounding districts and Paktika province of South East region (please see 2019 trend in the graph below).

As per the results of the focus group discussions and field monitoring reports, the key reasons for refusals include religious objection, campaign fatigue, contents of the vaccine and lack of other health and development services, particularly in the marginalized and under-served communities in the South Region. It is important to mention that part of such refusals exist in the currently inaccessible areas of Helmand, Kandahar and Uruzgan provinces with active WPV-1 circulation.

Some monitoring reports also indicate that use of non-local staff, involvement of young boys as front-line workers and lack of female vaccinators/social mobilizers also add to the challenges around community acceptance for polio vaccine. In addition, there is room to further strengthen involvement of other sectors including Ministry of Haj and Auqaf, community influencers, medical practitioners and local government authorities. Another challenge is the refusal by families whose underperforming members of the ICN have been removed from the program. These is exacerbated by community fatigue, multiple door knocking, staff capacity and low staff motivation posing additional challenges that needs to be addressed.

Figure 6: Reported, Covered, Remaining Refusals by region, by campaign - 2019





4. High Risk Mobile Population, Moving between Afghanistan and Pakistan

Due to strong socio-cultural ties, trade and inter-state commercial relations, there is significant population movement across the international border between Pakistan and Afghanistan. This movement is not just limited to the border areas and demographically linked areas close to the borders, but also to the areas far off the borders due to a variety of reasons. These mobile populations continue to play a very important role in the polio epidemiology of Afghanistan and Pakistan. This poses an ongoing challenge to be covered by campaigns and surveillance. The four main groups identified by the program include:

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

The UNHCR data shows more than 13 thousand refugees from Pakistan with ongoing influx of new Pakistani refugees from North-Waziristan Agency (Pakistan) to Khost and Paktika provinces in the South East Afghanistan, taking the total number to above 75 thousand. Moreover, an estimated 132,171 individuals were displaced by conflict in 2019 and profiled by OCHA as internally displaced persons (IDPs) in need of protection and assistance.

Precise estimation of figures for nomadic population and long-distance travelers remained a challenge. The program continues to focus on mapping of nomads, timely deployment of transit teams on the key routes of nomadic movement, further identification of any missed routes, and strengthening inter sectoral collaboration with ARCS, UNHCR, Disaster Management Unit and Nomad's Independent directorate.

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

Routine Immunization is among the four cornerstones for polio eradication. High routine immunization coverage provides a strong base for population immunity to prevent polio. The RI coverage continues to be very low in polio high risk provinces, particularly in the South region. According to the latest AHS survey (2018), the lowest Penta 3 coverage were reported from polio high risk provinces with the most intense polio transmission currently; that is Helmand (17.4%) Kandahar (29.5%) and Uruzgan (3.1%). Considering these figures, there is need to upscale the efforts to improve EPI services in these provinces, including the birth OPV dose strategy.

The NGOs working at the provincial / district level are supposed to cover the entire population of the province. With only 5\$ per capita and a contractual target population of 50% of the total actual population (comparing to NID population), even a high performing NGO only has resources for half of the eligible children.

There are geographical areas and population pockets missing (termed as white areas) due to inconsistent distribution of health facilities, insufficient budget, very few health facilities as well as governance issues. This results into existence of white areas and lack of financial resources to the NGO to cover the entire province. In addition, the system to follow up implementation of contractual obligations requires strengthening within the health system.

With more than a million new births every year in Afghanistan (Gavi Fact Sheet), there is a growing immunity gap. Reaching newborns is an operational and communication challenge, with factors like cultural practice of keeping newborns inside the house for 40 days from birth. Reaching newborns requires emphasis and monitoring during training and implementation of the EPI services as well as during house to house and transit points vaccination. Moreover, appropriate communication strategies need to be designed and utilized, accordingly. Timely OPV-0 through routine immunization will also have positive impact on stopping transmission. Moreover, timely EPI vaccination with IPV will help reduce paralytic disease from WPV-1 and cVDPV.



Section 4

Development and operationalization of NEAP 2020

Operations priorities include strong governance, management & planning

As mentioned earlier, 2019 was a very challenging year for polio eradication in Afghanistan. The ban on house to house vaccination lasted for more than twenty months at the time of compiling this document. In view of the current epidemiology and challenges, the National Emergency Action Plan was updated in 2020 using a bottom-up approach. The Regional EOCs conducted workshops to brainstorm with the provincial and district teams on identifying the current challenges, interventions implemented, and key lessons learned in 2019. Based on the reflections, adjustments in the current strategies and activities as well as new interventions aimed to address the remaining challenges.

Following these regional level sessions, the National EOC convened a workshop with regions to deliberate and compile the plans proposed by the regional teams. All the propositions were compiled and reviewed by the National EOC's Strategy Working Group for technical and operational feasibility and response was shared with the regional teams. Moreover, the NEAP document incorporating feedback

from regions and partners was shared with the TAG (and presented during a consultation video conference in March 2020) and guidance of the TAG was incorporated. The NEAP was also discussed with Polio Policy Dialogue group, shared with NGOs of High-risk provinces as well as widely shared with partners, and relevant comments were considered and incorporated.



For the effective operation of NEAP 2020, the program will take the below actions:

Improving the Implementation Mechanisms through Strengthened Management

The network of EOCs is playing a central role for coordinating and managing the implementation of NEAP as well as providing necessary oversight. The National program is trying to further strengthen the regional and provincial programs by setting up the EOCs in the highest risk provinces of South i.e. Helmand and Uruzgan. The Regional EOC of South Region will continue to provide necessary support to the provincial EOCs. The coordinator for the Provincial EOC Helmand is already onboard (the building / logistical arrangements are being made) while the Uruzgan EOC coordinator is yet to be recruited. The National EOC is also looking into strengthening the EOC in the South East region.

Implementation plan

An implementation plan (workplan) will be developed for the interventions of the NEAP, along with clearly outlined roles and responsibilities (Annex - 1).

Costing

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

Accountability framework

The National EOC will continue to utilize the accountability framework encompassing all levels of the program to monitor implementation of the NEAP (please see Annex - III). The National EOC's Strategy Working Group will review the accountability framework, latest in the quarter-3 of 2020 to make necessary adjustments and elaborations.





Coordination bodies

Polio executive committee:

- Chaired by H.E. the Minister of Health, H.E. Presidential focal point and participated by National focal point for Polio, country representative of WHO & UNICEF, and program executives
- Meets monthly to review the progress and challenges in polio eradication and provide feedback to H.E. The President

Polio partners dialogue:

- Meeting of polio executive committee with donor partners
- Meets quarterly to update and garner support of local donor partners

Meeting of Council of Ministers on Polio:

- Meet biannually to ensure coordination with other line ministries

National steering committee:

- Chaired by H.E. the President
- Meets biannually to review the progress and garner support from all parts of the Government including line ministries and Governor

Section 5

Goal

To stop transmission of wild poliovirus in the South and East regions of the country, stop any polio outbreaks in the non-reservoir areas and prevent the spread to currently polio-free areas.



Section 6

Objectives

2019 NEAP Objectives are focused on ending transmission

The NEAP 2020 has the following objectives:

1. To stop ongoing WPV-1 transmission in the South and East regions
2. To rapidly and effectively respond to any introduction of WPV1/VDPVs and/or emergence of VDPVs (particularly VDPV type 2) in the currently polio free areas of Afghanistan, ensuring no secondary cases following any importation
3. To maintain a scenario-based approach to rapidly adjust to any possible/anticipated access and programmatic situations
4. To improve community acceptance and demand for vaccination and address vaccine refusals through effective and locally appropriate communication strategies
5. Maintain effective access dialogue in coordination with all the national and international partners aiming to have access for house to house polio campaigns across the country
6. To achieve and maintain high population immunity among HRMPs
7. To enhance program quality with focus on high risk provinces/districts to uniformly reduce missed children to less than 3% at the sub-provincial level (especially in the accessible areas). Special emphasis will be laid on effectively reaching the new-born and infants.
8. To maintain sensitive and high-quality surveillance for polioviruses, across the country with consideration for possible expansion of environmental surveillance, as per feasibility



Section 7

Residual risks

Common epidemiological block and access remain risks

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

Impact on the program due to any deterioration in access.

Impact related to the fact that Afghanistan and Pakistan are one epidemiological block; both countries need to finish the job together.



Section 8

Strategies/ Strategic Interventions

2019 focuses on targeted strategies to address critical issues

This section describes the salient strategic course the program aims to take as well as the key interventions and steps planned during the period of April 2020 to March 2021. Below are the key strategies to fast track elimination of wild poliovirus in Afghanistan as well as mitigating the risk of cVDPV2 in 2020.

Three NIDs and 5 SNIDs in 2020 with bOPV (mOPV1 in two campaigns in high risk areas, if available) and IPV campaigns (in conjunction with multiantigen / accelerated campaigns), in selected high-risk areas as per the evolving WPV-1

Case response strategy for non-reservoir areas i.e. implement three vaccination rounds in conjunction with planned rounds (preferably within 8 weeks after the onset of last polio case)

Preparedness for responding to cVDPV2 as per the GPEI strategy, if / when required

Review the risk categorization for high risk areas and continue focus on the high-risk districts identified in NEAP 2020

Improving program quality in accessible areas with focus on high risk provinces/districts (special attention on reaching newborns and infants)

Maximizing reach in inaccessible areas

Re-think (in view of the evolving challenges), adjust and intensify communication / social mobilization strategies to improve vaccine acceptance and community demand

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

Maintain sensitive surveillance for polioviruses; and continue desk and field monitoring / reviews

Building population immunity through implementation of integrated services in identified very high-risk areas of South region in Kandahar, Helmand and Uruzgan

Overarching focus

Southern region

Given that south region was the driver of poliovirus circulation in Afghanistan in 2019, the programme will focus on interrupting transmission in this area in 2020.

Intensive HR support along with establishing infrastructure for provincial EOC in Helmand

- **“No tolerance policy”** for campaign quality gaps in accessible areas
 - o “Back to basics strategy” – improving frontline worker selection (minimizing interference, improving female participation at all levels), trainings, microplanning, monitoring and supervision.
 - o In-depth analysis of the absent children and devise appropriate interventions to reach them
 - o Disaggregate and analyze the refusals by reasons and geographic clustering and address them with “reasons specific strategies / plans”
 - o Further probe into the new-born (under a new-born strategy), sick and sleeping children and find out the real reasons of these missed children, to be addressed
 - o Disaggregate the category of “others” among the recorded missed children, analyze to understand the reasons and strategize to address
- **Ensuring maximum reach in inaccessible area**
 - o Intensified access dialogue with engagement of all partners and utilizing any possible opportunities at all levels
 - o Engage with local communities to enlist their support towards addressing operational challenges and build trust
 - o Roll out integrated services plan to reach maximum number of children
 - o Regular review and rationalization/strengthening of alternate strategies

such as PTT, IPV campaigns, utilizing alternate opportunities (measles campaigns, multi-antigen campaigns) based on changing access situation

- o Maintain preparedness and implement SIADS (3 passages) of H2H campaigns as soon as restrictions lifted

Eastern region

Continue to focus on quality assurance measures in all the areas that can implement house to house campaigns, with “no tolerance policy” for any under-performance

Recognizing the risk of cVDPV2 importation and shared WPV1 epidemiology with Pakistan, and to secure gains during 2019, the following strategies will be at priority:

- o Intensified surveillance with regular review at all levels
- o Close coordination with Pakistan program to address HRMPs, and co-ordinated vaccination strategies (SIAs & case response)
- o Continue to focus on reducing missed children in accessible areas
- o Enhanced emphasis on newborns and infants

Southeastern region

Systematically address refusals among refugees

Maximize efforts to reduce missed children and tailored vaccination strategies for HRMPs as per their movement patterns

Regular review of surveillance

Rest of Afghanistan

While focusing efforts in South and East region, program will maintain high population immunity by improving quality of SIAs and improving EPI in rest of the country (including the birth dose)



Under the overall strategic course, below is a brief description of the salient interventions planned as well as the measures to improve quality of the program activities.

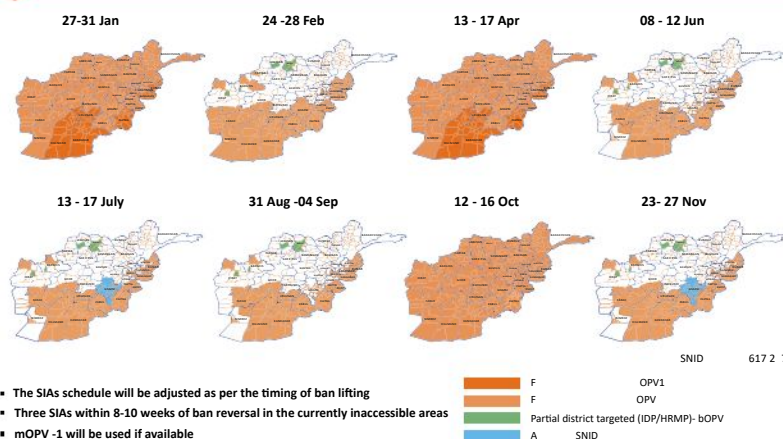


8.1 Conduct supplementary immunization activities

The program set plans late 2019 to conduct 3 NIDs and 5 SNIDs in 2020. Of these, 2 NIDs and 3 SNIDs will be conducted during the low transmission season whereas, 1 NID and 2 SNIDs will be implemented during high transmission season. The program will continue to coordinate with Pakistan to synchronize the major SIAs, when possible. Due to COVID-19 outbreak in February 2020, campaigns have been halted and the schedule will be reviewed once Afghanistan is in control of the situation.



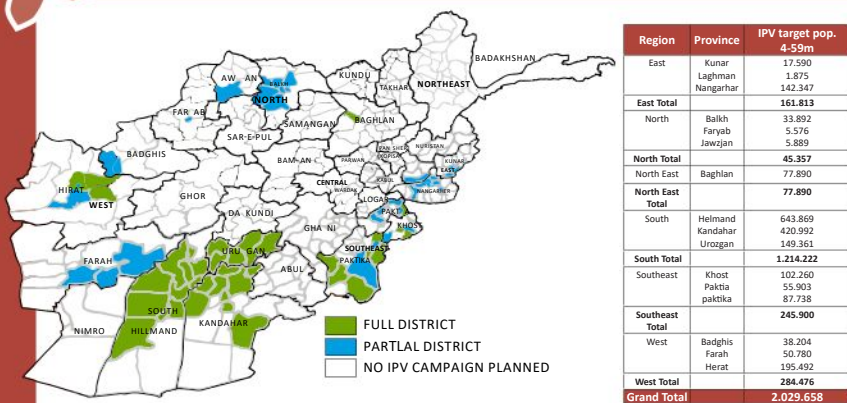
Figure 7: Proposed SIAs Schedule - 2020



The program has strategically selected the generic scope of SNIDs to include poliovirus reservoirs and districts at high risk (SNIDs target: 5.6 million children, aged < 5 years). Some districts of west and north regions have been partially included, targeting HRMP and other high-risk populations while some districts will be targeted in alternate SNIDs. The scope of the SNIDs will be reviewed before every round and necessary adjustments will be made as per the epidemiology, then.

IPV will be used in identified high-risk districts of south, southeast, east and west regions in the light of the evolving WPV and cVDPV epidemiology, maximally and utilizing the opportunities of multi-antigen and accelerated EPI campaigns. Inaccessible areas in focus and very high-risk districts which become newly accessible, will be prioritized for IPV usage, after delivering two to three bOPV doses.

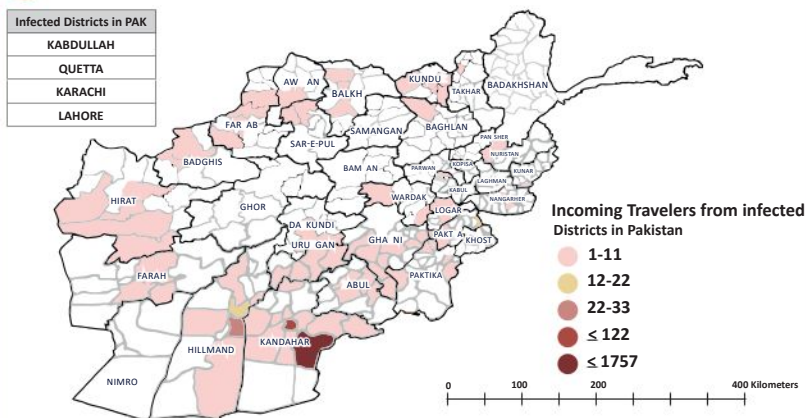
Figure 8: Proposed Plan for Targeted LPV Campaigns - 2020



8.2 Focus on high-risk provinces and districts

Based on polio epidemiology and other factors including access for implementation of SIAs, population immunity, presence of refugee/IDPs and travel patterns between infected districts in Pakistan and Afghanistan, the program has flagged 7 provinces and 85 districts as high risk for sustaining poliovirus transmission. The high-risk provinces include Kandahar, Helmand and Uruzgan in the South region, Nangarhar and Kunar in the East region, Paktika in the South East and Farah in the West region. These provinces account for 84% of all polio cases since 2010, with Kandahar accounting for 35% during this period.

Figure 8: Districts Travelers Coming from an Area Infected with Polio in Pakistan, Spin Buldak Crossing, 2019



Fifteen of the 85 high risk districts in the South region have been flagged as “focus districts” for all the program activities, especially the SIAs. Another 32 districts have been flagged as “very high-risk districts” and 38 as “high risk districts” (please see annex - II for list and map of focus and high-risk districts). The Program will continue to focus on these districts with flexibility to include additional ones, as per the evolving epidemiology. The program will enhance its focus on the districts having ongoing population movement with the core reservoir corridors i.e. northern and southern corridors, ranging from Afghanistan to across the border in Pakistan.



8.3 Improving program quality in accessible areas

The program 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 proportion of passed LQAS @ 90% above 90%. Every LQAS lot below 90% will continue to be considered failed. These benchmarks will be particularly monitored for the accessible areas where house to house vaccination is possible.

Unpacking and addressing the reasons for missed children will be the guiding principle for the programme. The programme will revise guidelines for recording various types of refusals for targeted interventions. Better understanding about recoverable children (who return to their houses within the period of campaign) and non-recoverable absent children (children who do not return within campaign) will be developed to ensure every child available for vaccination is reached. Further in-depth analysis will be carried out for the missed children currently recorded as “newborn, sick, sleeping (NSS)” to identify the real reasons for missing these children. The recording tools (used by FLWs / supervisors) and compilation / analyses at the regional / national levels will be revised accordingly to guide the program. Vaccinating newborns, identifying and vaccinating guests, convincing parents of sick or sleeping children will be focused during the trainings and will be highlighted in training modules.

The use of ICN will be focused in the highest communication risk regions / areas of the country. The ICN will be optimized to ensure quality community engagement that goes beyond house to house visits while also appropriately complimenting the work of vaccination teams / volunteers. This will possibly include segregating the use of ICN (and ICN registers) from the vaccination volunteer on the days of campaigns, to ensure that vaccination teams are asking all questions at the doorstep.

Efforts will continue to increase female’s participation in ICN through special gender strategies and incentives. Continued emphasis will be placed on overall efforts to reduce missed children based on analysis of non-vaccine reasons and subsequent action plans and appropriate messages use. ICN in the high-risk areas will continue to report and track missing and absent children and report on emerging rumors in clusters, silent refusals and proposed actions for the program to consider.

The areas fully accessible for house to house campaigns and monitoring, will be treated as “no tolerance areas/districts” for campaign quality gaps. Any quality gap will be treated as priority for addressing the reasons. Persistence of any bottlenecks in resolving the quality gaps will be immediately taken up by the National EOC for intervention from national level including the Ministerial level. “Back to basics” concept to improve the fundamental elements of implementation of campaigns will be adopted particularly focusing on microplanning, selection of front-line workers, trainings, monitoring & supervision, and data quality & utilization. Interventions listed below are directed to address these fundamental components of the programme.



The national EOC in coordination with the regional / provincial EOCs will develop mechanisms to improve quality of end-day / evening meetings during the campaigns, to be maximally utilized for improving the implementation quality. The national EOC will also hold regular post campaign review meetings (engaging the regional / provincial teams) to ensure that the feedbacks and lessons learned are documented and used for improvement.

8.3.1 Data analysis and use

Considering the observations by the TAG and other forums about extensive and complex data of PEI in Afghanistan, the programme is reviewing and streamlining/simplifying and standardizing all data collected at various levels. Systems are under development for digitizing data at the lowest possible level and creating dashboards for timely sharing and utilization of data. Data analysis and dashboards will be designed to perform disaggregated analysis by access type, clusters, by reasons of missed children etc. to enable the programme to take corrective actions effectively. CDC will lead this stream as a part of the GPEI Hub work plan. The GPEI hub conducted a workshop in February 2020 to kick off the simplification and streamlining of the data sets and data collection tools. Follow ups will be made during the quarter-2 and quarter-3 of 2020.

The programme will focus on analyzing SIAs coverage and monitoring data by access categories with the aim to enable better understanding and minimizing missed children. Capacity of regional and provincial teams will be strengthened to analyze and use SIAs and surveillance data for intervention.

The programme will continue to implement validation mechanisms to ensure data quality and completeness. Any negligence or falsification of data will be considered a serious deviation calling for disciplinary actions against the concerned staff.

Continued monitoring of process indicators such as team composition, team performance and supervision indicators will be done to address gaps affecting the quality of campaigns. Also, the monitoring and coverage data of revisits will be analyzed in a disaggregated manner to identify and address implementation issues.

8.3.2 Frontline workers

NEAP 2020, with the concept of “back to basics” will prioritize proper selection of FLWs. Unbiased selection of appropriate FLWs will be the primary focus of preparations for any campaign. Any favoritism or nepotism related to selection process will have no acceptance and punitive action will be initiated against anybody involved. Close monitoring from national level will be done for FLW selection through the following interventions:

Close monitoring and support to the FLW selection committees by the NEOC and empowering them to function effectively and transparently, without any interference

National level focal point for each province, particularly in SNIDs areas will be appointed to review FLW selection for each campaign. Any deviation from guidelines or influence on selection will immediately be brought to the attention of the Director National EOC and Strategy Working Group for appropriate action. When required, chronic interference and nepotism will be brought to the attention of the Ministerial level for support and rectification.

Selection committees will make transparent and active efforts to engage more females as FLWs including vaccinator, supervisor, ICN and ICM. Percentage of females as FLWs, particularly in urban areas, will be tracked over the rounds to monitor the progress.

The national EOC in coordination with regional / provincial EOCs will initiate mechanism for appropriate, timely and institutionalized escalation of interference in selection of FLWs. This would include timely reporting of such issues to the highest levels (Governors, Ministerial level etc.) and track the actions.

The National EOC will directly monitor and support the engagement of female FLWs and mid-level managers. The National EOC will also ensure an enabling environment at all levels for recruiting and sustaining female workers at all levels.

The program will review and strengthen accountability of FLWs and will track the implementation including removals based on objective documented criteria.

The program will recognize the best performing personnel and reward the best performing FLWs (using non-monetary incentives) to maintain their motivation.



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

Timely payments of FLWs will be ensured, i.e. 90% of payments to be intimated before the next campaign in SNIDs areas and within 1 month in non-SNID areas. This will be tracked from the national level.

A thorough review of the Direct Disbursement Mechanism (DDM) was carried out by global experts and the national program team during January 2020. The review came up with a clear action plan to improve the timeliness of payment to the frontline workers by June 2020. Expansion of DDM to additional areas of the country will be done as per operational feasibility and preparedness. The program will continue to periodically review the payment mechanisms to identify and fix the gaps and continue working towards improving the efficiency and timeliness.

Review / Revision of FLW incentives in first quarter of 2020 (done).

8.3.3 Training

Appropriate Training of the front-line workers will be among the key focus areas of the programme to improve the overall quality of campaign implementation. The following interventions will be done under close supervision of the National EOC:

Simplification of training module with focus on identification and recording of all eligible children, focus on newborns and guest children, and recovering missed children by the end of the campaign. Material not relevant to vaccination team's work will be taken out of the training module. The module will include components on IPC, reflecting different communication strategies for house to house and site-based vaccination (as applicable).

Trainings in high risk districts by programme staff themselves (rather than 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

Revised training module, although simplified, should include components on IPC and reflect different communication strategies for H2H and site-based vaccination.



8.3.4 Microplanning

Following the microplan validation exercises undertaken in recent years, revision and updating of microplans will be ensured before each campaign. Mechanisms to monitor the revision of microplans by each supervisor will be developed and implemented.

In addition, key components of microplanning such as team/supervisor/coordinator workload and team composition will be tracked for each campaign.

The program will continue to monitor the need for any major microplan revision based on the findings of campaign monitoring. If there is need (based on significant evidence), targeted microplan revision exercise will be carried out.



8.3.5 Focus on newborns and infants

Special attention will be paid to newborns and infants during vaccination campaigns including during revisit and catch up phase through:

Recording of newborns/infants by ICN in pre-campaign and in-between round phase and support to vaccination teams during the campaigns.

Emphasis on importance of vaccinating newborns and infants during training and monitoring.

Increasing female frontline workers for better interaction at household level to identify and vaccinate newborns and infants.

Increasing the participation of female supervisors and monitors to support the frontline workers.

Train the transit vaccination teams (including the cross-border teams) to appropriately approach families and vaccinate newborns / infants.

Strengthen referral mechanism to enroll and follow up newborns for EPI vaccination and other convergence aspects to gain and maintain trust in the community.

Engaging women and community at large on the importance of newborn vaccination through dedicated messages on the overall child vaccination, combined with complimentary giveaways at risk areas.

Improving accessibility of health service and vaccines through harmonizing existing and polio plus activities and integrated health services.

Identification of white and underserved areas (villages level) and coordinating them for inclusion within the outreach schedules with or without additional resources.



8.3.6 Revisit

Given that the most remaining missed children are absent or refusals, the program will take the below mentioned interventions to strengthen revisits for their vaccination:

The National EOCs will review the revisit strategy and make necessary changes for timing and modality as well as aim to streamline the work division among the vaccination teams / volunteers and ICN (whereas ICN role continues to focus on vaccine promotion and community engagement rather recovery and vaccination of missed children). The National and Regional EOCs are currently reviewing the impact of a revised revisit strategy piloted in some clusters of Kandahar city; and this assessment will guide an appropriate, well -weighed expansion of this strategy to entire Kandahar city and other Focus Districts.

Strengthen supervision and monitoring of the daily revisit during three days of the campaign to improve effectiveness of “recovery of missed children during campaign” followed by proper and focused planning and implementation of missed children catch-up on the revisit day(s).

Monitoring checklists will be revised to measure the effectiveness of revisits and analyze recoverable children missed.

8.3.7 Monitoring

Monitoring of campaign implementation will, focus on hard to reach areas, with an objective of improving the implementation quality, particularly understanding and reducing missed children. Special focus will be given to understand the recoverable absent children and reasons of missing recoverable absent children during revisits, and reasons for underperformance of vaccination teams.

The programme will continue to validate the PCM and LQAS for data quality assurance and to identify poor performing clusters for corrective interventions. All analysis based on LQAS will continue with a cut off threshold of lot passed at 90%. Clusters falling below the 90% threshold will be strengthened by improving quality of ICM through reviewing selection, training and supervision by REOCs

Remote monitoring will continue in all high-risk hard to reach areas and possible blind spots. Data from remote monitoring will be analyzed over the rounds to see the trends.

The National EOC will continue to deploy monitors to complement the regional / provincial level monitoring as well as to maintain oversight on campaign implementation. The EOC will consider organizing monitors in “buddy pairs”, where feasible, to maximize triangulation and transparency in interpreting and responding to shortfalls in campaign performance.

A pool of national/regional monitors with capability to move in AGE-controlled areas will be deployed and scaled up to at least 10 staff at national/ regional level. Their capacity will be built at national level, following which they will be assigned to the field in consultation with regional teams to high-risk areas on a campaign basis.

The National EOC in coordination with the regional and provincial EOCs will continue to monitor the flow and utilization of financial resources up to the implementation level, with the aim to ensuring transparency. Financial accountability will be exercised with zero tolerance for any misappropriation.





8.4 Maximizing reach in inaccessible areas

Access for vaccination in Afghanistan has been very dynamic; of note is the rapidly deteriorating and fluctuating access situation since May 2018. There is generally an increase in inaccessibility since May 2018 with a period of complete ban from April to September 2019. Despite the lifting of ban in end-September 2019, house to house vaccination remains restricted for more than 40% target population of the country, particularly in the South, South East and Western regions as well as some pockets of North and North East regions. Apart from these on – off bans, the program also faces chronic inaccessibility in some parts of the Eastern and Southeastern regions accounting for around 30,000 children missing vaccination opportunities for several years.

For gaining and maximizing reach to children in inaccessible areas:

The program will maintain neutrality for polio eradication and will keep all level of AGEs informed about PEI activities for confidence building.

Access dialogue will continue at all levels ranging from local to international, with engagement and support of all partners who can positively assist on gaining / maintaining access for house to house polio campaigns.

Local coordination will be maintained with the AGEs aiming high quality polio program implementation and reaching all the children with polio vaccine during all the planned vaccination campaigns. In case of some specific local situation or objection by AGEs on some component of the program, the Regional EOC/regional teams will take decision in consultation with the National EOC.

Program will continue local level dialogue (at village, district and provincial level) to address any local bans / restrictions through local staff and if not resolved, national level will take it up to appropriate level for interventions.

For ban on house-to-house-campaigns, the program will:

- Continue to utilize scenario-based approach / matrix to adapt to the evolving access situation
- Negotiate site to site vaccination in case there is utmost AGE resistance for house to house strategy
- Develop enhanced key messages and materials to explain why house to house vaccination approach the golden standard for polio eradication.

- For any site to site campaigns, there will be enhanced planning, mobilization and monitoring to achieve the highest possible quality. Program will continue to review and improve SOPs for site to site campaigns based on the lessons learnt from previous implementations.
- As S2S vaccination is primarily a contingency plan and has shown to not reach coverage required for eradication, the program will continue to negotiate for house-to-house campaigns while conducting S2S campaigns. Preparedness will be maintained to start SIAs within 10 days of gaining access
- Program will continue to use additional vaccination opportunities e.g. IPV-OPV campaigns, addition of OPV to other vaccinations activities, intensifying EPI and mobile health teams. Also, necessary modifications will be considered for Permanent Transit Team strategy as per access situation
- For chronic inaccessibility, e.g. the Eastern and Southeastern regions, the program will conduct:
 - Regular rationalization and redistribution of PTTs as per inaccessibility at entry/ exit and health facilities
 - Preparedness to conduct 3 passages of catch up SIADS within 10 days of opening-up. The program will assess the situation and may consider expanding age group during SIADS, depending on duration of inaccessibility and other epidemiological factors. The program will also explore the possibility of delivering IPV with one of the rounds.
 - Polio Plus activities/ mobile health teams and IPV/OPV from health facilities near chronically inaccessible areas through BPHS NGOs as well as other actors having capacity to deliver
 - Additional vaccination opportunities, e.g. addition of OPV to other vaccinations activities and intensifying EPI

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





8.5 Enhancing EPI/PEI convergence through delivery of Integrated Services to build population immunity in high risk districts of South Region

As mentioned above, the districts of South region with ban on house to house vaccination have been driving the polio epidemiology in Afghanistan in 2018 and 2019. Health facility-based vaccination campaigns in these districts could only reached 3% to 6% target children during the last quarter of 2019, as the health facilities merely operated in a usual daily routine, offering routine immunization for 4 days with a few additional permanent transit teams. It is noted that:

Many areas in the high risk / inaccessible districts of Kandahar, Helmand and Uruzgan (south region) do not have any health facilities.

Some of the existing health facilities are not fully functional and some could not be included in the plan and lack proper budget, staff and supervision/monitoring mechanisms.

More than 300,000 target children eligible children live at a walking distance of more than one hour from the nearest health facility in the AGEs controlled areas.

In a very fluid security situation in the AGE controlled areas, the families are not expected to walk for hours with several children unless there is a comprehensive package of health services and pluses at the HFs.

More than half (54%) of the population in Afghanistan lives is below the poverty. The 2019 Integrated Food Security Phase Classification (IPC) report shows that 37% of the population need of humanitarian assistance, and recent estimates indicate more than 41% children aged less than five years are stunted. These figures are even more significant for Kandahar, Helmand and Uruzgan provinces in the South Region. Moreover, very low literacy rates in these provinces (<15%) lead to very low community awareness for utilizing immunization services. Being very underserved, the communities in these provinces continue to demand other health services, increasingly refusing stand-alone polio vaccination. Embedding polio vaccination within broader routine immunization and health interventions is an option to be considered in the given scenario (no house-to-house vaccination since May 2018).

The National EOC in coordination with BPHS NGOs management, National EPI and in-country GPEI and development partner has developed a plan for the delivery of polio vaccination embedded within integrated health services. The goal of the plan is to fast-track the progress to interrupt poliovirus transmission in the south region of Afghanistan and to contribute to the strengthening of immunization services and health system to help achieve and sustain polio eradication. The plan aims to reach around 800,000 missed children, in coordination with all potential partners and utilizing existing and new health facilities through expanding immunization services and opportunities in fixed, outreach, mobile and health week strategies. With no access for house to house and site to site vaccination, this kind of approach becomes the mainstay for the program to reach maximum possible number of children.

Considering the prevailing situation in the South region, a comprehensive national “integrated services plan” was developed in consultation with in-country and global partners as we all as national and provincial teams (please see annex – IV). The plan aims to build population immunity in the chronic reservoirs of south region including the inaccessible areas and sustain it in medium to long term, in the context of persisting challenges in the South region. The plan is in line with 2019-2023 polio end game strategy and TAG recommendations in the scenario of continued ban on house to house vaccination. In addition, the plan is a follow up to the endorsement made in November 2019 at POB meeting in Abu Dhabi and IMB recommendations.

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

Key interventions for convergence, Integrated and Polio plus Service Delivery in South Polio-endemic Areas will focus on following areas and interventions:

In order to further boost polio eradication efforts, EOC and its partners will continue strengthening convergent interventions for addressing basic needs to facilitate the implementation of NEAP. The polio affected provinces of south region will be further used as entry points of convergence and integrated services; and the interventions will be made more accessible and be delivered closer to the community. Summary of planned intervention to enhance implementation of NEAP in South region includes the following major activities:

- 1. Health intervention:** BPHS NGOs are providing integrated maternal and child health in PHC units through fixed and outreach services. In order to strengthen the provision of basic health services to the people of high-risk districts, special focus is placed on increasing penta-3 coverage to >90% by the end of June 2021.

The proposed intervention will include:

- Establishment of 62 new HF, staffed with two to four vaccinators, one midwife and one nurse in three provinces of the south

- Establishment of additional 72 MHTs (Integrated Service Outreach teams) in high-risk provinces in the south,

- Improve utilization of health/immunization services through pluses at the health facilities to attract clients such as soaps and baby blankets

Improve routine immunization coverage through deployment of additional human and material resources (technical staff and outreach vaccinators, solar fridges) in polio high risk areas of South

Strengthening the capacity of existing HF, through training, technical and financial support inclusive of training of new vaccinators for underserved and white areas

Adjusting target age for OPV from under 1 to under 5 in high risk provinces in routine immunization in fixed, outreach and mobile strategies until WPV interruption is achieved.

Private sector health facilities / clinics will be possibly included in the microplans and their role to be defined by their capacity to provide routine immunization

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

This will be a two-member team and the first vaccinator will be female resident accompanied by her Mahram as the second vaccinator.

These teams will cover the entire village (depending on the size of village from 200-600 families, geographic distance maximum 1-2 km).

The vaccinators will deliver only OPV vaccines until their capacity is upgraded to eventually administer all vaccines.

2. Nutrition interventions:

- a. Integrate nutrition services into mobile health teams
- b. Provide deworming tablets to children 24-59 months
- c. Provide therapeutic food (RUTF) for treatment of children 6-59 months with Severe Acute Malnutrition (SAM)
- d. Distribute alternatively Vitamin A and Albendazole to all children during national polio campaigns.

3. WASH interventions:

- a. Construction of solar-powered water supply piped systems with house connection
- b. Introducing a full package of WASH in selected schools
- c. Introducing a full package of WASH in selected schools

4. Education Interventions: The education intervention will be implemented in response to the repeated request made by some community elders in inaccessible areas, where polio transmission has been intense. The intervention is unique as it reflects an innovative, coordinated approach between Education and Health through community-based initiatives with a solid complementary social behavior change approach. Interventions include:

- a. Establishing Community based schools / Accelerated Learning Centers, teachers as polio influencers,
- b. Providing scholarships to female students,

- c. Training teachers on INSET and formative assessment packages and
- d. Training teachers and children on immunization with the intention of making them education/health ambassadors.

5. Polio Plus activities to increase vaccine acceptance, promote polio and other vaccines, decrease missed children and increase routine immunization coverage

- a. Distribution of soaps for children vaccinated during routine immunization sessions.
- b. Distribution of blankets to newborn in maternity clinics.
- c. Distribution of crayons and exercise books for children.

6. Decentralized management

- a. Establishment/strengthening of provincial EOCs in Helmand and Uruzgan
- b. Consolidation of the newly established UNICEF provincial offices.

All the convergent interventions (listed above) will aim to improve vaccine acceptance and coverage in polio high-risk areas, by addressing the needs and demands put forward and valued by the communities.



The current support mechanisms of PEI support to EPI will be maintained. There will be further strengthened on:

Supportive supervision and monitoring of EPI with focus on outreach and mobile sessions

The PEI staff will also support on improving of EPI micro-plans.

Collated findings with basic analysis of PEI staff monitoring, including “Zero Dose AFP cases data” will be regularly shared with the National EPI as well as with NGOs, GCMU and PMU departments for planning and intervention (please see annex – VI for monitoring SOPs).

BPHS NGOs are expected to share information on actions taken for issues identified by the polio program.

Systematic engagement of ICN in demand creation

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

There will be provincial joint monitoring plan with focus of monitoring and oversight on districts at risk of virus transmission from reservoirs inside and outside the country due to high population movements. The highest risk districts have been identified through the recent two cross border surveys in late 2019.

Inter-sectoral approach in polio high-risk areas

To address additional needs felt by the communities for basic social services, the program will prioritize efforts in Kandahar and coordinate with other line ministries and UN agencies. Support from other line ministries will be garnered through the ‘Polio high council’ as well as the ‘council of Ministers’. These efforts will focus on water supply and sanitation, community-based education, expansion of nutrition services and expansion of mobile health teams and sub-centers.



Under the umbrella of integrated services plan, the National EOC will also explore and utilize the opportunities to collaborate with other stakeholders involved in Humanitarian Response Activities in the high-risk / inaccessible areas of South region.

PEI support to EPI is an integral part of the plan on delivery of Integrated Services. This subject is explained in detail in the section on “Enhancing EPI/PEI convergence in high-risk districts”, later in the document.



8.6 Communication

Strategic communication remains the key backbone to polio eradication in Afghanistan. In 2020, communication efforts will continue to promote vaccine acceptance across the country and address cross-border communication issues with Pakistan through constant cross border engagement and collaboration. Proven interventions including media engagement, partnerships, advocacy, influencers and community engagement will be executed with a view to maintain and increase vaccine uptake. The communication strategy is also developed to build community trust and increase demand for polio vaccine uptake. However, in 2019 the communication activities have been constrained by the ongoing ban which has limited visibility, media broadcast, high level campaign inauguration and display of polio IEC materials. In 2020, the communication team will explore and maximize opportunities through continued negotiations particularly in inaccessible districts.

Overall, Vaccine acceptance in the country is not critical. However, it is a concern in south and south east with clusters of refusal. External communication reviews conducted in 2018 and 2019, TAG and IMB recommendations as well as local surveys on attitudes and practices and focus group discussions provided guidance to the 2020 plan. Findings from these sources revealed that:

Insecurity and AGEs position against vaccine, vaccinators selection and professionalism, lack of female vaccinators, vaccine misperception issues, distance from health services were cited by caregivers as challenges to vaccination.

Vaccine substance and Islam, newborn vaccine, campaign fatigue, conspiracy against Muslims, infertility and wicked children and demand for other health service are the main barriers to vaccine acceptance.

Television (42%), radio (40%), public health staff (29%), and family/friends (19%) are main information sources in relation to vaccine.

Female health workers and community influencers as well as representatives of the local authorities are highly trusted sources of information.





To address priority communication gaps, national and regional communication plans for 2020 have been revised to involve the ICN network, health workers, female mobiliser/vaccinators, media/social media and engagement with various social groups such influencers, local authorities, community leaders, religious leaders and women's associations.

Promotional, motivational and branding materials will be provided to communities at risk to enhance vaccine uptake and address cross-behavioral issues including basic home hygiene. Key advocacy initiatives including the engagement of the Islamic Advisory Group (IAG), Ministerial partnerships such as with Ministry of Haj and Auqaf and Ministry of Education will be pursued across Afghanistan. This plan has limitations related to access and changes.

The strategic approach is outlined through:

- National communication Plan that integrates all aspects of C4D
- Regional plans focused on priority communication gaps.

Communication and advocacy interventions:

Media mapping in key polio priority areas will be conducted to ensure all trusted and reliable channels are included in the media plan to improve harmony in disseminating key polio messages. This initiative will strengthen media relations and hopefully keep polio and health related stories at the top of their news agenda;

Develop and implement comprehensive strategic media engagement plan that ensures proper and timely placement of polio communication products for all media in both accessible and inaccessible areas;

Developing and producing a package of multimedia content that addresses behavior

change among refusals and highlights reasons for missed children;

Building capacity of Journalists to understand polio and vaccines. Enhance their reporting skills on polio and health related issues, while observing the fundamentals of journalism ethics and accurate reporting;

Developing a comprehensive social media strategy with a view to expand social media engagement across all platform that will support and amplify vaccine uptake and address rumors/propaganda cropping from the social media sphere.;

Implement the existing crisis communications strategy by training the national and regional EOC members on how to effectively respond to known and unknown crisis contributed by anti-vaccine related rumors or propaganda; The region will maintain a vaccination related rumor tracking and action form.

Design and produce polio branded promotional materials such as baby blankets, soaps, crayons and books to increase polio awareness and build community trust;

Develop regional communication plans through joint planning with the regions, and ensure content development is aligned with data driven communication issues at local level, while observing cultural sensitivities and language dialects;

Improve and strengthen cross border coordination and communication initiatives with Pakistan following the high frequency of high-risk mobile population movement between the two countries;

Community Engagement Activities

In 2020, the community engagement activities will expand beyond ICN to use other interpersonal communication networks with a view to reach target audience. The expansion beyond ICN is informed by the Community Engagement Review findings in late 2019 as well as regional communication research with audience groups. Justification of the activities is discussed in the national and regional communication plans. This includes community partnerships, focus on health facility-based polio promotion activities, media for public education, dedicated communication products for stakeholders and workers, the engagement of local authorities, influencers workshops.

With regards the ICN, the sudden funding cut in early 2020 has resulted in drastic reduction of 2,065 full-time ICN workers and the discontinuation of 2,495 campaign based ICN and 250 community influencers persons (CIPs). In the areas where ICN was cut or reduced, the use of mass media will be boosted, with focus on engagement content through local channels. The program maintained 3,778 ICN in the polio priority areas (access, communication risks) of Southern and Eastern regions where active circulation of polio virus is combined with:

High number of refusals

Where ICN monitoring is possible

High mobile population movement

Key Activities include:

1. **Immunization and Communication Network (ICN)** will continue to mobilize communities with the aim to increase vaccine uptake. Strict recruitment policies will be applied to ensure merit-based recruitment. The program policy from now is to recruit only qualified female workers.
2. **Campaign-based influencers in AGE's areas:** campaign-based influencers will be identified and tasked in the AGE's areas to support site to site immunization activities when conditions permit.
3. **Females engagement in polio promotion:** 800 female vaccinators/mobilisers will be trained and deployed at health facilities in polio high risk provinces to disseminate polio and cross sectoral messages. In addition, females will be recruited at communication related leadership positions to guide and conduct communication activities at priority areas.
4. **Influencers Engagement:** The program will engage the religious and social influencers through support to Madrasas in high risk provinces, influencers led workshops on child health in Islam, sponsorship of advocacy and social gatherings among influencers as well as the Madrasas graduation ceremonies and provide giveaways for senior religious influencers. The NEAP will focus specific religious engagement especially mapping out of Masjid Imams and madras schoolteachers both in Government and Taliban areas and consider for continue engagement in to break the rumor and religious refusals. In addition to it, famous religious leader at regional and provincial level and influential doctors is key for 2020
5. **Local Authorities Engagement:** The program will work with local area representatives such as Wikili Guzar, Maliks, village elders to endorse vaccines as well as strengthen the local government involvement in mobilizing the communities for vaccine uptake.
6. **Tools for community engagement workers and vaccinators:** MNCH, polio and hygiene key messages will be packaged appropriately and disseminated to vaccinators and mobilisers to facilitate dialogue with caregivers. Need to add short videos (Islamic preachers, Fatwa books, COVID-19 and Polio) and convergence messages including COVID-19 and Polio will greatly help
7. **Community Outreach for messages dissemination:** this includes community led campaign inaugurations to maintain program neutrality and community ownership, the engagement of traditional healers in messages dissemination, listening groups and discussions with elderly women that have influence over families, engage the polio survivors in community events, hold polio messages drawing competitions at schools, Madrasa among others.





8. **Medical Professionals and Operators Engagement:** health workers at refusal areas will undergo inter-personal communication trainings including polio messaging. The program will partner with key medicine faculties & nursing, midwifery schools to organize seminars on vaccines for teachers and students. Engagement of Media in Campaign monitoring and documenting the vaccine impact stories and airing for general awareness
9. **Communication Tools & Products for Key Messages Dissemination:** Multimedia messages with polio question and answer, roundtables addressing vaccine uptake and MNCH will be conducted at priority areas. Stories of the polio families and lessons learnt will be disseminated and discussed in the community. Print materials and communication supplies such as radio sets will be disseminated for wider reach among nomad and women's groups. Key health facilities will be painted with polio, MNCH messages through graffiti and participatory artwork.
10. **Media Development Initiatives:** local media awards will be disseminated to produce educational stories addressing vaccine uptake issues.
11. **Motivation of FLWs:** The program will champion the distinguished workers and promote female's participation. Support includes vouchers for learning activities for dedicated workers, giveaways will be provided at key occasions and the World Polio Day will honor FLWs' efforts and sacrifices.
12. **Communication research:** FGDs will be held to gather feedback on communization activities and emerging vaccine uptake issues.
13. **Communication capacity building and planning meetings:** training and meeting facilities in selected areas will be supported to provide conducive environment for learning and with special consideration to females needs (e.g., females' toilets, lighting...etc.). Monthly communication planning meetings utilizing vaccine uptake data and trends will be held at priority areas at the end of each month to inform communication actions.

Special Initiatives of the Islamic Advisory Group IAG:

In 2020, IAG as member of the Communication Working Group of EOC will continue to work with religious influencers through communication capacity building and knowledge sharing with regards to immunization and child health in Islam. The following interventions will be pursued:

Training of IAG provincial focal points (religious scholars) on vaccine, child health from Islamic perspective.

Religious scholars training on interpersonal communication skills for polio and routine immunization promotion.

Development and implementation of training curriculum of child health, vaccine and Islam for medicine and Sharia school students as well as key Madrasa leaders.

Training of FLWs on the Fatwa book content for informed discussions during household visits and community meetings.



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

The evidence of shared transmission between Afghanistan and Pakistan continues to reinforce the role of mobile populations travelling within countries and across the border, in sustaining and spreading poliovirus transmission. To strengthen the mapping and vaccination activities for these population, the appointed HRMP focal points in the national and regional EOCs will follow the implementation of agreed strategies related to HRMPs (with enhanced focus on newborns / infants). In addition:

The programme will continue to collaborate with other UN agencies and line departments for elaborate information about IDPs and will immediately plan vaccination activities according to the dynamics of IDPs

SNIDs will continue to include HRMP settlements in non-endemic areas

Nomads: Continuous mapping and cross border information sharing about movements of nomads will be carried out with vaccination strategies (nomad campaigns in southeast and special transit teams along nomad movement routes in south and west)

Cross border:

- The programme will continue to vaccinate the travelers of all age group, crossing border with Pakistan at Torkham. This will be expanded to the southern border crossing point at Friendship Gate.
- Regular assessment of informal crossing points will continue, and cross-border vaccination teams rationalized accordingly
- The program will continue vaccination at all cross-border points and international airports and explore new informal crossing points to deploy vaccination teams
- Vaccination of travelers as per IHR will be continued.



- Returnees:
 - Through regular coordination with UNHCR, IOM and DoRR, the programme will monitor the flow of returnees to Afghanistan and adjust the vaccination teams in the repatriation centers as required
 - All major congregations will be identified, and special vaccination opportunities will be provided
 - The program will exercise all possible flexibilities while endeavoring to reach on cross-border resettling families during and outside the campaigns; with the core aim of “consistently reaching and vaccinating the children” in such families.



8.8 Maintaining sensitive surveillance

Afghanistan has maintained a sensitive surveillance system for poliovirus through AFP surveillance achieving internationally recommended indicators of sensitivity. Complementary to AFP surveillance, environmental surveillance continues to test sewage samples from 21 nationally, representing all the regions of the country. To ensure sensitivity in chronically inaccessible areas, the programme continues to carry out healthy children stool sampling in selected areas/districts. All the strategies to maintain sensitive surveillance will be maintained with a weekly review of surveillance indicators. Internal and external surveillance reviews will be conducted to identify any operational gaps and undertake corrective measures.

With growing risk of importation of VDPV2 from Pakistan, special measures are being taken in the East region. These include enhanced frequency of environmental sampling (fortnightly) and enhanced active search in the health facility and among high risk communities. The national surveillance unit will continue to send the national level surveillance staffs to review the surveillance sensitivity and quality of the surveillance related processes at the provincial and sub-provincial levels. These national staffs will also continue to assist the regional and provincial teams on periodic review and appropriating review of the surveillance network and reporting volunteers.



8.9 Enhancing EPI/PEI convergence in high-risk districts

The geographic scope of this plan is in six provinces, namely Kandahar, Helmand, Nangarhar, Farah and Uruzgan. However, the focus will be on Kandahar, Helmand and Uruzgan provinces. Interventions planned for enhancing EPI/PEI convergence in high risk districts, include:

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

- Establishment of sub-health centers: the facilities will be staffed with two to four vaccinators, one midwife and one nurse
- Establishment of Mobile Health Teams
- Training of new vaccinators for underserved and white areas
- Adjusting target age for OPV from under 1 to under 5 in high risk provinces in routine immunization in fixed, outreach and mobile strategies until WPV interruption is achieved.

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

- This will be a two-member team and the first vaccinator will be female resident accompanied by her Mahram as the second vaccinator.
- These teams will cover the entire village (depending on the size of village from 200-600 families, geographic distance maximum 1-2 km).
- The vaccinators will deliver only OPV vaccines until their capacity is upgraded to eventually administer all vaccines.

The current support mechanisms of PEI support to EPI will be maintained. The will be further strengthened on:

Supportive supervision and monitoring of EPI with focus on outreach and mobile sessions
The PEI staff will also support on improving of EPI micro-plans.

Collated findings with basic analysis of PEI staff monitoring, including “Zero Dose AFP cases data” will be regularly shared with the National EPI as well as with NGOs, GCMU and PMU departments for planning and intervention (please see annex – VI for monitoring SOPs).

BPHS NGOs are expected to share information on actions taken for issues identified by the polio program.

Systematic engagement of ICN in demand creation

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

There will be provincial joint monitoring plan with focus of monitoring and oversight on districts at risk of virus transmission from reservoirs inside and outside the country due to high population movements. The highest risk districts have been identified through the recent two cross border surveys in late 2019.

Section 9

Monitoring of NEAP implementation

Strategic work plans will be monitored quarterly

Implementation of NEAP will be monitored on quarterly basis by 'Strategy Working Group (SWG)' of the National EOC by tracking the process against NEAP work-plan and progress on identified key programmatic parameters against the objectives set in NEAP 2020.

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

There are several interventions in NEAP 2020 that are region specific (as in South, East, South-East and West regions) for which the respective Regional EOC will closely monitor the progress of the activities every month and address the bottlenecks (if any) in implementation. After the full establishment of the provincial EOCs in Helmand and Kandahar provinces, the program management and accountability will be appropriately shifted to the provincial level with continued necessary support from the Regional team. The National EOC will ensure provision of the necessary enabling support as well as full functionality of the provincial EOC (Helmand and Uruzgan) before this transition.

In South region, the Helmand provincial EOC will also monitor the progress of activities in the province each month, in addition to periodic review by the regional EOC in Kandahar. The regional EOCs will share the status of progress and their findings with the SWG of National EOC following review at their end. In addition to monitoring progress of the specific activities in

the NEAP work plan, the regional team will assess program improvements based on certain identified parameters and the SIA minimum standards.

Proportion of missed children in SIAs by district and province

Number of missed children due to inaccessibility by district and province

Number of children missed due to refusals (categorized by reason) by cluster and district

Number of functional selection committee by province and district

Proportion of female FLWs by district and province

Number of districts identified with high number of villages that remained uncovered by RI outreach by province

Proportion of under immunized children among non-polio AFP cases by district disaggregated by reason (as per investigation report)

Evidence based programming remains the backbone of designing responsive community engagement initiatives including drawing lessons on emerging barriers to vaccine acceptance amongst the population. In 2020 the program will engage with reputable communication institutions such as John Hopkins University in implementation of surveys to inform programme communication initiatives particularly in the Polio high risk districts to better understand Polio vaccine knowledge levels, prevailing attitudes and community practices. This will include undertaking qualitative research and feedback sessions with caregivers particularly those of chronic refusal category. Additionally, to facilitate timely generation of programme performance data the program will pilot digitization of field book in urban areas of Kandahar and Jalalabad. The programme will continue deployment of independent third party monitoring institutions to assess ICN performance.

A mid-term review of the NEAP implementation status and effectiveness of strategies will be carried out in mid-2020 and necessary mid-course correction and adjustments will be made, as necessary.



Section 10

Effective vaccine and cold chain management and accountability

2019 focuses on targeted strategies to address critical issues

To maintain effective vaccine and cold chain management in the country, the national polio eradication programme will prioritize the following activities:

On time procurement and delivery of 122 million of OPV vaccines planned for 2020. Procurement of 200 solar fridges to support PEI and EPI in the Southern provinces. Continued strengthening of the cold chain system for PEI based on regular cold chain equipment inventory and gap analysis for both PEI and EPI. PEI-related CCE gaps will be addressed in collaboration with National EPI Programme.

Strengthen the functioning and capacity of vaccine and cold chain management structure which is the platform for providing oversight for both PEI and EPI vaccines and cold chain systems in the country. These structures will also be strengthened at regional levels.

The programme will sustain trainings and refresher on vaccine and cold chain management at all levels, with special emphasis during training of FLWs for SIAs. Based on lessons learnt over the recent years and campaigns, focus will be made to strengthen capacity for vaccine distribution and logistics planning and management at the lower levels of service delivery during SIAs – at district, cluster and FLW levels.

The programme will strengthen accountability of all vaccines deployed, including its proper management and use at all levels (especially field level). Monitoring/Supervision component will focus on this aspect.

Section 11

Possible effects and adjustments in the Context of Corona Virus Disease 2019 (COVID-19) Pandemic

2019 focuses on targeted strategies to address critical issues

While the Polio NEAP 2020 is being rolled out, the world is facing the challenge of COVID-19 pandemic. Afghanistan has also been hit by the pandemic and has reported close to 1,000 COVID-19 cases, as of 19 April 2020. The pandemic is significantly affecting the global polio program, including Afghanistan. The program is continuously monitoring the COVID-19 situation in the country and will continue to adapt to the situation. The EOC/MoPH has issued a position paper for program adjustment until the end of May 2020 (please see annex VII); further decision about the polio program course after May 2020 will be made after careful situation analysis during the second half of May 2020.



Annexures

- Annexure I: NEAP 2020 work-plan (will be finalized by end May 2020)
- Annexure II: List & map of FDs, VHRDs and HRDs (Risk Categorization)
- Annexure III: Accountability framework
- Annexure IV: Integrated service plan in south region
- Annexure V: Minimum standards for SIAs
- Annexure VI: SOPs – Support of PEI staff on RI monitoring
- Annexure VII: EOC, MoPH position paper on “adjustment to the Afghanistan polio program during the COVID-19 pandemic, and polio program support for COVID-19 response”



We know a future where every child can grow up without fear of polio is possible.

We are determined to make it happen.