



JANUARY 30, 2019

NATIONAL EMERGENCY ACTION PLAN
2019

POLIO ERADICATION INITIATIVE, AFGHANISTAN

NATIONAL EMERGENCY OPERATIONS CENTER, AFGHANISTAN



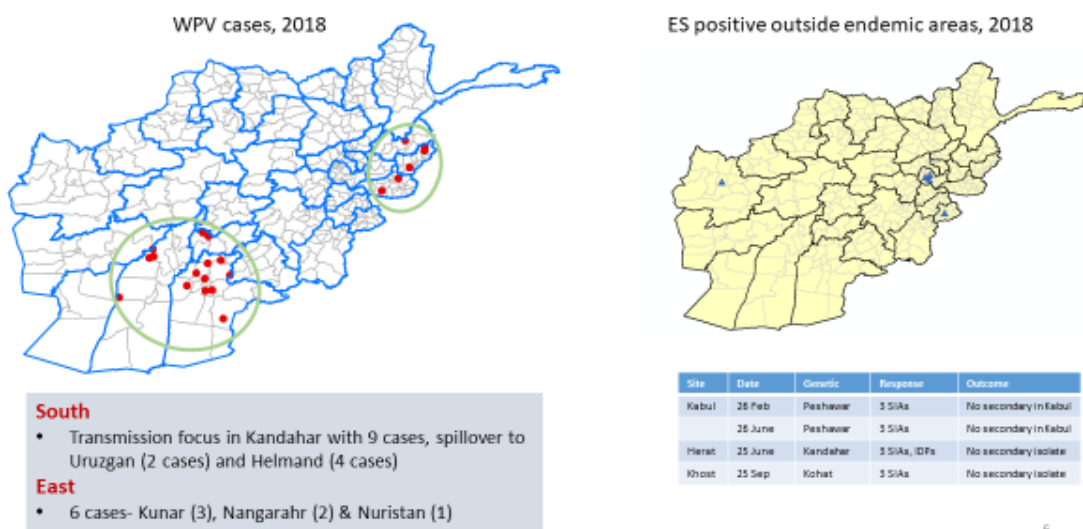
Context and background

Epidemiology

Currently polio transmission in Afghanistan is limited to Southern and Eastern regions with no polio cases detected from the rest of Afghanistan. Afghanistan has detected 21 polio cases in 2018. Of these, 15 cases are in the Southern region; while 6 cases are in the Eastern region. Ongoing transmission in the Southern region is internal transmission, while that in Eastern region is part of Northern corridor transmission involving bordering areas of both Afghanistan and Pakistan.

Polio transmission, 2018

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



South region:

In 2018, 15 cases have been confirmed-transmission mainly in Kandahar (9 cases) with spread to neighboring provinces Helmand (4 cases) and Uruzgan (2 cases). Unlike the 2014-2016 outbreak, transmission has not spread to other provinces due to reasonably high population immunity maintained.

Key reasons for continued transmission in South region are:

- Inaccessibility in Shahwalikot and surrounding districts since April 2017, resulted in immunity gap and inability to respond timely
- Continued ban and expansion to ban to Helmand, Uruzgan and Kandahar in May 2018 (>840,000 under 5 children)
- Refusals in and around Kandahar city
- Compromised quality of SIA campaigns in some of accessible areas

Eastern region

In 2018, 6 cases have been confirmed-3 from Kunar, 2 from Nangarhar and 1 from Nuristan. It is worth noting that the transmission in the East is part of Northern corridor transmission which spans both Afghanistan and Pakistan. Genetically similar viruses have been detected in Nangarhar, Kunar, Kabul and Khyber-Pakhtunkwa as well as Rawalpindi, Islamabad, and Lahore.

Key reasons for ongoing transmission in East region are

- Presence of Social/ geographical clustering of unreached population groups which includes high risk mobile populations like long distance travelers, straddling populations, refugees and returnees
- Small scattered pockets of chronically inaccessible children (28,000 children missed more than 3 vaccination opportunities)
- Refusals, particularly among displaced population from KP/FATA

Outside endemic zones

Program detected transmission outside endemic zone, Polio virus was detected in environmental samples from Herat, Khost and Kabul. These were responded rapidly and strongly resulting in no further spread or continuation of transmission.

Surveillance

Sensitive surveillance system was maintained throughout Afghanistan irrespective of access for SIAs. Reporting network was expanded to 2,510 zero reporting sites and 34,548 reporting volunteers across the different parts of country.

Program also conducted Environment surveillance from 20 major population centers of the country.

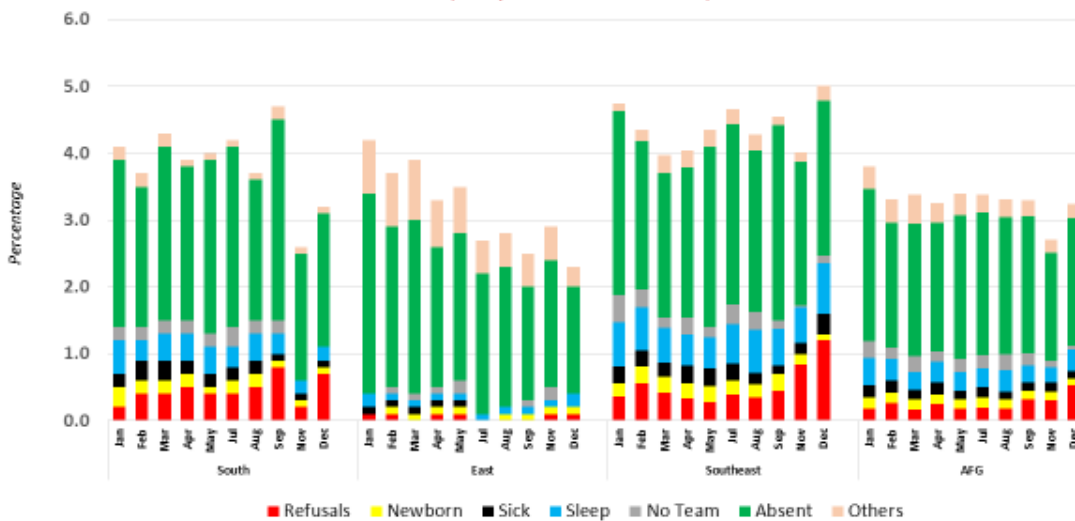
In internal surveillance review was conducted in 2018 in all the regions except South. Country also took initiative of conducting healthy children sampling form chronically inaccessible areas. Total 132 samples were tested.

Vaccination campaign quality, access and refusals

As part of NEAP 2018, program undertook many interventions to improve quality of vaccination campaigns. These interventions included microplanning validation, monitoring of train sessions for interventions, direct oversight from National EOC monitors.

However, program still misses around 4% children in accessible areas, absent and refusal being two primary reasons for that.

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



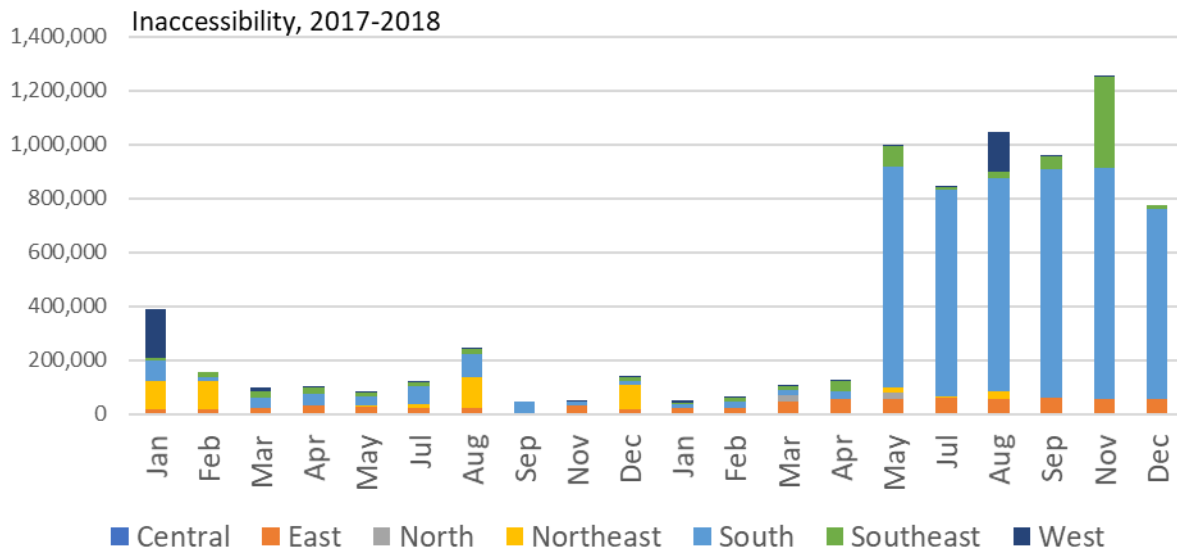
Scope of Dec SNID was smaller than other SNIDs

Source: PCA data

Inaccessibility:

Country program maintains dialogue with AGEs at local, provincial and higher level on program neutrality for polio and supporting activities. It has helped in gaining and maintaining access for polio vaccination in most of the country including most of Southeast, west and northeast region.

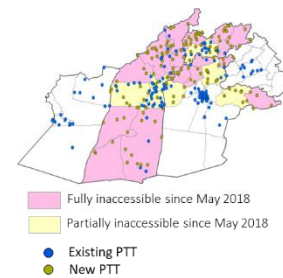
Program had relatively good access till May 2018 when a ban on house to house activity was imposed on large parts of south region.



Program has come up with contingency plan to address the ban in South region under which following interventions have been done

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

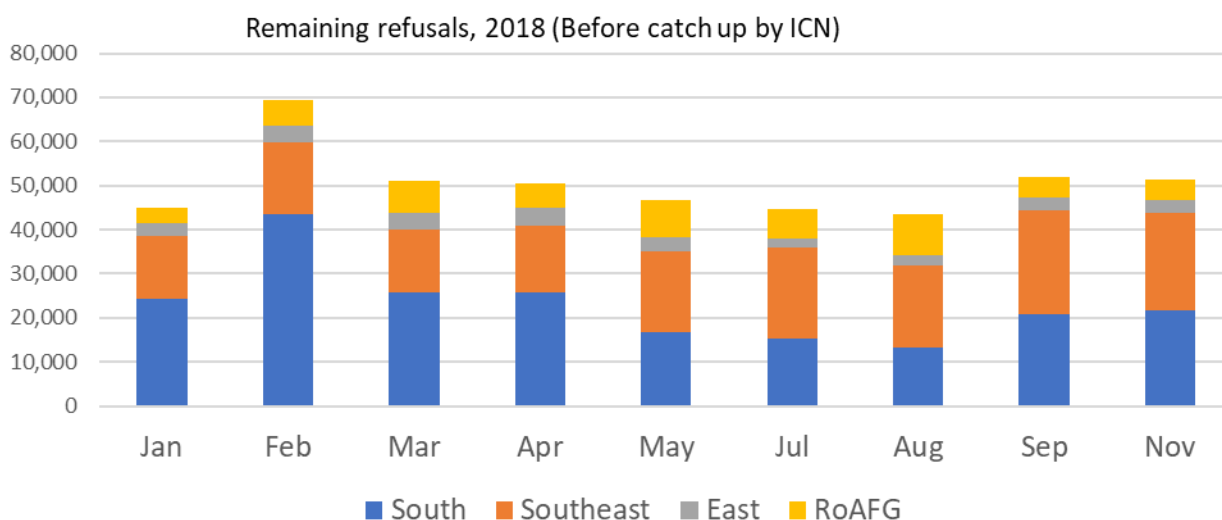
Expansion of PTTs for inaccessibility



Vaccine acceptance issues

Overall there is high vaccine acceptance in Afghanistan, however, there are small pockets of refusals for vaccine particularly in South and Southeast region.

For addressing issues in vaccine acceptance, program does cluster level refusal analysis and develops action plan on campaign basis. Immunization Communication Network has been deployment in all high risk areas. Qualitative analysis is being done to understand reasons of refusals (FGD), systematic influencer engagement is being done according to local need, and Media and Social Media is engaged to address rumors.



As part of framework of change, below new interventions has been taken

- **External review of communication strategy:** Conducted Nov/Dec 18 recommendations are incorporated in 2019 NEAP and CWG workplan
- **EOC refusal oversight committees:** Newly established at national & regional level
- Expansion of network of influencers: Review existing list of influencers (including from Pakistan) and refusal resolution committees
- **Strengthened engagement of ministry of Hajj and Auqaf:** Meeting for religious scholars (IAG)
- **Addressing other felt needs:** Initiated in high risk areas of the South (Water supply/ sanitation, expansion of mobile health teams & subcenters, expansion of nutrition services, support to outreach vaccination, community based education)

High-risk mobile population strategy

Afghanistan program maintains close coordination with Pakistan in three corridors on HRMP. It has identified four types of HRMP and has specific strategies for each type:

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

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

For nomads, nomad specific SIAs are conducted in Southeast upon entry in Afghanistan and Nomad specific PTTs are deployed in movement routes in South and West regions.

Straddling populations have been mapped and focused for coverage in East, Southeast and South regions. Returnees are vaccinated at border, UNHCR/IOM center and are included in SIA microplans at the point of settlement

Tailored key messages and communication materials to support HRMP vaccination are planned in 2019.

Coordination with Pakistan

Afghanistan and Pakistan has shared epidemiology and are treated as one epidemiological block. There is extensive population movement between these two countries.

Jointly, both the countries have identified three transmission corridors viz. Northern, Central and Southern. Joint corridor action plans were developed and are being implemented for all three corridors.

There is close coordination on operational and technical aspects at national and subnational levels which includes Information sharing on Surveillance, communication, population movement, SIAs and case response, and coordinated response to poliovirus

EPI

One of the important factors in polio eradication is strong routine immunization. However, there is low Routine Immunization coverage in polio high risk areas of South region. This is largely due to 1) lack of resources, insufficient number and distribution of EPI services, 2) Suboptimal implementation of existing plan.

PEI field staff supports implementation of existing plan through direct support in microplanning, monitoring and social mobilization.

However, it is well recognized that to improve EPI services, there is need for additional resources, particularly in South region high risk provinces.

Challenges and risks to stopping polio

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

- The most significant risk facing the program remains the continued **ban on the house-to-house strategy** in major parts of the Southern region.
- In the Eastern region small pockets of chronically inaccessible children and **high population mobility between Afghanistan and Pakistan**
- **Pockets of refusals** particularly in and around Kandahar as well as in the Eastern and South east regions.
- **Sub-optimal campaign quality** in some key areas under control of AGE, due to management issues
- **Low EPI coverage** in high risk polio areas

For 2019, in the view of prevalent epidemiology and need to address the remaining challenges, National Emergency Action Plan was developed through bottom-up approach. Provinces and regions reviewed what worked or not and came up with interventions to address remaining challenges in their area.

Development and operationalization of NEAP 2019

Regional EOCs conducted workshops involving provincial teams to identify key challenges, interventions done in 2018 & outcome and plan for 2019 to address those challenges.

Following these workshops, a national level workshop was conducted with regions to discuss and compile the interventions proposed by regions. A compiled document, developed as outcome of workshop, was shared with regions for the feedback. These feedbacks were further reviewed and incorporated in the current version of document.

The NEAP incorporating feedback from regions and partners, was presented to TAG during its meeting in January 2019. TAG reviewed the NEAP and made some additional recommendations which have been incorporated in this version.

For effective operational of this National Emergency Action Plan, program will take below action.

Review and strengthen governance and management

EOCs are playing crucial role in providing oversight, coordination and management of polio efforts. To strengthen EOCs, a workshop was conducted by the CDC with all members of national and regional EOCs. A subgroup has been formed at the National EOC to revise the current organogram and working modality to ensure that the EOC structures are fit for the purpose.

Implementation plan

An implementation plan will be developed for the interventions of NEAP along with persons/ group responsible for every intervention and timelines.

Costing

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

Accountability framework

National EOC will develop an accountability framework encompassing all levels of program for implementation of NEAP

Coordination bodies

- National steering committee chaired by H.E. the President. This will meet biannually to review the progress and garner support from all parts of the Government.
- Council of Ministers chaired by H.E. the Chief Executive. This will meet quarterly to ensure coordination with other line ministries.
- Polio high council, co-chaired by H.E. the Minister and H.E. Presidential focal point and participated by all line ministries will meet quarterly
- Polio executive committee which is formed of H.E. the Minister, H.E. Presidential focal point, National focal point for Polio, country representative of WHO & UNICEF reviews the progress and challenges in polio eradication. This committee will meet monthly and will provide feedback to H.E. The President
- Polio partners dialogue will meet quarterly where Polio executive committee will update and garner support of local donor partners

Goal

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

Objectives

NEAP 2019 has following objectives

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

Residual risks

Even with full implementation of all interventions outlined in this NEAP, we caution that there are some factors beyond control of program and those factors can derail progress.

- Looking at dynamic security and access situation, we caution of limitation posed to the polio eradication due to any deterioration in access situation.
- Afghanistan and Pakistan are one epidemiological block; both countries need to finish together.

Strategic interventions

Below are key strategies for 2019 to address the key challenges and ensure progress towards polio free Afghanistan.

- Strong **focus on Kandahar province** and South region while maintaining focus on Eastern region.
- Addressing the remaining gaps in Southeast and West region
- Continued focus on identified **high risk provinces and districts**
- **3 NIDs and 6 SNIDs** in 2019 along with IPV campaign in polio high risk areas. Using mOPV1 for at least 2 SIAs in high risk areas.

- Systematize collection, **analysis and use of data at lowest possible level**, particularly at provincial and regional level for improvement in program
- Interventions to **reduce missed children in accessible areas**: addressing gaps in program quality including issues related to vaccine acceptance
- Ensuring **maximum reach in inaccessible areas**
- Identification, mapping and coverage **of High Risk Mobile Populations with focus on Eastern and Southeastern region**
- **Intensify communication strategies** incorporating feedback from communication review
- Maintain **sensitive surveillance** system
- **Strengthen EPI and convergent services in polio high risk areas**, particularly in South region with focus in Kandahar

South

For next 6 months, country will focus on stopping transmission in Kandahar which is the engine of transmission in southern corridor.

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

East

While recognizing that the transmission in Eastern region is shared one with Pakistan in Northern corridor. Program will

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

Southeast

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

Rest of Afghanistan

While focusing efforts in South and East region, program will maintain high population immunity by improving quality of SIAs and improving EPI in non SNID areas

Focus on high risk provinces and districts

Program has by and large decided to retain existing risk categorization of districts which was for NEAP 2018 period while making some adjustments as per the current risk.

Program has identified 15 FD, 34 VHRD and 37 districts as HRD and will continue focus these districts with flexibility to include additional districts, if new and significant risk factors emerge.

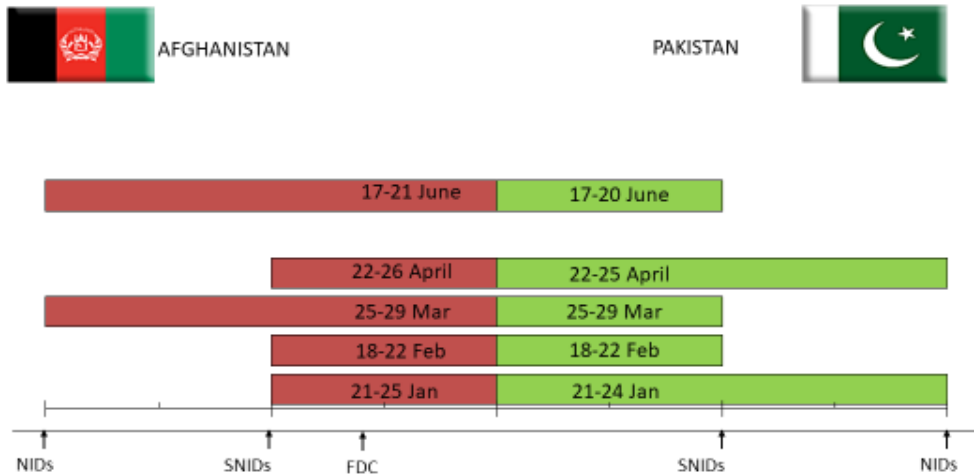
Changes in risk categorization of districts				
Region	Province	District	2018	2019
Central	Ghor	Lal Wa Sarjanganl	HRD	No HR
Central	Kapisa	Mahmud-e- Raqi	HRD	No HR
Central	Parwan	Charikar	HRD	No HR
East	Kunar	Ghaziabad	HRD	VHRD
North	Faryab	Ghormach	HRD	No HR
East	Kunar	Chawkay	No HR	HRD
East	Nangarhar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

Also, for intensified focus, Kandahar, Helmand, Nangarhar, Kunar, Paktika and Farah have been identified as high risk provinces. These provinces are responsible 84% of all polio cases since 2010 with Kandahar giving maximum cases (35%).

SIA

Program will conduct 3 NIDs and 6 SNIDs in 2019. Of these 2 NIDs and 3 SNIDs will be conducted in low transmission season. High transmission season will have 1 NID and 3 SNIDs. All the SIAs in 2019 will be synchronized with Pakistan.

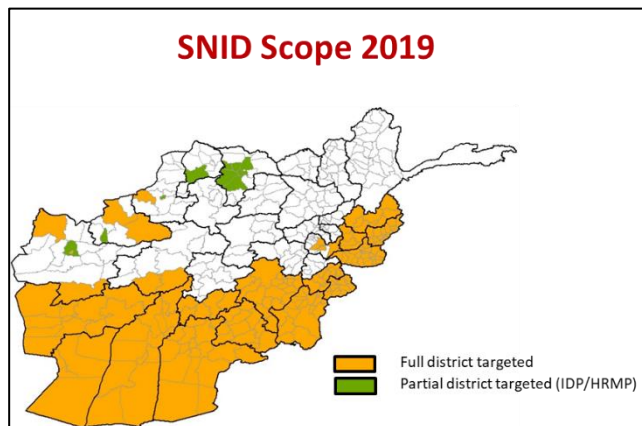
SIA schedule AFG & PAK, Jan to June 2019



Program has decided to expand the scope of SNID to include whole of Nuristan province, and major clusters of HRMPs identified outside endemic areas.

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

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



Data analysis and use

Program will analyze SIA coverage and monitoring data by access categories with aim to minimize missed children in accessible areas

Capacity of regional and provincial teams will be strengthened to analyze and use SIA and surveillance data for intervention.

It has been recognized that there is sometime data are being collected which are not well utilized as well there is some duplication in data being collected. To streamline this, program will review all data streams being collected and will take steps to rectify this. Also, before introducing any new data stream or format or changing existing one, regional and provincial teams will be consulted on feasibility, usefulness and additional workload which it will put.

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

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

Program will develop profile of clusters with high proportion of missed children to identify the core issues and address.

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

Addressing missed children in accessible areas

Program will target to reduce and sustain proportion of missed children to less than 5% at district and cluster level in high risk areas. For LQAS, aim will be to have lots passing at 90% rather than 80%, all visualization and presentation of LQAS data will be changed to reflect that.

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

ICN is a valuable resource for polio. In ICN areas, their performance will be measured on the basis of reduction of missed children during campaigns and in catch-up activities, based on robust analysis of all reasons for missed children, including but not limited to refusal. ICN will track both chronic absentee and chronic refusals.

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

Frontline workers

The FLW efforts will focus on missed children, particularly in VHRDs. Program will take below interventions for FLW Selection:

- Formation, composition and functioning of FLW selection committee will be directly monitored by NEOC.
- Selection committees will make transparent and active effort to engage more females as FLWs including vaccinator, supervisor, ICN and ICM. % of females as FLWs, particularly in urban areas will be tracked over the round to monitor the progress.
- Program will institute as system of and will track the accountability of FLWs including removal based on objective documented criteria.

Along with this, below measure will be taken to sustain motivation

- Payments of FLWs will be ensured timely i.e. before next campaign in SNID areas and within 1 month in non SNID areas
- DDM expansion will be for transparency with flexibility in DDM/cash payment through financial committees wherever there are challenges.
- Rates of p[ayment to FLWs will be reviewed in mid-2019 in view of inflation

- Support of security departments including focal persons from Security for every province to address issues related to FLW security will be coordinated by OPFPPE
- Support from Security authorities will be garnered for PTT vaccination. They will help in vaccinating children on move by stopping the vehicles with children of target age.

Training of frontline workers

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

- Review of modality (venue, duration, incentive, methodology) and monitoring to harmonize between operations and communications wherever feasible
- The training of 5 high risk provinces to be 100% monitored by independent training monitors.
- Provincial and regional team members to facilitate training at VHRD and HRDs level
- Revision of training committee TOR for 5 HR provinces and Fully Functionalizing of provincial training committee.

Microplanning

Program has successfully completing micro plan validation exercise in 290 districts in 2018.

- In 2019, program will complete microplanning exercise where not done and is feasible. This exercise will be repeated again in second half of 2019.

Revisit

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

- NEOC will review the planning day and if needed, give flexibility of using 4th day as revisit day. This decision will be taken on case to case basis as per the local context in provinces.
- Strengthening supervision for same day revisits and 5 day revisits
- ICM checklist will be revised to strengthen specific component for daily revisit
- In ICN areas, support of ICN for revisits will be tracked and strengthened

Overall missed children (including absent children) tracking and vaccination will now continue between campaigns, and catch up days will be extended where necessary.

Addressing vaccine acceptance issues

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

- Operations and communication will be fully integrated, particularly at frontline level (ICN and vaccinator teams) but also at strategic planning levels.
- For refusals, mapping of geographical clustering and subsequent analysis of reason for clustering will guide prioritization and resolution strategies
- Refusal oversight committee at National, regional and provincial level will be formed to track, guide and monitor implementation and effectiveness of strategies
- Integrated refusal approach will be developed at provincial level by provincial oversight committees

- Program will review and revise list of influencers/ refusal resolution committees and enhance their IPC skills
- In AGE controlled areas, program will explore ways to record the number of refusals to understand the extent and prioritize
- Efforts of resolving refusals in between campaigns will be intensified and documented
- In order to minimize knocks as well as reduce chances of false finger markings/reducing, program will strengthen triage system which will take off pressure from FLWs (vaccinators and ICN). ICN-SM will not be held responsible for resolution of chronic refusals, rather they will be responsible for identifying and reporting them.
- To strengthen triage system, program will do analysis on the proportion of refusals resolved by different level to assess the effectiveness and strengthen.

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

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

Monitoring

Monitoring is one of the important component of program. It informs the program on quality of campaign and guides the interventions for reducing missed children. Below interventions will be taken to strengthen monitoring

- Monitoring of monitors, both PCM and LQAS, will be continued and outcome will be tracked from national level
- LQAS cut off will be changed to 90% and all failed lots will be investigated for reasons and corrective actions by regional teams
- ICM will be strengthen by improving quality of ICM selection, training and supervision by REOCs
- Remote monitoring will be expanded to all high risk areas and possible blind spots. Data from remote monitoring will be analyzed over the rounds to see the trends.
- Program will explore engaging third party for post campaign monitoring
- A pool of national/regional monitors with capability to move to AGE controlled areas will be developed and increased to have at least 10 such people at national/ regional level. They will be assigned to the field in consultation with regional teams to high risk areas on campaign basis.

Capacity building of PEMTs

PEMTs are the leader of polio eradication activities at provincial levels. All PEMTs need to be fully engaged and take leadership in implementation of SIAs. Towards this,

- National EOC will institute a mechanism to track the engagement of PEMTs

- Workload and capacity of PEMTs will be reviewed and, possibility of placing additional human resource in SNID provinces will be explored
- For high risk districts of Kandahar, District level officer (DEMT) will be deployed for managing program at district level

Maximizing reach in inaccessible areas

Inaccessibility in Afghanistan is very dynamic and program has seen increase in inaccessibility since May 2018, particularly in South and Southeast region resulting from ban on house to house campaign. Apart from these off-on bans, program also faces chronic inaccessibility in some parts of East and Southeast regions accounting for around 30,000 children missing vaccination opportunity.

For maximizing reach to children in inaccessible areas

- Program will maintain neutrality for polio and will keep all level of AGEs informed about PEI activities for confidence building. In case of objection by AGE on some component of program, REOC/ regional team to take decision in consultation with NEOC.
- In case of ban/ inaccessibility, dialogue at village, district and provincial level through local staff will be continued and if not resolved, national level will take it up to appropriate level for interventions.
- For ban on house to house activity, e.g. in South and Southeast, program will
 - Develop a matrix will for decision making for using site to site approach
 - Negotiate for site-to-site (S2S) vaccination and conduct in place of house to house vaccination.
 - Developed enhanced key messages and materials to explain why H2H is the only viable eradication strategy.
 - Wherever S2S will conducted, there will be enhanced planning, mobilization and monitoring to achieve the maximum quality. SOP for site to site will be further strengthened using the lessons learnt from Kandahar. Data from these campaigns will be analyzed in disaggregated way for vaccination of infants.
 - As S2S vaccination is just a contingency plan, program will continue to negotiate for house to house campaign while conducting S2S campaigns. Preparedness will be maintained to start SIA within 10 days of gaining access (push-button mechanism)
 - For ban exceeding 3 months, additional vaccination opportunities will be used e.g. IPV-OPV campaigns, addition of OPV to other vaccinations activities, intensifying EPI and mobile health teams. Also, Permanent Transit Team strategy will be reassessed in areas and strengthened as per the access.
- For chronic inaccessibility e.g. East and Southeast regions, program will conduct
 - Regular rationalization and redistribution of PTTs as per inaccessibility at entry/ exit and health facilities
 - Polio Plus activities/ mobile health teams and IPV/OPV from health facilitates near chronically inaccessible areas
 - Preparedness for catch up SIADs once area opens up within 10 days. IPV in at least one of the rounds (Push button mechanism)
 - Additional vaccination opportunities e.g. addition of OPV to other vaccinations activities, intensifying EPI and mobile health teams.

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

Identification, mapping and coverage of High Risk Mobile Populations

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

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

In addition,

- Program will focus on new IDPs, particularly those coming from and/or residing in endemic zones.
- HRMP surveys will be conducted by ICN in ICN districts of East and in Kandahar district on quarterly/biannual basis.
- HRMP in non-endemic zone with linkage to endemic zones will be included in SNIDs.
- Nomads:
 - Nomadic plan of South and Southeast will be reviewed to identify gaps in identification, microplanning and deployment of PTTs. Corrective actions will be taken on the basis of these findings. Nomad's elder will be identified and taken as focal point for SIAs, surveillance and RI.
- Cross border:
 - Program will continue vaccination at all cross border points and international airports and explore new informal crossing points to deploy vaccination teams.
 - Vaccination will be expanded to cover all age group at Torkham cross border.
 - Special SMs will be engaged at major cross-border vaccination points
- Returnees:
 - Program will continue to follow up new returnees in coordination with OCHA/UNHCR/IOM and line departments and maintain state of preparedness for major influx
- All major congregations will be identified and special vaccination opportunities will be provided.

Communication

- **Overall:**
 - Evidence-based messaging guide to ensure all components of program are effectively communicating.
 - Development and training on crisis communication plan to quickly and effectively address emerging issues.
 - Improved coordination between NEOC and REOC through monthly conference calls, regular field visits, and other activities. Targeted workplan to enable evaluation and modification as appropriate.
 - Suite of tested and tailored materials to address targeted issues and priority audiences.
 - Strategy engagement of media for SIA-specific and ongoing support
 - Revised suite of IEC materials (including billboards) to address fatigue
 - Integrated engagement strategy to convert anti-vaccine influencers (religious and medical doctors)

- Convergence activities to be embedded in all communication plans
- Community mobilization/sensitization not to be only campaign based but continue on regular basis through IEC and print and electronic media talks and conferences
- Increase use of social media/radios for targeting chronic refusals and anti polio propaganda
- **Improving the operations of the ICN:**
 - Continue deployment based on SOPs: focus on risk categorization (VHRDs) with technical Shifts to overall missed children; including absent children tracking and vaccination in between campaigns, updating SOPs /TORs and checklists etc
 - Intensified cluster level profiling and planning, with focus on Kandahar
 - Move two-member team districts to regular ICN with female recruitment (where possible)
 - Strengthening of the application of management tools for selection, accountability, etc in the field.

Tailored Social Mobilization and Community Engagement Activities

- Expand coverage to all clusters with >1% of refusal after a campaign
- Improve integration/triage system to identify relevant influencers while reducing number of knocks on the door
- Conduct qualitative research on perception on expanded age vaccination in possible targeted districts focusing on eastern region

Communication Review and Way Forward

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

Maintaining sensitive surveillance

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

In 2019, program will undertake the following additional activities

- **Healthy Children Sampling in Inaccessible areas:** Program recognizes that negative results may not mean anything epidemiologically however notes that quarterly sampling may uncover pockets of

under immunized children. Healthy Children sampling will be conducted every quarter in the chronic inaccessible areas of South, Southeast and East.

- In line with Global Standards the program will ensure monthly sampling of environmental samples from the 20 identified areas in Afghanistan.
- Recognizing the need to ensure global confidence in the surveillance system in preparation for certification post viral transmission the program will conduct an External Surveillance Review in the second half of 2019.

Inter-sectoral approach in Polio high risk areas

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

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

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

For improving EPI coverage in polio high risk areas, program will make three pronged intervention. This includes enhancing PEI/EPI convergence by implementation of MOU between EPI, PEI and BPHS NGOs (Annexure), Implementation of 'RI improvement framework' (Annexure), and Implementation of 'Enhancing EPI/PEI convergence in high risk districts' (Annexure).

PEI support to EPI will be strengthened by

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

Enhancing EPI/PEI convergence in high risk districts

The geographic focus of this plan is in six provinces viz. Kandahar, Helmand, Nengarhar, Farah, Nuristan and Uruzgan. The focus of this plan will be on Kandahar and Helmand provinces.

In total 42 districts will be targeted through these: Kandahar (6), Helmand (13), Farah (4), Nengarhar (17), Urozgan (1) and Noristan (1).

Summary of interventions planned in 'Enhancing EPI/PEI convergence in high risk districts' is as below

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

- Establishment of 82 Sub-health centers: the facility will be staffed with two vaccinators, one midwife and one nurse. There will be 28 in Helmand, 26 in Kandahar, 2 in Urozgan, 4 in Farah, 21 in Nengarhar and 1 in Noristan province.
- Establishment of Mobile Health Teams: only one MHT is required for the Paron district of Noristan province.
- Training of new vaccinators: 165 new vaccinators will be trained
- Strengthen community-based polio immunization services through deploying permanent local teams (community contract)
 - This will be two member team and first vaccinator will be female resident accompanied by her Mahram as 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).
 - This will be rolled out in only two districts-Shahwalikot and Nawzad districts. A total of 301 two-member permanent teams will be deployed
 - The vaccinators will deliver only OPV vaccines until their capacity is upgraded and eventually administer all vaccines.
- Strengthening capacity of R/PEMT teams: one SIAs manager for each of the five high risk provinces. These managers will coordinate and lead SIAs on behalf of Government.

Mid-term review

NEAP implementation status and effectiveness of strategies will be reviewed in July 2019 and changes will be brought in to address new challenges and for mid-course correction.