



AFGHANISTAN POLIO ERADICATION INITIATIVE

ANNUAL REPORT, 2019

unicef 

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Acronyms and Abbreviations

AFP	Acute flaccid paralysis
AGE	Anti-government element
ARPO	Assistant Regional Polio Officer
BPHS	Basic package of health services
CE	Community engagement
CVA	Complementary vaccination activity
cVDPV	Circulating vaccine-derived poliovirus
cVDPV2	Circulating vaccine-derived poliovirus type 2
DDM	Direct disbursement mechanism
DPOs	District Polio Officers
EOC	National Emergency Operation Centre
EPI	Expanded Programme on Immunisation
FGD	Focus group discussion
FHAG	Family Health Action Group
FLW	Frontline worker
GCMU	Grant and Contract Management Unit
H2H	House to house
HF	Health facility
HRD	High-risk district
HRMP	High-risk mobile population
IAG	Islamic Advisory Group
ICN	Immunisation and Communication Network
IDP	Internally displaced population
IEC	Information, education and communication
IMB	Independent Monitoring Board
IOM	International Organisation for Migration
IPV	Inactivated polio vaccine
LQAS	Lot quality assurance sampling
MoPH	Ministry of Public Health
NEAP	National Emergency Action Plan
NEPI	National Expanded Programme on Immunisation
NID	National Immunisation Day

ODF	Open defecation-free
OPV	Oral polio vaccine
PEI	Polio Eradication Initiative
PEMT	Provincial EPI Management Team
PPO	Provincial polio officer
PTT	Permanent transit team
REMT	Regional EPI Management Team
REOC	Regional Emergency Operation Centre
RI	Routine immunisation
RPO	Regional polio officer
RRL	Regional reference laboratory
S2S	Site to site
SDD	Solar direct drive
SIA	Supplementary immunisation activity
SNID	Sub-national immunisation day
SOP	Standard operating procedure
TAG	Technical Advisory Group
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VHRD	Very high-risk district
VUR	Vaccine utilisation report
VVM	Vaccine vial monitor
WASH	Water, sanitation and hygiene
WHO	World Health Organisation
WPV	Wild Poliovirus
WPV1	Wild Poliovirus type 1

Executive Summary

Afghanistan's Polio Eradication Initiative (PEI) ('the programme') witnessed considerable uncertainty in 2019 as the year was dominated by political instability, security challenges, peace negotiations between the United States and anti-government elements (AGEs) and presidential elections. The AGE ban on house-to-house vaccination was particularly challenging, leaving 1 million children in the south region unvaccinated in May 2018 and at its peak in December 2018 leaving more than 1.2 million children unvaccinated.

Despite hurdles, the programme was able to continue supplementary immunisation activities (SIAs) via four rounds of national immunisation days (NIDs) with partial access, two rounds of sub-national immunisation day (SNIDs), one round of extended SNIDs and one case-response vaccination round. SIA quality, however, suffered because of staff selection issues, late frontline worker payments, poor social mobilisation, low female participation, and the AGE ban. In addition, post-campaign monitoring results showed that the proportion of missed children ranged from 2.8 to 3.6% in accessible areas, mainly because children



were absent from their homes. The programme, therefore, identified refusals and clusters of chronically missed children to ensure that communications and operational plans were aligned at the cluster level.

The National Emergency Action Plan (NEAP) 2019 provided strategic guidelines for the implementation of polio eradication activities in the country, focusing on reaching all children, improving SIA quality and strengthening routine immunisation. NEAP's eight strategic objectives were only partially met. Transmission in the southern and eastern regions continued, access was an issue, and vaccine acceptance was stagnant. However, headway was made in maintaining high population immunity in (very) high-risk areas, and in decreasing the number of missed children. The greatest successes were responding to the importation of wild poliovirus (WPV), maintaining immunity among high-risk mobile populations, and ensuring high levels of surveillance quality across the country.

WPV circulation continued in Kandahar city. Some 29 confirmed polio cases came to light in 2019—eight more than the previous year. The southern region was largely responsible, accounting for 71% of all cases. The number of infected districts also increased from 14 in 2018 to 20 in 2019.



PEI's surveillance system—both acute flaccid paralysis (AFP) and environmental—performed well, maintaining high sensitivity for key indicators and surpassing global targets. Some 808 focal points and 36,000 reporting volunteers supported the AFP surveillance system in 2019, reporting 3,768 AFP cases. Environmental surveillance was similarly effective, collecting 259 samples, of which 56 were positive for WPV. Overall surveillance was reviewed regularly and supported through desk and field reviews to ensure system sensitivity. It was learnt that the system was well-structured at all levels, documents and records were

well-maintained, sites were geographically well-distributed, AFP focal points were well-trained, population

coverage was good, and that cross-border coordination on AFP surveillance between Afghanistan and Pakistan had improved significantly.

Complementary vaccination activities aimed to vaccinate moving populations and prevent WPV transmission from infected areas. These activities were carried out by special vaccination teams operating at border crossing points and permanent transit teams. Some 49 teams vaccinated 1.6 million travellers at 18 border crossings in 2019—a significant increase from 2018's 1.1 million. Vaccination centres at UNHCR and IOM also witnessed considerable success in vaccinating returnees. Permanent transit teams worked at unofficial border points and other high-traffic places, administering 17.5 million oral polio vaccine doses to target children—compared with just 13.7 million the year before.



Vaccine refusals were low overall but concentrated in the southern and south-eastern regions of the country. However, Immunisation and Communication Network (ICN) interventions were able to convert a third of refusals in 42 ICN districts. Focus group discussions showed that key reasons for refusal were religious objections, campaign fatigue, suspicion of vaccine content, and a lack of other health and development services. The ICN, therefore, sought to expand its network influencers and increase local authority engagement.

Media engagement and monitoring played a significant role in 2019. The programme partnered with numerous TV and radio stations to broadcast videos, public service announcements and key messages. Monitoring findings contributed to the development of evidence-based messaging and crisis communications. In addition, decentralising communication response needs was found to be effective in influencing communities' vaccine perceptions.

PolioPlus activities were also conducted in 2019 to supplement the programme's main polio focus. They included distributing polio-branded promotional materials, deploying health teams to underserved communities in the southern region, referring mothers to services for non-polio issues, and promoting sanitation and hygiene. In addition, routine immunisation activities were conducted through 3,970 vaccinators, 32% of whom were women. These activities helped boost immunisation coverage in polio-priority provinces.

Vaccines and cold chains were well-managed in 2019. Despite security challenges and the vaccination ban, vaccines were neither delayed, nor under- or overstocked in the country. Certain strategies also helped keep the vaccine wastage rate low.

The programme's assessment of 2019 will serve as a set of lessons for 2020. It will continue identifying, mapping and covering mobile populations, particularly in the eastern and southern provinces through agency collaboration and cross-border vaccinations. WPV surveillance will remain a top priority to ensure good population coverage with other health services. SIA quality will be improved through assessment data and the review, streamlining and standardisation of data collection tools.

Strategic communications will help increase vaccine acceptance. The programme will engage the media, communities, religious influencers, the education sector, medical professionals and female mobilisers. Finally, PEI will make greater efforts to work with line ministries through the Polio High Council and other forums.

1. Oversight, Coordination and Programme Management

Afghanistan's Polio Eradication Initiative (PEI) ('the programme') continues to sustain strong political commitment from the President, the Minister of Public Health and the government of the Islamic Republic of Afghanistan's highest-level leadership. The World Health Organisation (WHO), United Nations Children's Fund (UNICEF) and other national and regional partners, in collaboration with donors also remain fully engaged and supportive of the programme to ensure effective delivery.

1.1 Governance and leadership

The polio programme in Afghanistan enjoys the highest-level support in the country. The President maintains a direct oversight of the programme to ensure goals are met at all levels. In addition, several national level bodies also exist to govern and oversee the implementation of the National Emergency Action Plan (NEAP). Of these, the Polio Steering Committee chaired by the President is the highest forum used by the national leadership to maintain oversight and provide support to the programme.

Another forum at the national level includes, the Polio High Council chaired by the Presidential Focal Point for Polio Eradication. This forum comprises the Minister of Public Health, representatives of line ministries and departments, members of the polio team and representatives from donor and partner agencies. The Presidential Focal Point for Polio Eradication represents the presidential office and provides day-to-day support through line ministries and governors, regularly updating the President on the programme's progress. Various important decisions in support of the programme are taken at ministerial focal point meetings, which are then implemented by the line ministries accordingly. In 2019, three such meetings were held for coordinating PEI affairs, nine memorandums of understanding (MOUs) were signed between line ministries and the MoPH to support polio eradication activities, and ministries introduced their PEI focal points who work closely with the National Emergency Operation Centre (NEOC) and the MoPH.

While the various bodies above mainly provide oversight support, the delivery of the polio programme in Afghanistan is led by the Ministry of Public Health (MoPH), which oversees and coordinates the implementation of PEI activities, provides effective leadership to all partners and ensures coordination between the various bodies established to govern and manage the polio eradication programme. An MoPH appointed Senior Adviser acting as the Focal Point for PEI supervises the day-to-day management of the programme and ensures continued support from the various MoPH departments.

At the regional level, the leadership remains supportive of the programme. The provincial and district governors, particularly those in the high-risk provinces of the southern, eastern and western regions remain fully committed to the programme, while the provincial and district polio task forces in the five priority provinces continue to provide backing to the polio campaigns. A crucial support provided by the regional leadership in 2019 included several provincial and district task and multi-sectoral meetings, which were chaired by the provincial governors prior to each campaign round in all priority provinces and districts.

1.2 Implementation and coordination

Under the leadership of the MoPH, the NEOC has the overall responsibility for the stewardship of the national polio eradication programme. It defines the strategies, identifies the high-risk areas, develops the tools needed, evaluates the programme and tracks the performance of districts. It ensures that all the strategies developed at the national level are shared with the provinces and undergo consultation before finalisation.

The NEOC is supported by the Regional Emergency Operation Centres (REOCs), which manage the daily operation of the polio eradication programme and coordinate and execute the strategies set at the national level. Currently, the regional EOCs are functional in Herat, Kandahar, Jalalabad and Gardez provinces, representing the western, southern, eastern and south-eastern regions, respectively. In addition, a provincial EOC established in Hilmand provides more focused PEI support in this very important province.

2. National Emergency Action Plan Progress in 2019

Considerable efforts were made to fully implement the National Emergency Action Plan (NEAP) in 2019. However, geopolitical developments in the country presented tremendous hurdles in its implementation. NEAP 2019 had eight strategic objectives for ending wild poliovirus (WPV) transmission in Afghanistan. The main objective, stopping WPV circulation (and two other objectives), was not met. Two other objectives were partially met, and three objectives were fully met (Table 1).

Table 1: Status of implementation of NEAP 2019 objectives

Objective	Status
1 Stop ongoing transmission in southern and eastern regions	Not met
2 Achieve and maintain high population immunity in the rest of HRDs* and VHRDs*, ensuring no secondary cases following possible importation	Partially met
3 Gain and maintain access through flexible approaches	Not met
4 Rapidly and effectively respond to any importation of WPV1 and/or emergence of any cVDPV* (in particular cVDPV2) in polio-free areas	Fully met
5 Achieve and maintain high population immunity among HRMPs*	Fully met
6 Enhance programme quality with a focus on high-risk provinces/districts to decrease missed children to less than 5%	Partially met
7 Improve vaccine acceptance and contribute to a decrease in refusals	Not met
8 Maintain high levels of surveillance quality across the country with surveillance quality indicators meeting global standards in all provinces	Fully met

HRD = high-risk district; VHRD = very high-risk district; cVDPV = circulating vaccine-derived poliovirus; cVDPV2 = circulating vaccine-derived poliovirus type 2, WPV1 = wild poliovirus type1; HRMP = high-risk mobile population

3. Epidemiology

Afghanistan reported 29 confirmed WPV cases in 2019 compared with 21 cases the year before. The number of infected districts in 2019 increased to 20 from 14 in 2018.

The southern region continued to be the focus of active WPV1 circulation with Kandahar city as the main epicentre of this transmission. Of the 29 confirmed polio cases in 2019, a total of 20 (71% of the overall

cases) were reported from the southern region alone. These were reported in Uruzgan (9 cases), Kandahar (6 cases) and Hilmand (5 cases) provinces. All of these provinces reported cases in 2018 too — 2, 9, and 4 cases, respectively.

The eastern region reported two confirmed cases of WPV1 in 2019, one each in Kunar and Nangarhar provinces. One compatible polio case was also reported from Kunar province in 2019. Prior to this, the last recoded compatible case had been reported in June 2015 from Farah province in the western region.

In 2019, confirmed polio cases from the southern region were found to be genetically linked to clusters of R4B5C5B2B and R4B5C4C2, while in the eastern region they were linked to clusters R4B5C5B2B and R4B5C5B2A.

WPV1 transmission remained limited to the southern and eastern regions in the first half of 2019 but started to appear outside these polio reservoirs during the second half of the year. Majority of the cases reported in 2019 originated from severely access compromised areas where provision of vaccination has faced many setbacks over the last few years.

Bermal district in Paktika province in the south-eastern region reported two confirmed cases after a three-year gap. The western region reported three confirmed cases in Badghis (1 case) and Farah (2 cases) provinces, while the north-eastern region reported one case in Baghlan province.

4. Surveillance

A sensitive surveillance system remains the cornerstone of polio eradication efforts guiding all other aspects of the programme. Afghanistan's PEI is using both acute flaccid paralysis (AFP) surveillance and environmental surveillance to detect confirmed polio cases and to monitor the circulation of WPV in the environment. The polio programme continues to conduct surveillance activities at all levels across the country through designated field staff.

The AFP surveillance system in Afghanistan was established in 1997 and, despite various hindrances, is functioning and maintaining high sensitivity for key indicators, and surpassing global targets. Since its inception, the surveillance system has been able to detect AFP cases across the country, including the most remote and security-compromised areas. It has also been able to report cases among nomads.

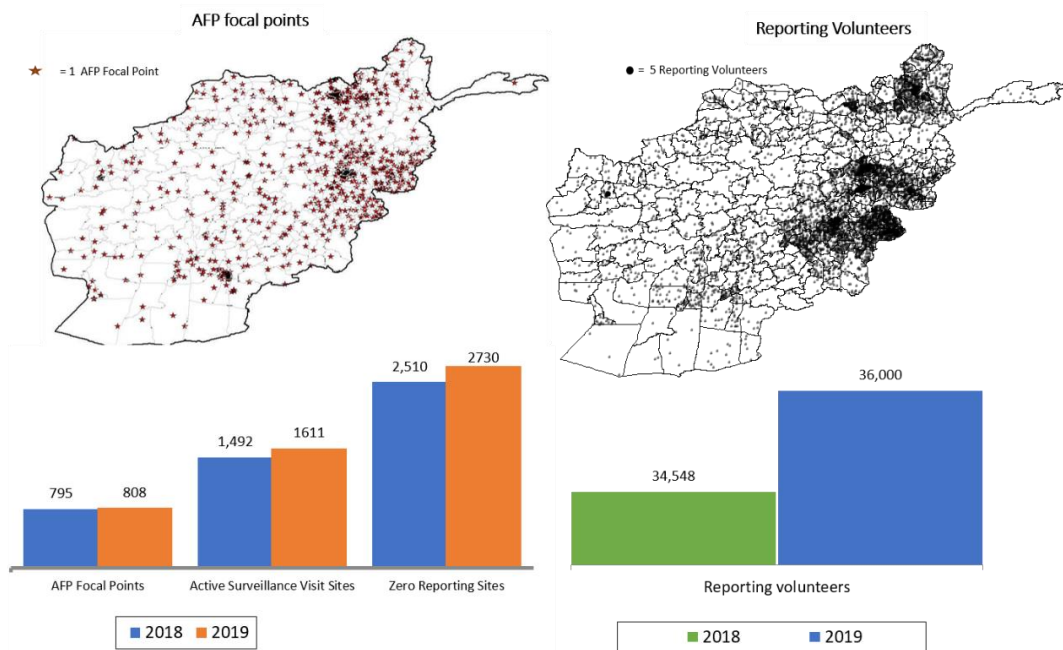
Environmental surveillance in Afghanistan has been functioning since 2013 with reach across major regional centres and some polio-priority provinces.

4.1 AFP surveillance

Afghanistan's AFP network includes major national, regional and provincial level hospitals, district-level health facilities (HFs), private practitioners, physical rehabilitation centres, pharmacies, mid-level health workers, traditional healers, shrine keepers and community volunteers. In 2019, some 808 focal points and 36,000 reporting volunteers supported the AFP surveillance system, compared to 795 and 34,548 in 2018, respectively. The WHO surveillance staff made active visits to 1,611 sites in 2019, compared to 1,492 in 2018.



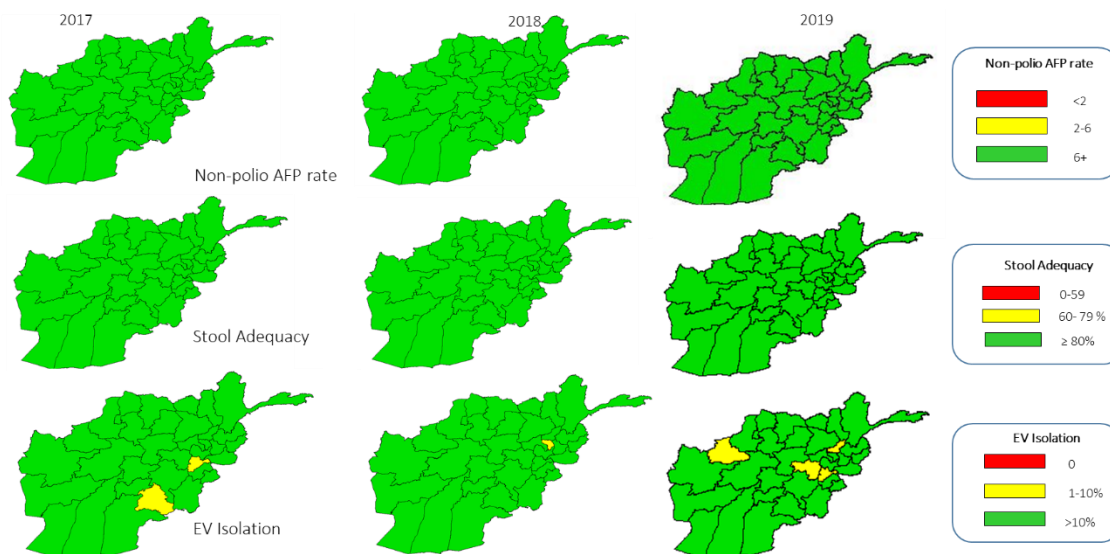
Figure 1: AFP surveillance network in Afghanistan, 2018–19



The surveillance system reported 3,768 AFP cases in 2019 with a non-polio rate of 18 per 100,000 population below 15 years of age. The male-to-female ratio of AFP cases in 2019 was 56:44. The system also reported 43 cases in nomadic populations in 2019.

The stool adequacy rate was 94% in 2019, ranging from 90% in the southern region to 98% in the central region. The non-polio enterovirus isolation rate was 16%, and the Sabin-like virus isolation rate was 8% at the national level. Figure 2 shows province-wise surveillance indicators from 2017 to 2019.

Figure 2: AFP surveillance quality indicators in Afghanistan, 2017–19



4.2 Environmental surveillance

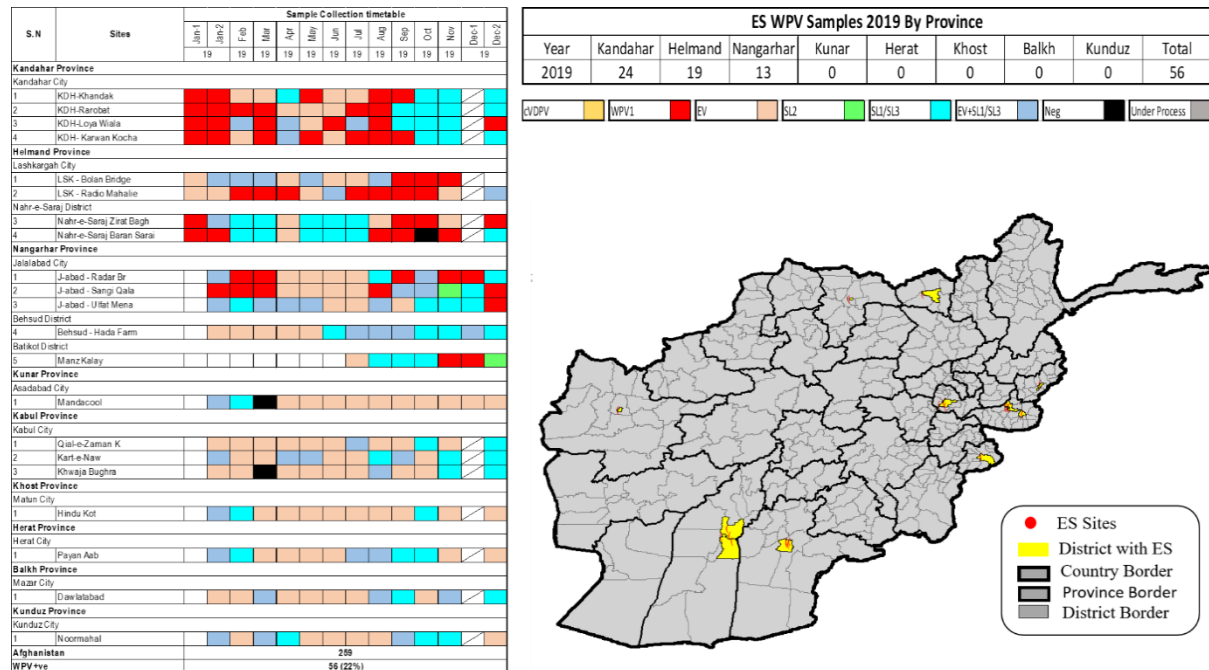
Environmental surveillance has been in place in Afghanistan since 2013 to supplement AFP surveillance. It aims to detect wild or circulating vaccine-derived poliovirus (cVDPV) in sewage and determines possible routes of transmission in the environment.

In 2019, the number of sample collection points increased to 21 from 20 in 2018. A new site was also established in Batikot district of Nangarhar province in the eastern region.

The environmental surveillance sites collected 259 samples in 2019 and sent them to the Regional Reference Laboratory (RRL) for testing. Results showed that 56 samples were positive for WPV. Figure 3 shows a summary of environmental laboratory results and locations of environmental surveillance sites.



Figure 3: Environmental surveillance lab results and site locations



4.3 Review of surveillance

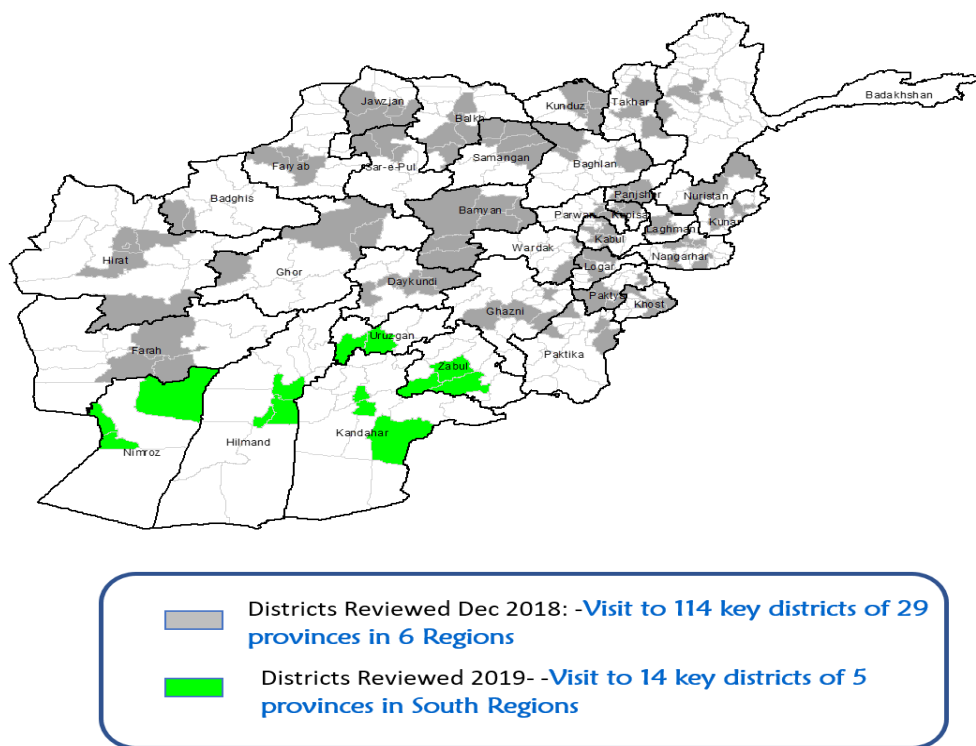
The PEI programme held weekly surveillance update meetings to review progress and performance indicators to ensure surveillance system quality. It also undertook desk and field reviews of the surveillance to ensure the system remained sensitive to detecting WPV circulation.

An internal surveillance review (Figure 4) was conducted all over the country in two phases during 2018–19. It was carried out in 128 districts across 34 provinces, covering all regions. The review assessed the current surveillance system and its sensitivity and efficiency in detecting AFP cases across the country with technical and operational support from the NEOC and WHO Country Office.

The review concluded the following:

- There was no evidence of missed AFP cases.
- The surveillance system was well-established with a clear structure and assigned responsibilities at district, provincial and regional levels.
- AFP surveillance documents and records were well-maintained and updated, surveillance visits and zero-reporting were generally regular, sites were geographically well-distributed, and data was thoroughly used for system strengthening.
- District AFP focal points were well-trained and linked to community-based reporting volunteers.
- There was good population coverage through community networks, active surveillance and zero-reporting.
- All-important HFs were included in the network, and the private sector was supportive.
- Specimen collection and transport to the RRL in Islamabad had improved at all levels, and standard operating procedures (SOPs) were being followed.
- Cross-border coordination on AFP surveillance between Afghanistan and Pakistan had improved significantly.

Figure 4: Scope of surveillance review, 2018–19



5. Supplementary Immunisation Activities

Supplementary immunisation activities (SIAs) are the most important part of Afghanistan's polio eradication programme. The Technical Advisory Group (TAG) approved a proposed SIA calendar in January 2019 for the first semester. A second meeting in August 2019 approved the second semester and first quarter of 2020. PEI Afghanistan conducted four rounds of national immunisation days (NIDs), four rounds of sub-national immunisation days (SNIDs) and two case-response SIAs in 2019.

Persistent inaccessibility linked to reasons beyond the programme's control continued to be a key hurdle. Anti-government elements (AGEs) banned house-to-house (H2H) vaccinations in May 2018. A total ban on polio campaigns across the country followed in April 2019, which affected the campaign calendar and scope of SIAs. SIAs were not conducted again until August the same year. Before the SIA in August 2019, a careful assessment of the security situation was conducted along with taking all necessary measures to ensure the security of the frontline workers (FLWs).

AGEs lifted the ban in October 2019, but with the condition that SIAs be conducted in health facilities only. Despite this restriction in place, the programme managed to conduct SIAs using the H2H approach in government-controlled areas as well as a few AGE-controlled areas (Table 2).



Table 2: SIAs and their implementation modality in 2019

SIA type	Date	No. of children vaccinated	Implementation modality (%)		
			H2H	S2S	Inaccessible
SNID	21 Jan 2019	6,192,127	77	17	6
SNID	18 Feb 2019	6,602,878	74	17	9
NID	25 Mar 2019	9,920,319	83	10	7
NID	5 Aug 2019	5,025,513	48	0	52
NID	14 Sep 2019	6,073,357	56	0	44
SNID extended	14 Oct 2019	5,610,299	57	2	41
NID	11 Nov 2019	6,768,581	64	2	34
SNID	16 Dec 2019	4,414,803	68	0	32

H2H = house to house; S2S = site to site

5.1 SIA quality

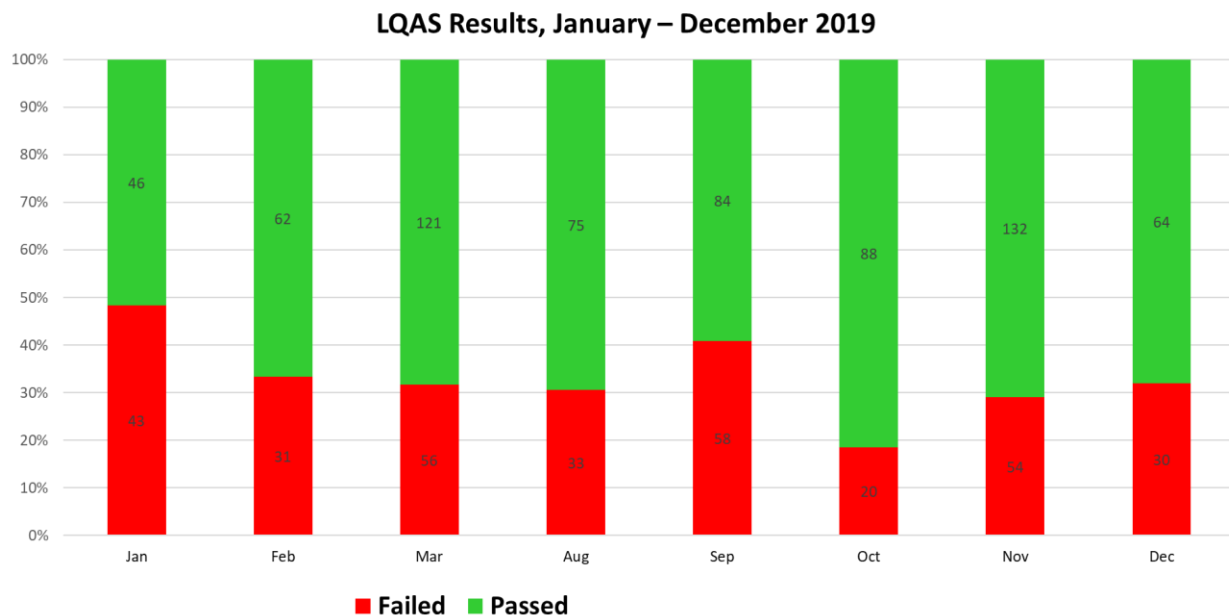
NEAP 2019 strove to improve programme and SIA quality to decrease the number of missed children and address high-risk mobile population (HRMP) issues and refusal challenges.

Operational, managerial and technical challenges defined 2019. Issues included staff selection, training, supervision and monitoring; timely frontline worker payments; accountability; complex data collection tools; poor social mobilisation; low female participation; a lack of follow-up actions between SIAs; poor implementation of revisit strategies; and poor implementation of micro-plans.

Poor overall access and lack of total access to large number of districts in 2019 was also a major challenge due to the AGE ban.

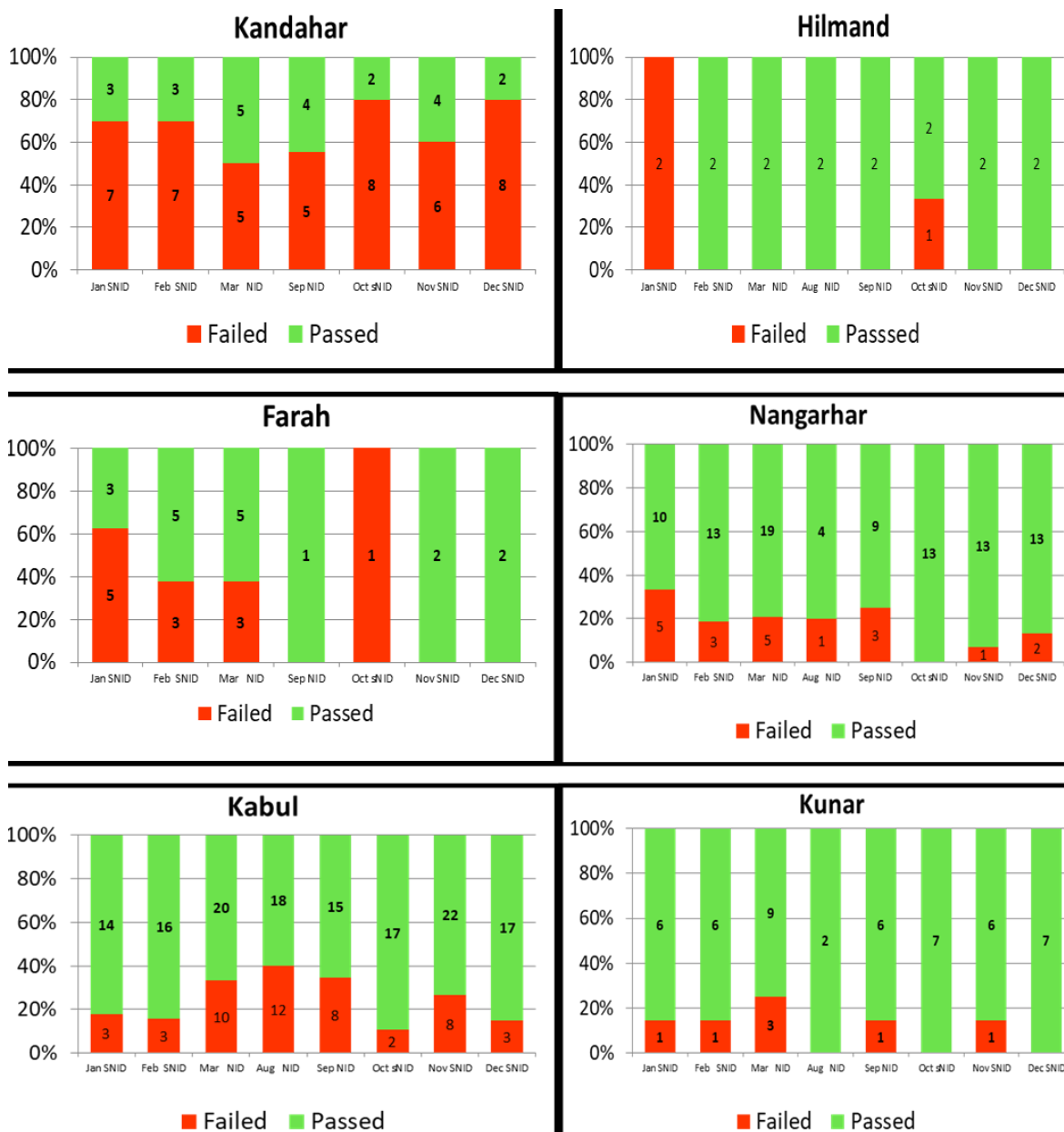
The programme planned and conducted lot quality assurance sampling (LQAS) in campaign areas where the H2H-based strategy was being implemented. National LQAS results showed that the proportion of failed lots decreased from 48% in the January SIAs to 32% in the December 2019 round. However, the LQAS results also showed that accepted lots during the 2019 SIAs were below 90%, ranging from 52% in the January round to 81% in the October round. This indicated quality issues (Figure 5).

Figure 5: LQAS results of SIAs, Jan–Dec 2019



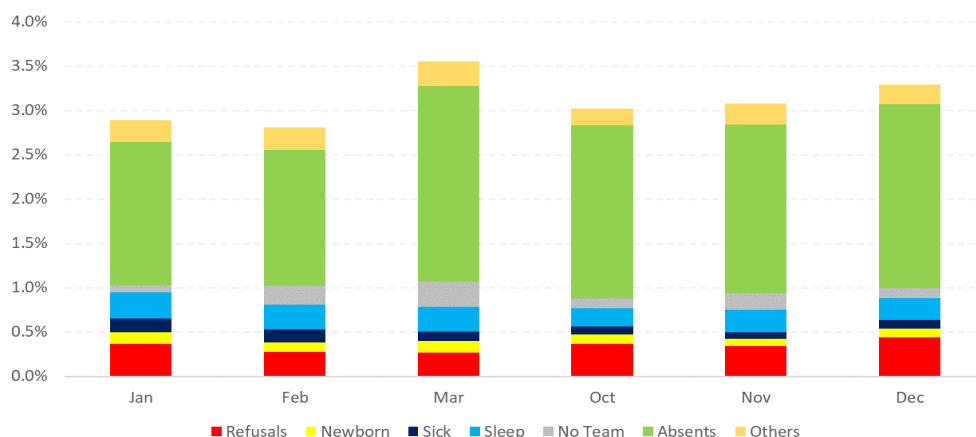
In priority provinces, Kandahar showed an increase in the number of failed lots from 70% in January to 80% in December 2019, while in Hilmand, two of two lots in January 2019 failed, but subsequent lots passed, except in October when two of three lots passed. In Nangarhar, the proportion of failed lots decreased from 33% in January to 13% in December. Kabul showed an increased proportion of failed lots during the March, August, September, and November SIAs—33%, 40%, 35% and 27%, respectively). The number of lots in Farah was small, but failed lots decreased from 62% in January to 0% in December 2019. The exception was November, where one lot was checked and did not pass (Figure 6).

Figure 6: LQAS results in focus provinces during 2019 SIAs



Post-campaign monitoring results in 2019 showed that the proportion of missed children ranged between 2.8–3.6% in accessible areas. Absence of children from their homes during the campaigns was one of the main reasons behind this. Refusals at the national level remained less than 0.5%, but with disparities by region and district (Figure 7).

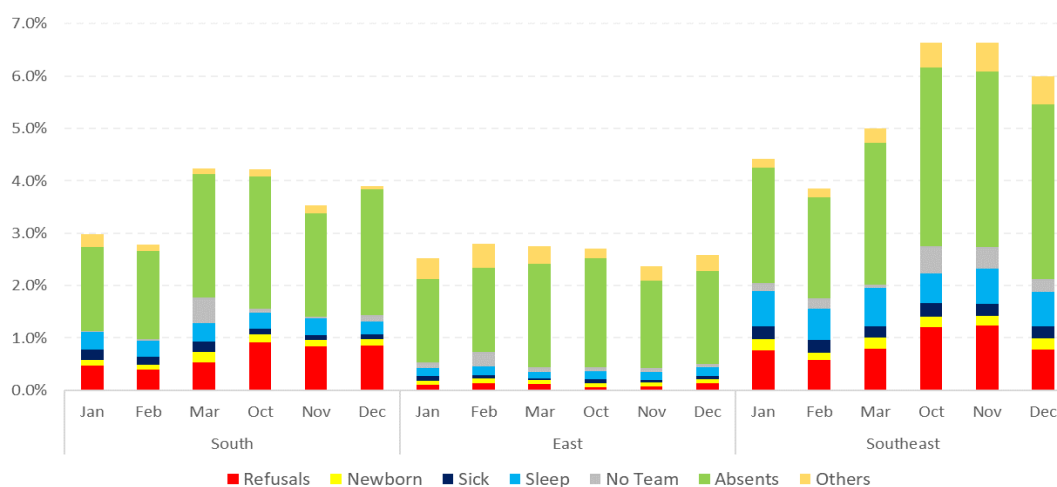
Figure 7: Reasons for missed children (accessible areas) via post-campaign assessment by SIA rounds, 2019



A breakdown of post-campaign monitoring data in priority regions showed an increase in the proportion of missed children in the southern region from 3% in January to 3.9% in December—the highest was in October (4.1%), and the lowest was in February (2.8%). Likewise, there was an increase in the proportion of missed children in the south-eastern region from 4.2% in January to 6% in December 2019. However, the proportion remained around 2.5% over rounds in the east.

The proportion of children missed during the campaigns due to refusals was higher in the south and southeast as compared to the national average. Children missed in the southeast due to sickness/sleep and by virtue of being new-born remains a challenge to be addressed through FLW training (Figure 8).

Figure 8: Campaign-wise breakdown of missed children in priority regions (accessible areas), 2019



The programme continued to identify refusals and clusters of chronically missed children to ensure that communications and operational plans were aligned at the cluster level.

6. Complementary Vaccination Activities

Complementary vaccination activities (CVAs) include vaccinations of moving populations between districts, provinces and regions; vaccinations of populations crossing border points; and vaccinations of straddling populations and HRMPs.

The objective of CVAs was to bridge the gap in immunity and seize the chance to vaccinate children on the move, thus preventing WPV transmission from infected areas.

CVAs were carried out by special vaccination teams operating at border crossing points, and permanent transit teams (PTTs). Specific campaigns for nomadic populations moving within the country and across common reservoirs were also conducted.

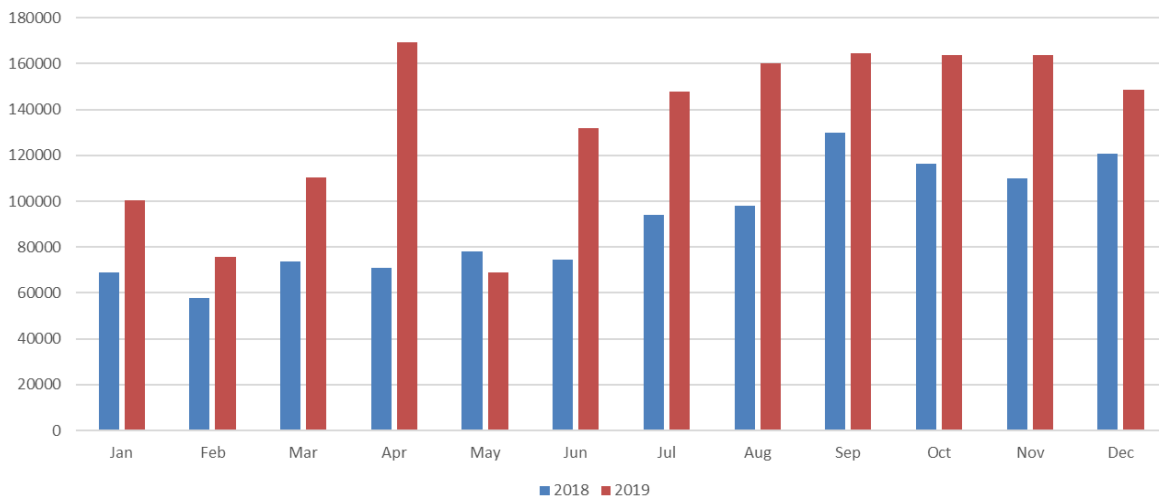
6.1 Cross-border teams

Population movement between Afghanistan and Pakistan continues to be very high. To respond to this challenge, the programme has established permanent vaccination teams at official border crossing points to vaccinate all children under ten years of age crossing from either side of the border. Afghanistan instituted mandatory all-age vaccinations for travellers crossing the border at Torkham in 2019. A similar arrangement exists at the Chaman crossing, except vaccination is voluntary.

Finger marking and social mobilisation messages were harmonised for target age groups on both sides of the border. This proved successful as 49 vaccination teams vaccinated 1,605,104 travellers at 18 border crossings on the Afghan side in 2019. The corresponding figure for 2018 was 1,092,973. The numerical increase was mainly due to vaccinating people of all ages (Figure 9).



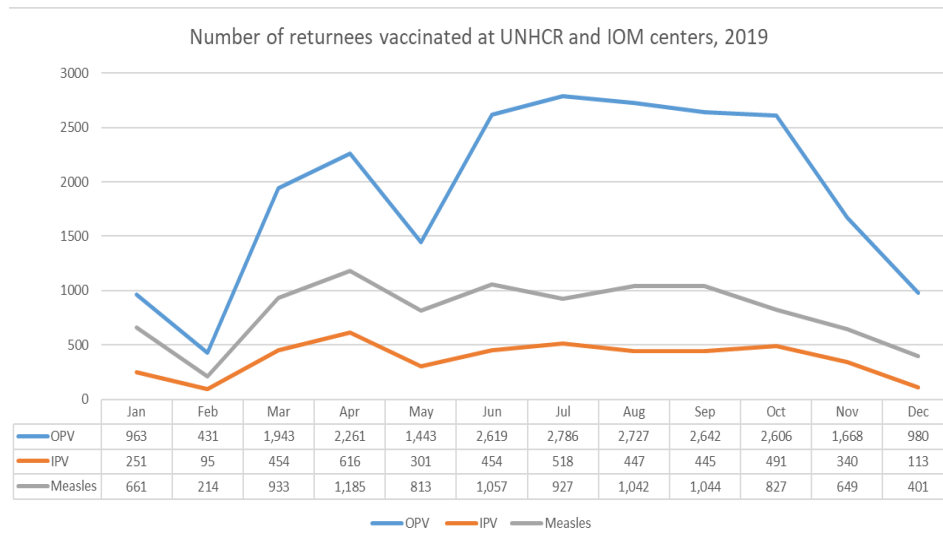
Figure 9: Month-wise vaccination at border points with Pakistan, 2018–19



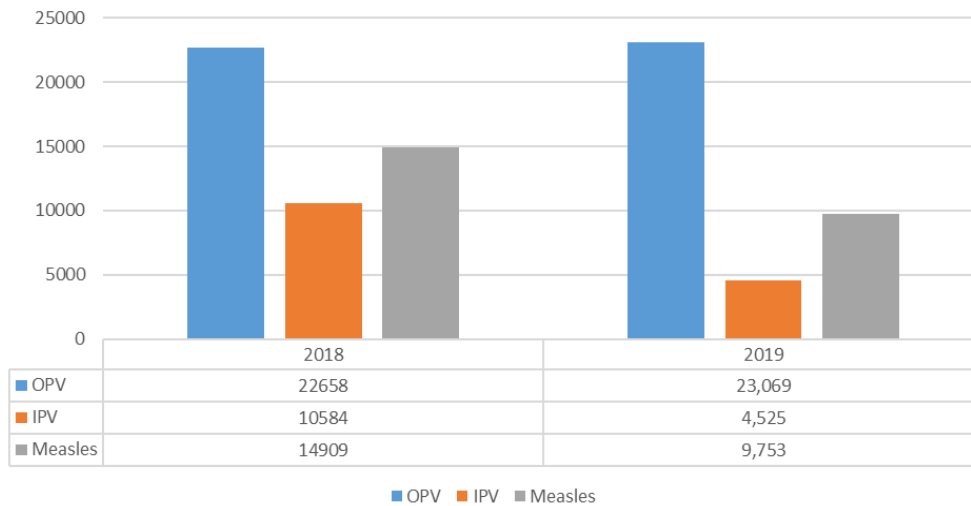
6.2 Vaccination of returnees at UNHCR/IOM sites

Afghanistan has a large number of refugees and unregistered citizens residing in Pakistan and Iran. In 2019, Afghan vaccination centres at the United Nations High Commissioner for Refugees (UNHCR) and International Organisation for Migration (IOM) returnee facilities vaccinated 23,069 returnees with the oral polio vaccine (OPV), 4,525 with the inactivated polio vaccine (IPV) and 9,753 with the measles vaccine. Figure 10 shows the number of vaccinated returnees in 2019 by month and in comparison to 2018.

Figure 10: Vaccination of returnee children, 2019



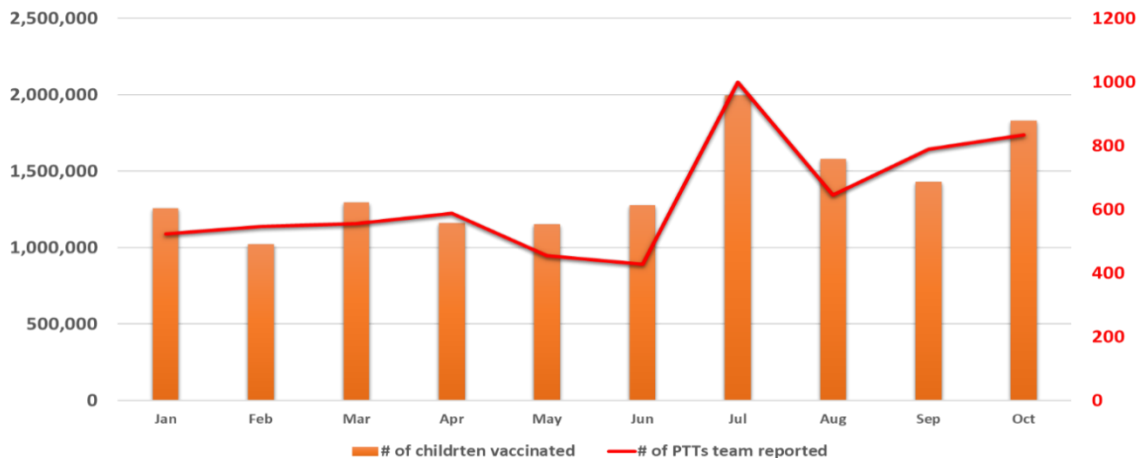
Number of Returnees Vaccinated by Antigen, 2018-19



6.3 Permanent transit teams

PTTs were established at strategic points where large numbers of people, including children, pass. These included unofficial border points, bus stops, central marketplaces, busy hospitals and health facilities, and the entry and exit points of inaccessible areas. PTT locations were selected based on regular reviews and on need and necessity. PTTs administered 17,514,158 OPV doses to target children in 2019, compared to 13,762,878 doses in 2018. Figure 11 shows their month-wise vaccinations.

Figure 11: PTT coverage by month and number of teams, 2019



6.4 High-risk mobile populations

NEAP 2019 assigned considerable importance to HRMPs, defining strategies to cover all such population groups, including long-distance travellers within corridors, nomads, straddling populations and returnee refugees.

The plan [NEAP] suggested recruiting five focal points, but just one HRMP in a southeast region REOC was recruited to coordinate interventions with line departments, UN agencies and field teams. SIAs in 2019 focused on internally displaced populations (IDPs), and SNIDs included IDPs in non-endemic areas with linkages to endemic areas.

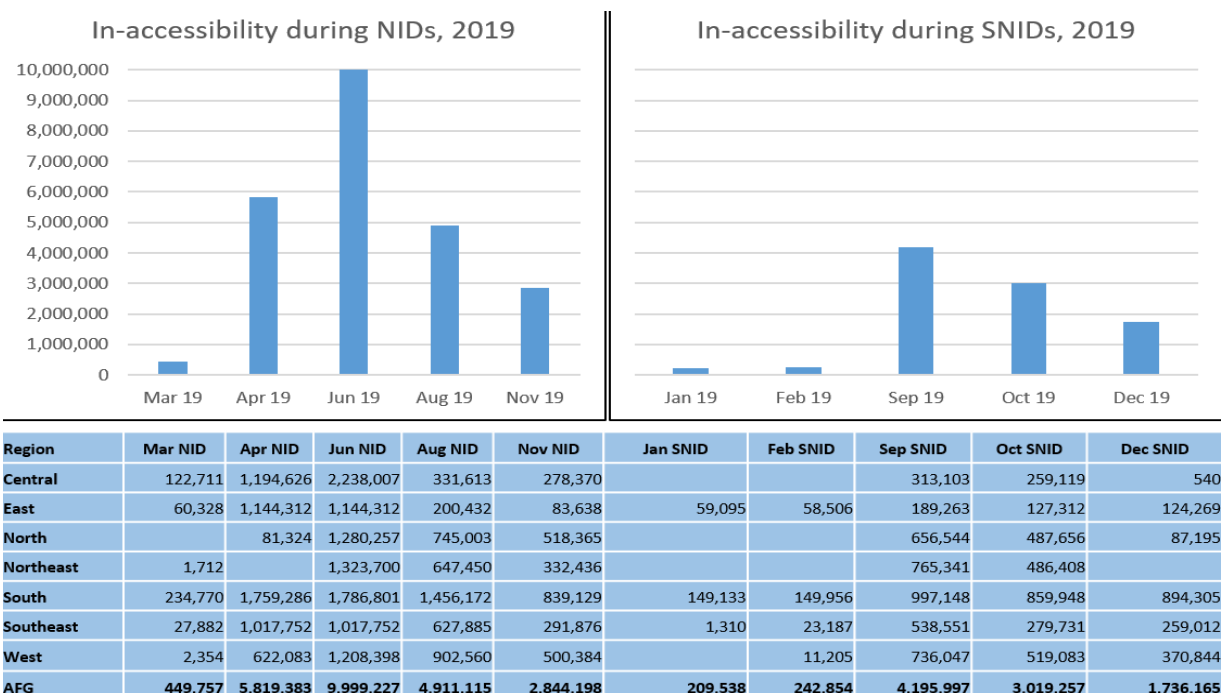
7. Access

Access remains a major obstacle to reaching target children with the polio vaccination—it is the main reason for missed children. Inaccessibility in 2019 was exacerbated following the AGE’s total ban on polio vaccination campaigns, which resulted in no SIAs being conducted during the March–July 2019 period.

The number of inaccessible children reached 449,756 during the March NIDs, jumping to 5.8 million in April. June’s NIDs were not conducted and were postponed to August 2019. Some 4.9 million children were not reached during this round of SIAs. Local-level negotiations with AGEs resulted in decreasing the number of inaccessible children to 2.8 million in the November 2019 NIDs.

During SNIDs, the number of inaccessible children jumped from 209,538 in January 2019 to 4.1 million in the September round. It decreased to 1.7 million in the December 2019 SNIDs. The southern region remained the most inaccessible. Figure 12 shows the number of missed children due to inaccessibility in 2019.

Figure 12: Number of children missed due to inaccessibility, 2019



8. Communication

8.1 Increasing vaccine acceptance and decreasing refusal

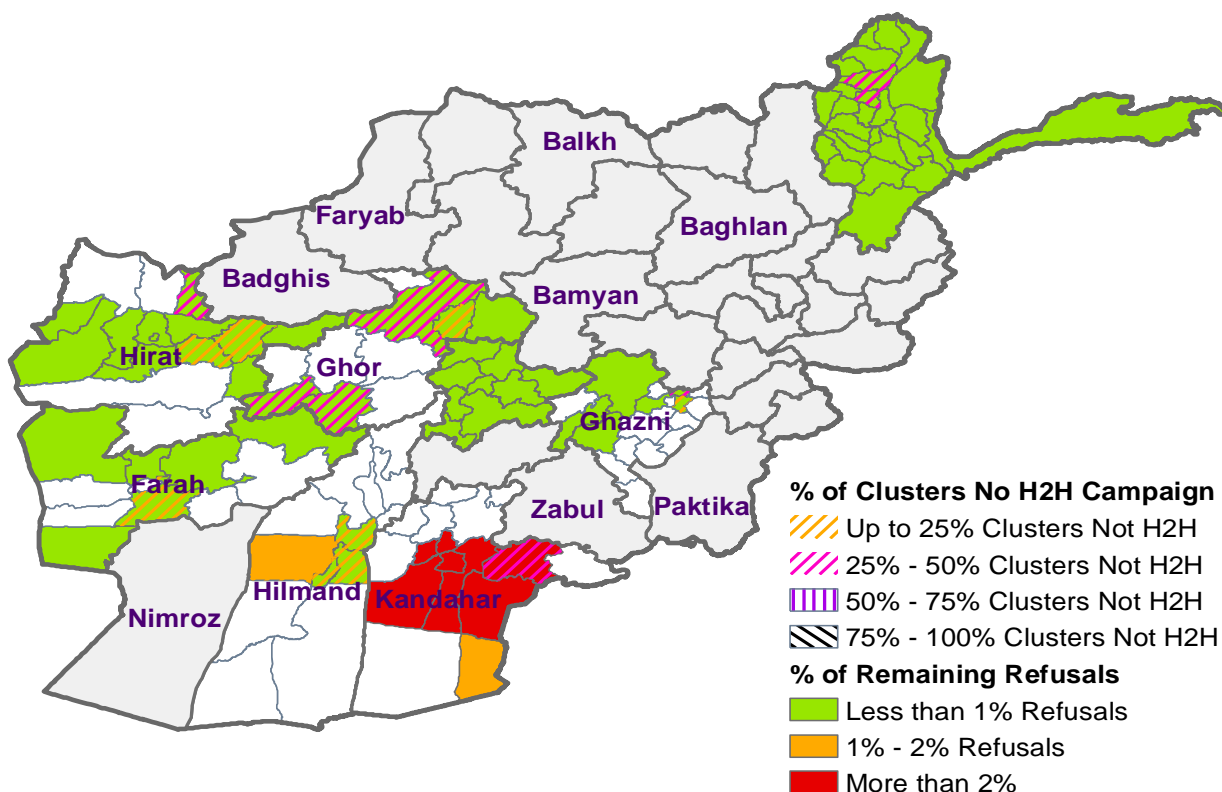
Although the number of refusals in Afghanistan constitutes less than one percent of the total target, its clustering in certain parts in the southern and south-eastern regions is of concern. Refusal concentration is higher in Kandahar city and surrounding districts, as well as in Paktika province in the southeast region.

Figure 13 shows districts with higher refusal percentages—more than two percent in red—localised in the south and southeast. The green hatch districts are areas where H2H campaigns were not conducted and no data related to missed children was collected.



Actions undertaken to mitigate missed children due to refusals are outlined in section 8.2 of this report.

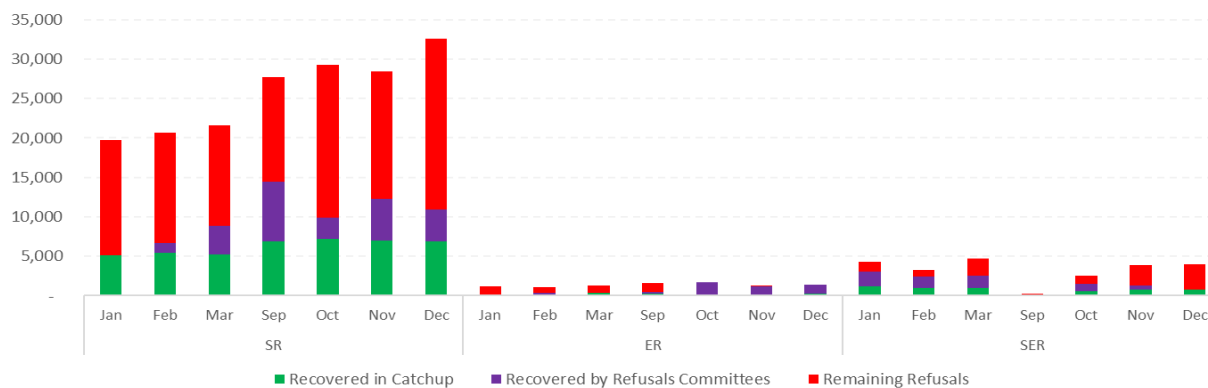
Figure 13: No. of refusals by round and region, 2019



Source: Administrative data, November 2019 (NID)

Data on Immunisation and Communication Network (ICN) interventions to convert refusals in 42 ICN districts showed that a third of refusals in each round were converted and convinced to accept polio vaccinations (Figure 14).

Figure 14: ICN catch-up data on covering refusals in priority districts, Jan–Dec 2019



As per focus group discussion (FGD) results and field monitoring reports, the key reasons for refusals include religious objections, campaign fatigue, suspicion of vaccine content, and a lack of other health and development services, particularly in the marginalised and underserved communities of the southern region. It is important to note that such refusals exist in the currently inaccessible provinces of Hilmand, Kandahar and Uruzgan, which have active WPV1 circulation. Some monitoring reports also indicate that the use of non-local staff, involvement of young males as FLWs and the lack of female vaccinators/social mobilisers add to the challenges around community acceptance for polio vaccines. Furthermore, community fatigue, excessive door-knocking, inadequate staff capacity and low staff motivation are additional challenges that need to be addressed.

Despite challenges, the programme continued interventions to cope with vaccine refusal through community engagement (CE), communications and advocacy interventions, and by involving the Islamic Advisory Group (IAG).

Major CE activities included the following:

- Continued community mobilisation by the ICN to increase vaccine uptake. Drastic funding cuts will decrease ICN presence by 40% in early 2020, limiting activity to key areas in the east and south.
- Increased female engagement in the communication network.
- Expansion of the influencers' network.
- Increased local authority engagement, e.g., with *wakili guzars* (community representatives) to endorse vaccines and strengthen local government involvement in mobilising communities' vaccine uptake.
- FGDs conducted to gather feedback on communications and emerging vaccine uptake issues.
- External communications review conducted in December 2019 to provide critical input on CE strategies and activities to sustainably decrease the number of missed children in VHRDs. The key review recommendations included, strengthening C4D through integrated communication approaches, decreasing interference in ICN selection, increasing female enrolment, increasing ICN wage increments, strengthening partnerships, addressing CE access issues through different approaches, and targeting provision of other services that build support for vaccination. The TAG, Independent Monitoring Board (IMB) and CE review recommendations and learnings from local surveys and FGDS on attitudes and practices provided guidance to elaborate the 2020 plan.

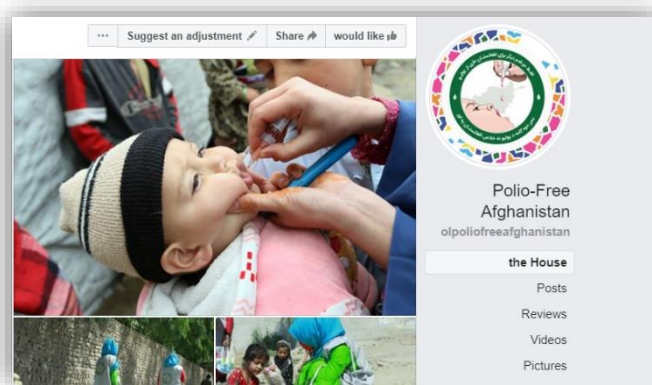


8.2 Communications and advocacy interventions

- **Media engagement:** In 2019, the programme strengthened partnerships with seven earned media partners as well as paid media partners, which included 150 radio stations and 55 television stations. These channels broadcast videos and public service announcements, which provided key messages before and during the polio campaigns. This activity was undertaken to positively influence community behaviour and attitudes towards vaccine uptake. The messages were broadcast across

the country with a special focus on the south, southeast and eastern regions, where poliovirus circulation was high. The messages sought to remind communities to vaccinate their children.

- **Media monitoring:** Monitoring is critical to identifying potential problematic stories and understanding trends so that the programme can remain responsive. All pro- and anti-polio media content aired in Afghanistan was tracked through an external service provider. This included taking stock of paid and earned media airtime as well as print and social media. The findings contributed to the development of evidence-based messaging and crisis communications, including ascertaining modalities for reaching intended target audiences.
- **Regional communication plans:** Despite having a national communications plan, a need for locally driven community-level communications initiatives was identified. This involved developing regional content based on local context, factoring in cultural sensitivities and local dialects. Regional communications teams were empowered to swiftly respond to communication issues as they emerged. Decentralising communication response needs proved to be an effective way to influence communities' vaccine perceptions. For instance, initially, the production of communications materials was done at the national level, and materials were then disseminated through the national media. When an external communications review was conducted in December 2018, it was found that most communications materials did not resonate with rural communities. On the other hand, regionally focused materials factoring in local culture and language were well received and created an impact. Regional communications initiatives in the south, east and western regions proved to be instrumental in influencing community behaviours towards vaccine uptake.
- **Production of materials:**
 - **Branding:** Polio re-branding was completed in 2019 following TAG recommendations to address the fatigue associated with the programme. A rapid assessment survey showed that the move was welcomed by communities. The idea behind this was also to ensure a consistent framing that responded to priority issues and target populations.
 - **Multimedia:** Throughout the year, various videos, photographs, infographics and public radio announcements were produced addressing key vaccination issues such as reasons for missed children and refusals. The materials produced were disseminated through media channels/social media to reinforce key messages around the risk of polio among unvaccinated children. This was a critical awareness strategy. It helped ensure parents were aware of campaigns and could make sure their children were home during campaign days.
 - **Suite of information, education, and communications (IEC) materials and murals:** IEC materials with key polio education messages were produced and distributed for national and sub-national campaigns. Polio-branded stickers were printed and pasted on long-distance buses carrying crucial messages about polio vaccines and the need to protect children against polio. Around



100 murals and 1,000 stencils were painted in key polio provinces across the country to increase polio knowledge and awareness.

- *Polio-branded promotional materials:* The communications team focused on building community trust through the distribution of polio-branded promotional materials, including baby blankets and bath soaps for mothers delivering at HFs. The baby blankets aimed to promote care and warmth during winter for new-borns, while the provision of antiseptic soap intended to improve household hygiene and decrease virus transmission through handwashing to address the fact that the poliovirus is easily transmitted through oral routes. Polio promotional materials were branded with the polio programme logo and simple immunisation messages. The aim was to improve perceptions towards polio vaccines, build trust and encourage mothers to vaccinate their children.



9. PolioPlus Activities

In October 2019, the IMB reiterated the need for more integration of services.

The polio programme collaborated with partners in the provision of essential maternal and child health integrated packages through different activities. Progress to date is as follows:

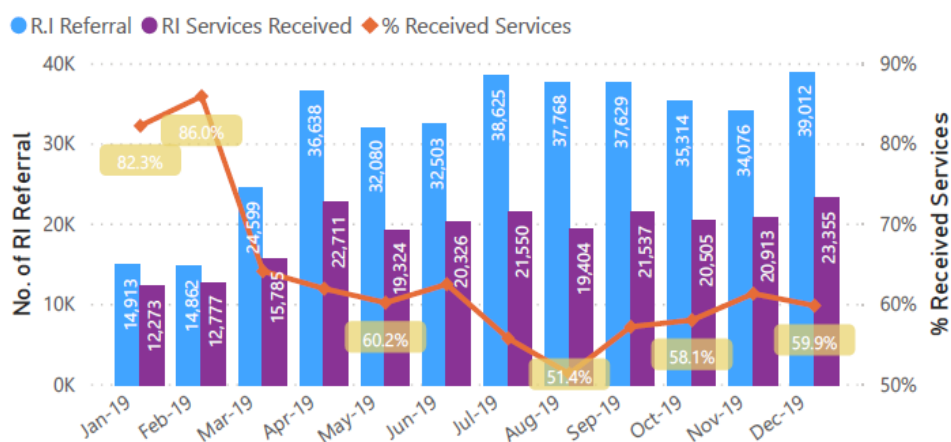
- The distribution of polio-branded promotional materials in the east and south, such as baby blankets for pregnant women and babies less than three-months-old, and beds and bedsheets for maternity wards to increase polio awareness and build community trust.
- Additional mobile health teams or health camps deployed to cater to underserved communities in the southern region.
- Children immunised for OPV/Penta 1-2 and 3 through RI at HFs were supported with hygiene kits.
- ICN played a critical role in strengthening referral service outreach systems by referring mothers with children under five years of age to services for RI, malnutrition, measles, birth registration, pneumonia, and diarrhoea.
- In 2019, ICN referred 580,702 children to health services, and 66% received services (Table 3, Figure 15).



Table 3: Number of referrals by ICN, 2019

Location	Total Referral	No. Referral Received Services	% Received Services
ER	286,429	218,153	76.2%
Kunar	40,857	29,230	71.5%
Nangarhar	245,572	188,923	76.9%
SR	294,273	153,510	52.2%
Hilmand	40,304	31,212	77.4%
Kandahar	236,258	112,439	47.6%
Nimroz	11,130	6,863	61.7%
Zabul	6,581	2,996	45.5%
Total	580,702	371,663	64.0%

Figure 15: Total number of referrals by SIAs

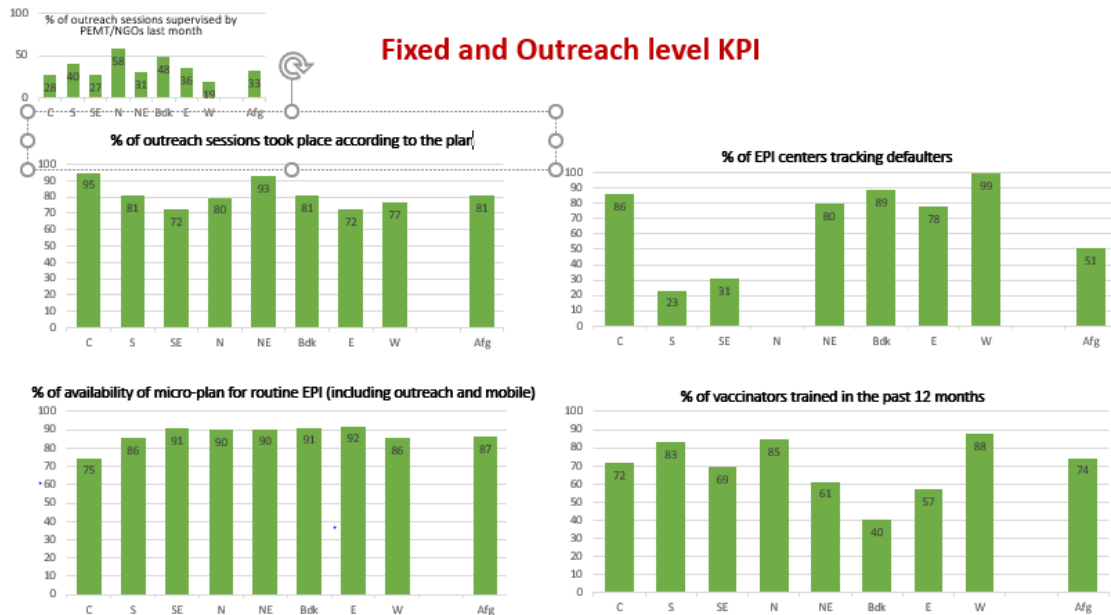


- ICN supported RI monitoring. Table 4 shows the number of sessions monitored by province and strategy. All RI monitoring findings were shared with EPI and basic package of health services (BPHS) for action (Figure 16).

Table 4: RI visits by ICN, 2019

Province	Fixed	Mobile	Outreach	Total
Nangarhar	219		235	454
Herat	143	13	97	253
Kunar	96	2	142	240
Badghis	178	16	23	217
Farah	169	7	20	196
Kabul	160			160
Kunduz	90	15	40	145
Hilmand	11		124	135
Ghor	116			116
Kandahar	18	3	64	85
Laghman	50	1	21	72
Khost	51	1	4	56
Nimroz	36			36
Faryab	6			6
Nuristan	3			3
Total	1346	58	770	2174

Figure 16: ICN's RI monitoring findings



- UNICEF's water, sanitation and hygiene (WASH) section, in collaboration with partners, implemented WASH interventions in Kandahar's polio-endemic areas:
 - Access to sanitation and hygiene:
 - Around 161,000 people found access to living in 374 open defecation-free (ODF) communities—150 peri-urban and 224 rural communities in Loya Wala, Manzil Bagh, Panjwai, Nawa, and Nahri Saraj.
 - Some 15,997 new latrines were built and upgraded/improved by people.
 - Some 1,632 members of the Family Health Action Group (FHAG) and 1,580 members of community-led total sanitation (CLTS) committees were trained in hygiene.
 - Access to safe drinking water in communities:
 - More than 33,000 people gained access to safe drinking water in the high-risk polio districts of Kandahar (Maiwand and Zhari) and Hilmand (Lashkar Gah, Nahar-e-Saraj, Nawa-e-Barakzai and Nadali).
 - Access to WASH facilities in schools and healthcare centres:
 - More than 20,000 students—10,286 girls and 10,483 boys—gained access to safe drinking water, adequate and segregated sanitary toilets, and handwashing facilities in schools in the high-risk polio districts of Kandahar and Hilmand.



- More than 117,000 people gained access to safe drinking water, adequate and segregated sanitary toilets, and handwashing facilities in health centres in the high-risk polio districts of Kandahar and Hilmand.
 - Access to improved environmental sanitation:
 - More than 2,400 people—1,386 children, 590 women and 544 men—benefited from drainage upgrades in Kandahar City (Loyawala).
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10. Vaccine and Cold Chain Management

10.1 Vaccine procurement and management

In 2019, the Afghanistan PEI programme mobilised resources and procured vaccines necessary for all campaigns and CVAs as per NEAP. Some 69.9 million doses of bivalent OPV and 12.4 million doses of monovalent OPV type 1 were procured in 2019 and distributed in a timely manner to service delivery points.

There was consistent availability of OPVs throughout 2019—no stock-outs or vaccine vial monitor (VVM) changes were reported. The distribution of vaccine and non-vaccine supplies to respective zones and provinces, districts, clusters and service delivery points was completed as per a national schedule, maintaining optimum temperature. A strategy to decrease vaccine wastage was followed which involved OPV distribution according to a micro plan, the use of semi-used vaccine, and returning remaining OPVs after each SIA to the Regional EPI Management Team (REMT)/Provincial EPI Management Team (PEMT).

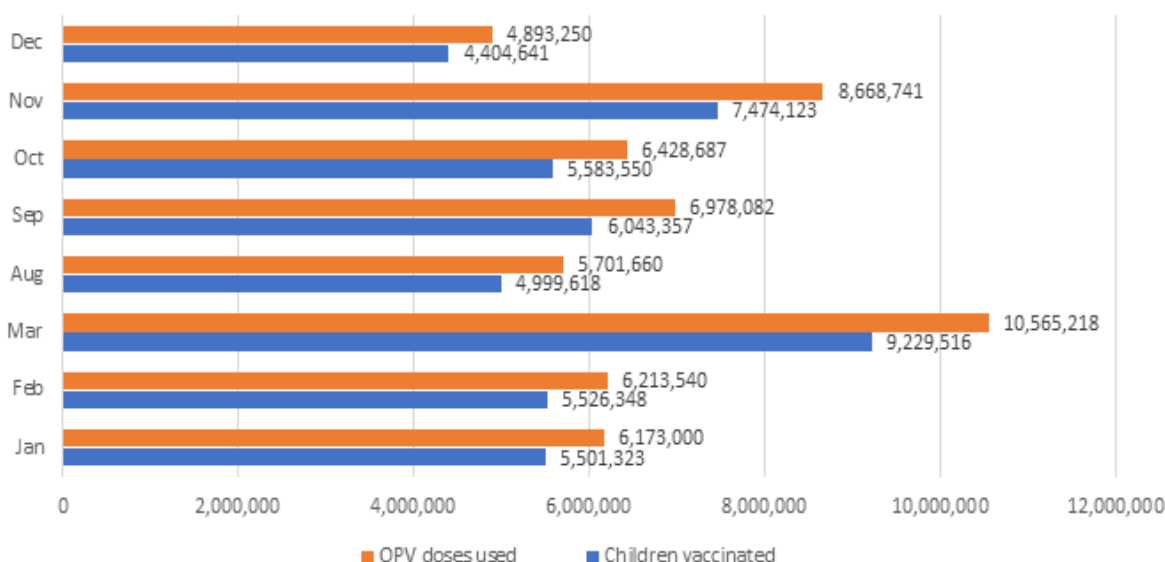
In collaboration with the Health and Nutrition sections, vaccines, cold chains and micronutrients were managed for PEI within the overall context of EPI and health for the interruption of WPV and reduction of other vaccine-preventable diseases.

Despite security challenges and the vaccination ban, vaccines were neither delayed, nor under- or overstocked in the country.

OPV coverage and vaccine utilisation reports (VURs) were collected after each SIA and analysed. Observations were shared with relevant regions and provinces as feedback and follow-up actions were monitored. In 2019, some 48,762,476 children received OPV doses in four NIDs and four SNIDs. Some 55,622,178 OPV doses were used, bringing the vaccine wastage rate to 12.3% (Figure 17).



Figure 17: OPVs used vs. children vaccinated during SIAs in 2019



10.2 Cold chain management

The programme also strengthened the cold chain system through quarterly inventories at all levels and the provision of cold chain equipment as per a gap analysis. In 2019, the National Expanded Programme on Immunisation (NEPI), with support from UNICEF’s polio section, purchased 35 SDD (Solar Direct Drive combined refrigerator/freezer TCW40 (B Medical system) for EPI activities.

11. Monitoring and Capacity Building

Coordination at the national and zonal levels for vaccine and cold chain management was strengthened. This was done through regular meetings of the Vaccine and Cold Chain Management Committee at the national level, and similar committees at zonal levels in the southern and eastern regions. Five such meetings (facilitated by UNICEF and NEPI) took place in four zonal offices in 2019—one each in the central, southern and south-eastern regions, and two in the eastern region.

These meetings sought to ensure that a functional vaccine and cold chain system was in place and to build the capacity of staff involved. Challenges, experiences, the way forward, and lessons learnt from polio SIAs, routine EPI, CVAs and cold chain inventory were discussed to improve performance on-ground.

These meetings led to 172 relevant cold chain staff being oriented on vaccine management, cold chains and logistics. They included 5 REMT managers, 18 PEMT managers, 6 cold chain managers, 29 EPI supervisors from PEMT, 19 EPI supervisors from NGOs, 30 cold chain



technicians, 15 provincial communications officers (PCOs), 12 WHO provincial polio officers (PPOs)/regional polio officers (RPOs)/assistant regional polio officers (ARPOs), 7 UNICEF staff, 8 EPI trainers, 8 UNICEF supported extenders, 5 data managers and 10 others.

Results achieved included timely and consistent availability of required vaccines at all levels. There were no vaccine stock-outs at any time for SIAs and CVAs, no vaccine losses due to VVM change or expiry, and no breakdowns in cold chains (leading to a reduction in vaccine wastage). No NEAP activity was delayed or cancelled due to unavailability of vaccines.

12. Routine EPI Strengthening

12.1 EPI activities and immunisation coverage

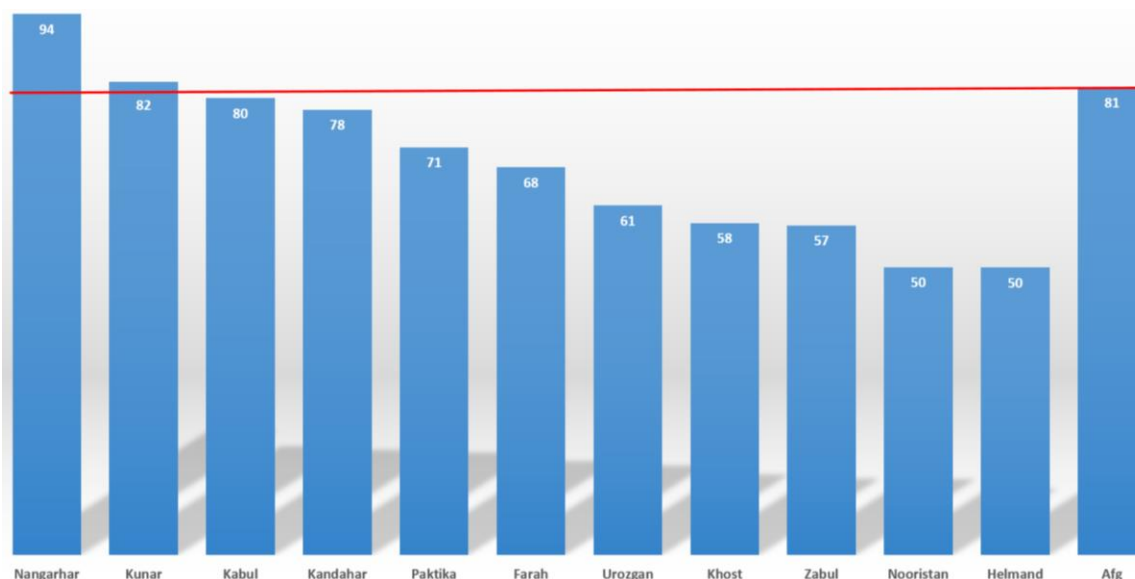
Routine EPI activities in Afghanistan were conducted by contracting out to BPHS partners in most parts of the country, and through the Government via strengthening mechanisms in a few provinces. The MoPH oversaw programme implementation at the national level through the NEPI and the grant and contract management unit (GCMU), and at the regional and provincial level through REMTs and PEMTs.

An annual programme review with representation from all 34 provinces was conducted in July 2019 to identify programme gaps and achievements.

In summary, 2,229 facilities provided EPI services through 3,970 vaccinators, 32% of whom were women. Fifty-three HFs had been established in Kandahar and Hilmand by mid-2019 with support from the Bill and Melinda Gates Foundation (BMGF). These activities helped boost RI coverage in polio-priority provinces.

An immunisation coverage survey was not conducted in Afghanistan during 2019 but reported national-level data showed 95% coverage for Bacillus Calm ette-Guerin (BCG), 81% for IPV, 72% for measles and 81% for OPV3. OPV3 coverage in polio-priority provinces ranged between 94% in Nangarhar to 50% in Nooristan and Hilmand (Figure 18).

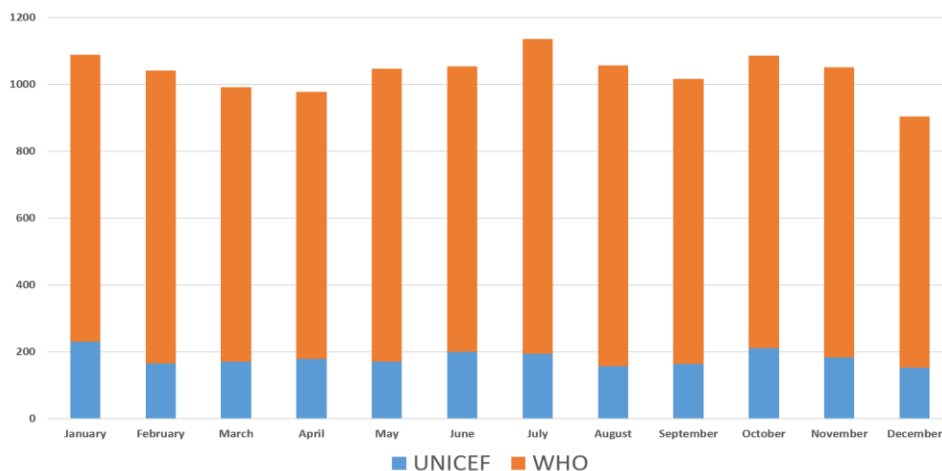
Figure 18: OPV-3 RI coverage in polio-priority provinces, 2019



As part of support to EPI, the PEI field staff supported the monitoring of RI activities at both fixed sites and outreach and mobile sessions. WHO PPOs and district polio officers (DPOs) and ICN field staff supported by UNICEF performed 12,446 visits to RI activities in 2019. They shared their findings and observations with concerned PEMTs during provincial health coordination meetings.

WHO PEI field staff also conducted 3,024 quick coverage assessments in the catchment areas of EPI centres, assessing outreach and mobile teams, as well. Figure 19 shows the number of RI visits performed by WHO and UNICEF field staff in 2019.

Figure 19: RI support from WHO and UNICEF field staff, 2019



To equip WHO PEI field staff with the necessary knowledge, 25 PPOs, RPOs and ARPOs were trained in RI and RI monitoring skills in December 2019 jointly with the EPI Section. Remaining field staff will be trained in 2020.

12.2 Challenges in 2019

Programme-level challenges included ensuring low bedding costs and low prices for EPI indicators in the Sehatmandi project, data discrepancies, denominator issues, poor support supervision and coordination at various programme levels, BPHS implementing NGO turnover, and variance in vaccinators' salary scales.

Routine EPI and other public health services faced both national strategic level and programme and field-level challenges. Political instability was the main national-level challenge. The programme and field level was characterised by the AGE ban, poor referral systems, mobile health team ineffectiveness due to overlaps with HF catchment areas, low community demand, low service utilisation (compared with access), inappropriate use of IEC materials, and competing priorities (e.g., frequent campaigns).

13. The Way Forward

13.1 Key strategies

The eventual goal of the programme remains to be able reach all children with vaccination to eradicate polio from the country. In particular, the programme will stay focused on stopping WPV transmission in the south and east region, stopping polio outbreaks in non-reservoir areas and preventing virus spread in polio-free areas. To this end, the PEI programme will develop a set of smart objectives and ensure their achievement.

The programme will update NEAP through a consultative workshop with PEMTs, REMTs, REOCs and all national-level partners. Drawing on lessons from 2019, NEAP 2020 will take actions to improve implementation mechanisms through strengthened management, an implementation plan, providing intervention costing, and implementing accountability frameworks at all levels.

The implementation of NEAP, 2020 will be monitored on a quarterly basis at the NEOC and REOCs. The programme will conduct a midterm review of NEAP for course correction as required. Accordingly, the National Emergency Centre for polio eradication will continue its functions at the national and regional level.

PEI's key strategies to fast-track WPV elimination and mitigate the risk of cVDPV2 include implementing three NIDs, five SNIDs and IPV campaigns in selected high-risk areas as and when required. Case-response vaccination will also be conducted within eight weeks of the last polio case in an area.

The programme will also review the categorisation of high-risk areas and increase interventions in them. It will continue efforts to improve the quality of SIAs, increase reach in accessible areas, intensify communications and social mobilisation approaches to improve vaccine acceptance and increase community demand for vaccination.



13.2 Coverage and surveillance

In 2020, the programme will continue the identification, mapping, and coverage of HRMPs, particularly in the eastern and southern provinces. To cope with shared transmission of WPV between Afghanistan and Pakistan, the programme will continue placing efforts on HRMPs within the country and across the border by collaborating with other agencies, including HRMPs in SNIDs in non-endemic areas, cross border vaccination and providing special vaccination opportunities.

Maintaining sensitive WPV surveillance will remain a top priority and will be supported by desk/field reviews and field monitoring. Regular and planned reviews will be conducted to ensure maintenance of surveillance quality. Integrated health services will be launched in the high-risk areas of Kandahar, Hilmand and Uruzgan in the southern region to ensure the population is well-covered with other health services.

Reported coverage and assessment data will be extensively used to improve the quality of SIAs—the programme will review, streamline, simplify and standardise data collection tools for various levels. LQAS

will be used to assess SIA quality, and validation mechanisms for quality and completeness will be implemented. Process indicators will also be closely monitored to address the gaps affecting quality.

13.3 Performance rewards and training

The programme will prioritise FLWs through unbiased selection by local selection committees and increase women FLWs, particularly in polio-priority areas. Accountability based on performance as well as rewarding will be part of polio eradication rewarding system. In addition, FLW payments will be prioritised—at least 90% of payments will be made prior to subsequent rounds via direct disbursement mechanisms (DDMs) or non-DDM mechanisms.

Training modules will be simplified, high-quality micro-planning and implementation will be reviewed and updated, new-borns and infants will be prioritised, revisit strategies will be strictly implemented, and finally, campaign preparation, implementation and assessment will be effectively monitored to ensure high-quality SIAs.

13.4 Maximising reach and vaccination acceptance

Reaching and accessing children across the country, including in security-compromised areas, will be of paramount importance. PEI will continue adhering to a policy of neutrality and political impartiality to ensure this.

The NEOC will launch integrated health services in the southern region to increase polio vaccination acceptance and address people's doubts and vaccination fatigue. This joint effort will include BPHS partners, NEPI, and in-country and global polio partners. The service package will include health interventions, nutrition, WASH, education and PolioPlus activities. In addition, PEI's on-ground resources will support RI activities by providing monitoring, supportive supervision, coordination and surveillance data.

Vaccine acceptance will be promoted through strategic communications—engaging the media, communities, religious influencers, the education sector, medical professionals and female mobilisers. IAG activities will also be integrated with communications. In addition, ICN will continue to improve vaccine uptake, and recruitment will be on merit and qualifications.

13.5 Inter-sectoral approaches

PEI will enhance inter-sectoral approaches in high-risk areas to improve community participation and address basic social needs by engaging line ministries through the Polio High Council and other forums. It will also support EPI and convergence will be enhanced across the country (with more focus on polio high-risk areas) by providing basic health services through sub-health centres and mobile teams, and by deploying community-based permanent local teams.
