National Emergency Operations Centre, Afghanistan

National Emergency Action Plan 2022

Polio Eradication Initiative Afghanistan

National Emergency Operations Centre, Afghanistan

National Emergency Action Plan 2022

Polio Eradication Initiative Afghanistan

List of acronyms

AFP	Acute flaccid paralysis
AHS	Afghanistan Health Survey
APIMS	Afghanistan Polio Information Management System
ARCS	Afghan Red Crescent Society
BPHS	Basic Package of Health Services
COVID-19	Coronavirus Disease 2019
CVDPV	Circulating Vaccine Derived Poliovirus
DDM	Direct Disbursement Mechanism
DoRR	Department of Refugees and Repatriation
DPO	District Polio Officer
GCMU	Grant and Service Contracts Management Unit
EMRO	Eastern Mediterranean Regional Office
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunization
ERC	Expert Review Committee
ES	Environmental Surveillance
FLW	Front-line workers
FRR	Financial Resource Requirement
GPEI	Global Polio Eradication Initiative
HF	Health Facility
HRMP	High Risk Mobile Populations
IAG	Islamic Advisory Group
ICM	Intra-campaign monitor/monitoring
ICN	Immunization and Communication Network
IDPs	Internally Displaced Persons
IFA	Information for Action
IHR	International Health Regulations
IOM	International Organization for Migration
IPCI	Interpersonal communication for immunization
IPV	Inactivated polio vaccine
KAP	Knowledge Attitude Practices
KP	Khyber Pakhtunkhwa
LQAS	Lot Quality Assurance Sampling
MCV	Measles Containing Vaccine
NEOC	National Emergency Operations Centre
NIAG	National Islamic Advisory Group

List of acronyms

NGO	Non-governmental organization
NEAP	National Emergency Action Plan
NID	National Immunization Days
nOPV2	Novel Oral Polio Vaccine
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OPV	Oral polio vaccine
PCM	Post-campaign monitoring
PHD	Provincial Health Director
PEI	Polio Eradication Initiative
PEMT	Provincial EPI Management Team
PIRI	Periodic Intensification of Routine Immunization
POB	Polio Oversight Board
PTT	Permanent Transit Team
REOC	Regional Emergency Operations Centre
RI	Routine Immunization
REMT	Regional EPI Management team
RRL	Regional Reference Laboratory
SIA	Supplementary immunization activity
SM	Social Mobilizer
TD	Tetanus Diphtheria
TAG	Technical Advisory Group
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VMWG	Vaccine Management Working Group
PHC	Primary Health Care
PMU	Program Management Unit
PIRI	Periodic Intensification of Routine Immunization
POB	Polio Oversight Board
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
WASH	Water Sanitation Hygiene
WHO	World Health Organization
WPV	Wild poliovirus

Contents

Section 1:

Epidemiology and Situational Overview

The overall polio epidemiology in Afghanistan seems to have slightly improved during the year 2021. Despite the ongoing challenges in consistently reaching all children with polio vaccine, the number of WPV-1 cases and positive environmental samples significantly reduced compared to 2020. A total of four WPV-1 cases were reported from two districts compared to 56 polio cases from 38 districts in 2020. The same trend was seen for environmental samples: the number of WPV-1 positive environmental samples decreased in 2021 to 1 compared to 35 in 2020. In 2021, 43 cVDPV2 cases were reported from 28 districts (as of 10 January 2022), compared to 308 cVDPV2 cases in 2020 from 118 districts. Poliovirus surveillance activities generally went on uninterrupted during 2021. An external desk review in December 2021 concluded that the reduction in poliovirus detection in 2021 and the current low level of transmission seem to be an accurate reflection of the situation despite the broadening immunization gaps.

Significant reduction in the WPV-1 transmission intensity in the polio reservoir South and East Regions is encouraging and represents a significant opportunity to fast-track progress towards stopping WPV-1 transmission in the country. South Region has been the hotspot for WPV-1 transmission for several years, with Kandahar city acting as transmission driver. No WPV-1 case was reported from the South Region in 2021 compared to 38 WPV-1 cases in 2020 (16 from Helmand, 14 from Kandahar, 4 from Uruzgan, 3 from Zabul and 1 from Nimroz province). There was a one WPV-1 positive environmental sample from Helmand province of South Region in 2021, compared to 24 in 2020. The epidemiological situation in the East Region remains encouraging. The region did not report WPV-1 from any source in 2021, compared to two WPV-1 cases and four WPV-1 positive environmental samples in 2020. The cVDPV2 outbreak in both South and East Regions also declined in 2021, following vaccination response with type-2 containing vaccines. South Region reported 12 cVDPV2 cases in 2021 (last case in July) compared to 145 in 2020; while the East Region did not report any cVDPV2 case compared to 70 cases in 2020.

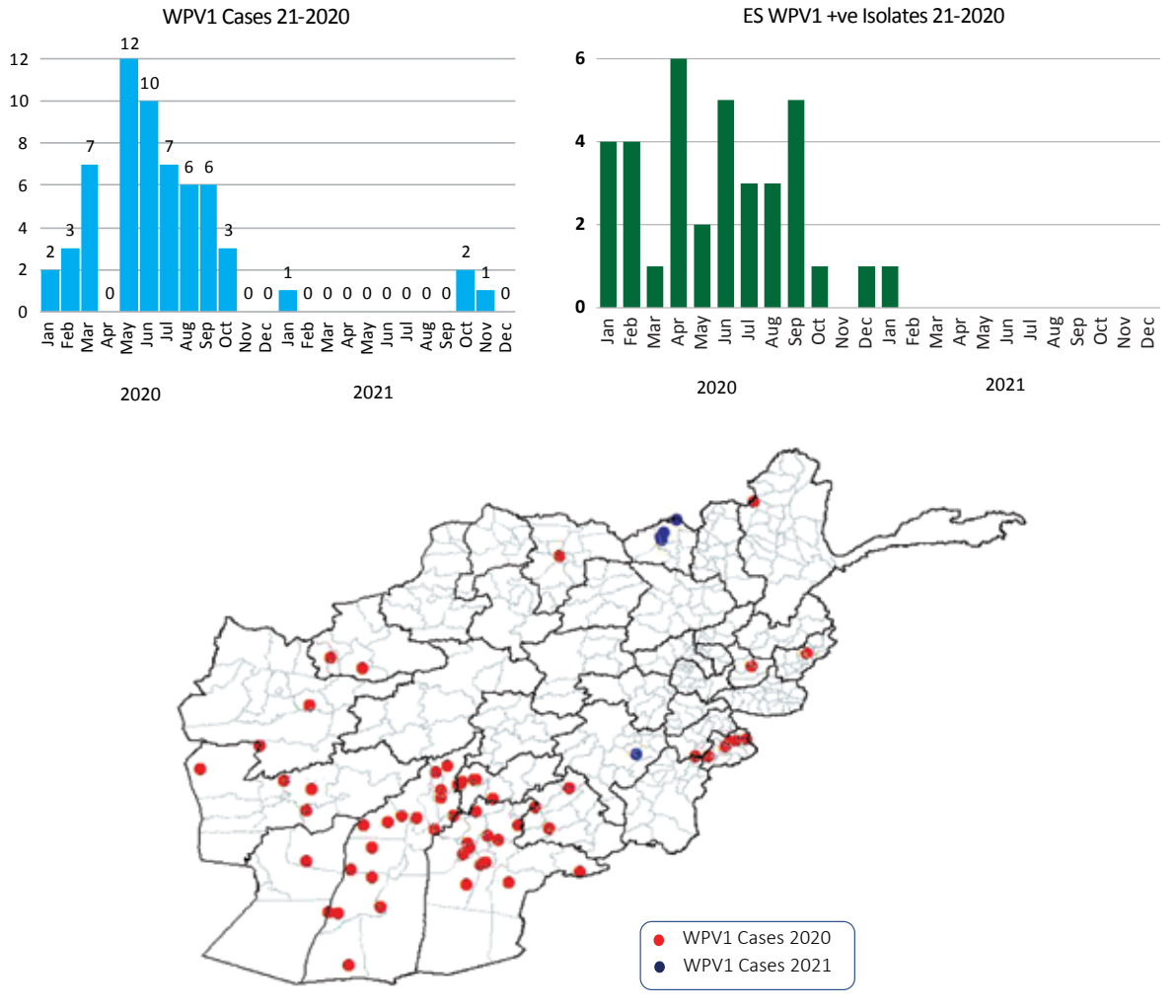
It is assuring to note that the WPV-1 transmission during 2020 outside the reservoir regions (South and East) also curbed in 2021. However, WPV-1 isolation from the North East Region is concerning, more so because one of the WPV-1 isolates is an orphan indicating ongoing transmission for about two years.

It is pertinent to mention that the WPV-1 transmission in Pakistan also showed a downward trend during 2021. The

epidemiological situation in the northern and southern cross-border epidemiological corridors improved in 2021. The WPV-1 isolation (in South KP) in the central corridor (South-East, Afghanistan and South KP, Pakistan) is concerning and represents a significant risk of WPV-1 spread during the high transmission season.

Genomic sequencing analysis of poliovirus isolates indicates ongoing cross-border transmission between Afghanistan and Pakistan in 2021, as well as sustained local transmission. During January to December 2021, one of four WPV-1 cases and the only WPV-1 isolated in environmental samples had closest genetic links to the earlier WPV1 and environmental WPV-1 isolates from Pakistan. During January to December 2021, two WPV-1 genetic clusters were detected in Afghanistan, compared to eight genetic clusters detected in 2020. Two WPV-1 isolates in 2021 (from a polio case in Kunduz province and environmental sample in Helmand province) were found to be orphan (genetically >1.5% divergent from the closest matching WPV-1 isolate). Among the cVDPV2 cases reported in 2021, 28 (65%) belonged to PAK-GB-1 emergence, first detected in Gilgit-Baltistan (Pakistan); while 15 (35%) belonged to emergences in Afghanistan (AFG-NGR-1 and AFG-HLD).

Figure 1: Situation Summary, 2021



Section 2:

Progress on NEAP 2021

2021 was quite a challenging year for Afghanistan in terms of consistently implementing high quality SIAs across the country and significant number of children remained unreached. The security situation was varied, resulting from full scale armed conflicts across the country that lasted till the middle of August followed by takeover by the Islamic Emirate of Afghanistan. The security situation since mid-August 2021 improved in general, but has not fully stabilized across the country, with on-going security incidents including attacks on polio vaccination workers during the first quarter of 2022.

On the average, more than 3.5 million children aged less than five years remained unreached during the first half of 2021 and the scheduled campaign in September 2021 could not be implemented. Despite some overall improvement in access for polio vaccination campaigns since November 2021, a significant number of children (more than one million) remained unreached during the nationwide campaigns in November and December 2021 as house-to-house vaccination strategy could not be utilized in several areas including the critical South and East Regions. In fact, the areas that were implementing house-to-house vaccination campaigns during the first half of 2021 were not able to implement the same during the second half of the year, leading to a significant increase in the number of unreached children. It is important to recall that house-to-house SIAs could not be implemented in significant parts of the country from April 2019. The inconsistent vaccination coverage in the country, especially the South and East Regions, poses a significant threat to the current encouraging epidemiology. It is important to implement high quality house-to-house campaigns in 2022 to build on the progress made in 2021 towards interrupting WPV-1 transmission.

In general, five out of the twelve objectives set in the NEAP 2021 were met and seven were partially met.

NEAP 2021: Summary Progress by objective

#	Goal/Objective in NEAP 2021	Status
Objective 1	To stop ongoing WPV-1 transmission in the South and East Regions, with special focus to stop transmission in the accessible areas in 2021	Achieved
Objective 2	To stop cVDPV2 transmission in the accessible areas by end-2021	Partially achieved
Objective 3	To review, streamline and optimize the functioning of polio EOCs, by quarter 3 of 2021	Partially achieved
Objective 4	To respond to any of WPV-1/VDPVs outbreaks rapidly and effectively in the polio free areas of Afghanistan, ensuring no secondary cases following any importation	Achieved
Objective 5	To ensure safety of polio health workers at the forefront and communities through maintaining effective infection prevention and control for COVID-19 transmission during the polio eradication activities	Achieved
Objective 6	To maintain a scenario-based approach to rapidly adjust to any possible/anticipated access and programmatic situations	Achieved
Objective 7	To improve community acceptance and demand for vaccination and address vaccine refusals through effective and locally appropriate communication strategies	Partially achieved
Objective 8	To integrate gender equity considerations at the program planning and implementation level, appropriate to the Afghanistan context; and monitor adherence to these considerations from the EOCs level	Partially achieved
Objective 9	To maintain effective access dialogue in coordination with all the national and international partners aiming to have access for house- to- house polio campaigns across the country	Partially achieved
Objective 10	To achieve and maintain high population immunity among HRMPs	Partially achieved
Objective 11	To enhance program quality with focus on high- risk provinces/districts to uniformly reduce missed children to less than 3% at the sub-provincial level (especially in the accessible areas). Special emphasis will be laid on effectively .reaching the new-born and infants	Partially achieved
Objective 12	To maintain sensitive and high-quality surveillance for polioviruses, across the country with consideration for possible expansion of environmental surveillance, as per feasibility	Achieved

While tracking the reach of SIAs in the country over the last few years, it is noted that the Taliban's ban on vaccination in 2018 initially limited to the high-risk provinces of the South, gradually expanded at the beginning of 2019 The ban extended to the whole country in April 2019 and no campaigns could be implemented from April to July in 2019. Despite gradual resumption of campaigns during the second half of 2019, house-to-house vaccination strategy could not be utilized in large parts of the country, including the reservoir South Region. Reportedly, the health facility-based campaigns could not reach more than 20% children in the South Region in 2019. In 2020, one NID and one SNID were implemented before the COVID- 19 pandemic hit Afghanistan and all polio vaccination activities were temporarily paused for 5 months from March to July 2020 following the recommendation of the POB. Despite the resumption of SIAs in July 2020, house-to-house strategy could again not be utilized to implement the SIAs everywhere. All the case response activities, NIDs and SNIDs were partially house-to-house and health facility based.

The challenges continued during the year 2021 in terms of consistently implementing high quality SIAs across the country. Under the advice of the TAG for Polio Eradication in Afghanistan, the programme planned for four NIDs (January, March, May, September) and two SNIDs (November and December) in 2021. However, only three NIDs could be implemented during the first half of the year. The NIDs planned for September 2021 could not be implemented due to ongoing conflict in the country leading to the suspension of campaigns from July to November 2021. The three nation-wide campaigns implemented during the first half of 2021 (January, March, and June) could not reach the desired target and, on average, more than 3.5 million children remained unreached across the country as house-to-house vaccination campaigns were not allowed in many parts including the South Region. As per the reported administrative data, the health facility-based campaigns could reach a maximum of 20% of targeted children and this low coverage is mainly due to challenges such as very few health facilities in some districts, difficult terrain, long distances, and lack of motivation among communities to walk extended distances for only polio vaccination.

Table 1: Total Target Population and Target Population by Vaccine Type, Campaigns- 2021

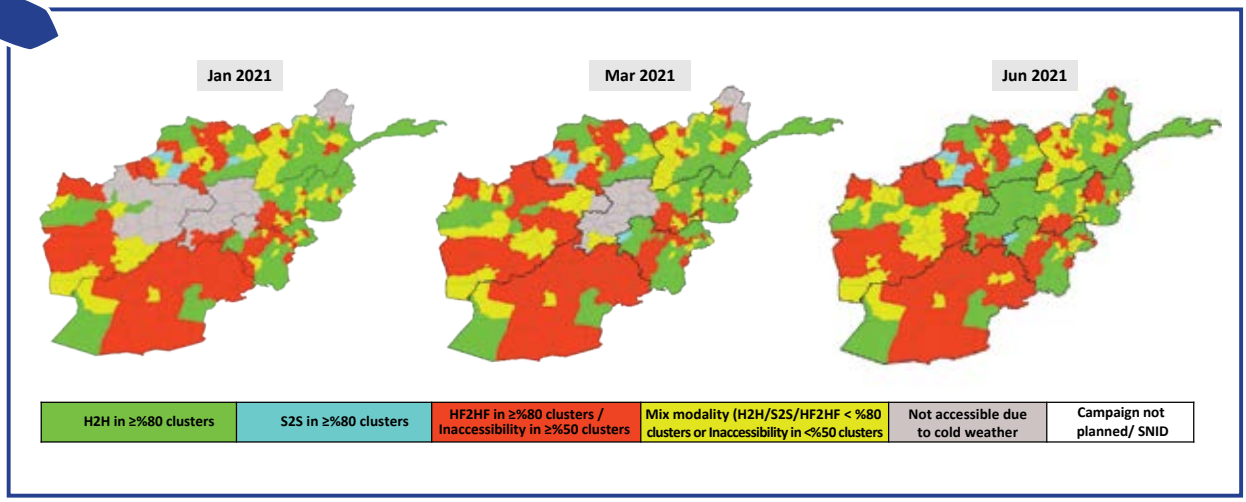
Activity/ vaccine type	Total Target Population and Target population by vaccine type				
	Total	bOPV	mOPV2	tOPV	mOPV1
Jan'21 NIDs	9,999,227			9,999,227	
March'21 NIDs	9,999,227			9,999,227	
June'21 NIDs	9,999,227			9,999,227	
Nov'21 NIDs	9,999,227	1,047,534		8,951,693	
Dec'21 NIDs	9,999,227			9,999,227	

In 2021, the program also had a major setback when polio workers were attacked in the East Region. In March 2021, three female polio vaccination workers were gunned down in Jalalabad and Surkhrod districts of Nangarhar province while conducting house-to-house to vaccination during a campaign. In the June campaign, 10 polio workers were attacked in Nangarhar and six of them succumbed to injuries. The campaign was suspended in Nangarhar following these incidents. These incidents seriously dented the Programme's efforts to improve women participation in campaigns: the percentage of women vaccinators reduced in Jalalabad from 72% in March 2021 to zero in June 2021.

After the resumption of campaigns in November 2021, a significant number of target children (more than one million) remained unreached during the nationwide campaigns in November and December as house-to-house vaccination strategy, the gold-standard for polio eradication, could not be utilized in several areas including the critical South and East Regions. In both the campaigns, tOPV was used except in Kabul district where bOPV was used in the November campaign.

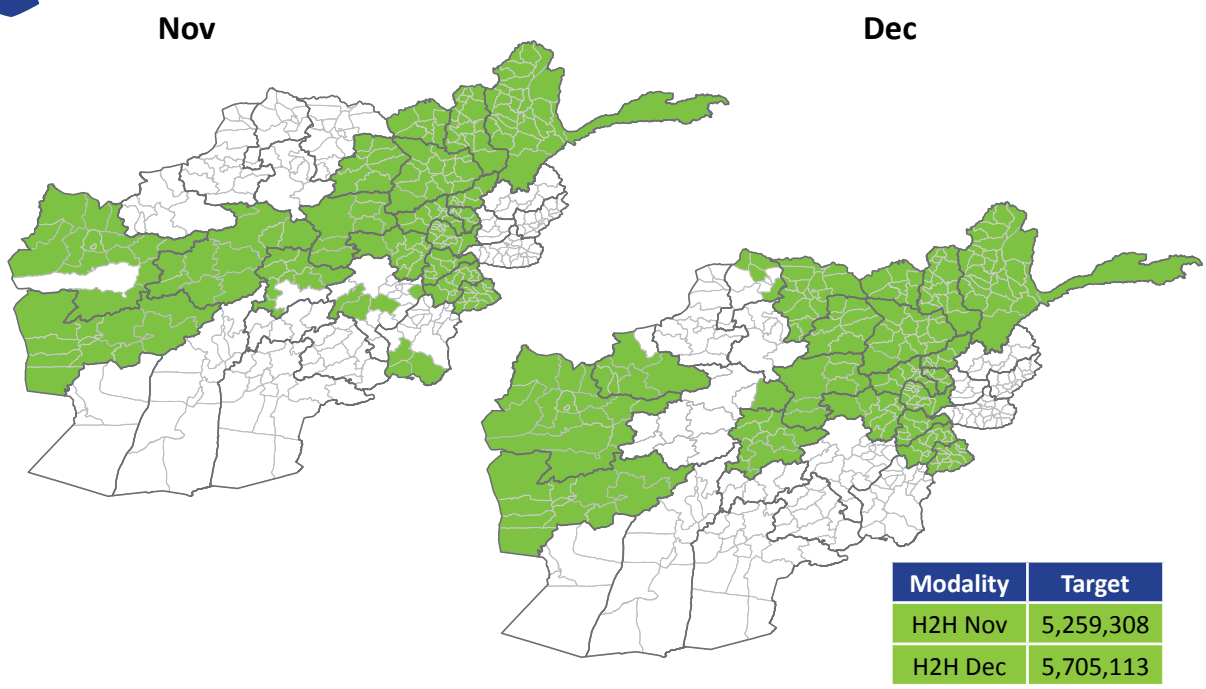
The PEI's support to the COVID-19 response, which started in early 2020, continued in 2021. The entire AFP surveillance network of more than twelve hundred medical doctors and paramedics supported COVID-19 surveillance while the polio community networks were utilized to engage the communities and orient them on preventive measures on COVID-19.

Figure 2: Campaign Implementation Modality by district; Jan-Jun 2021



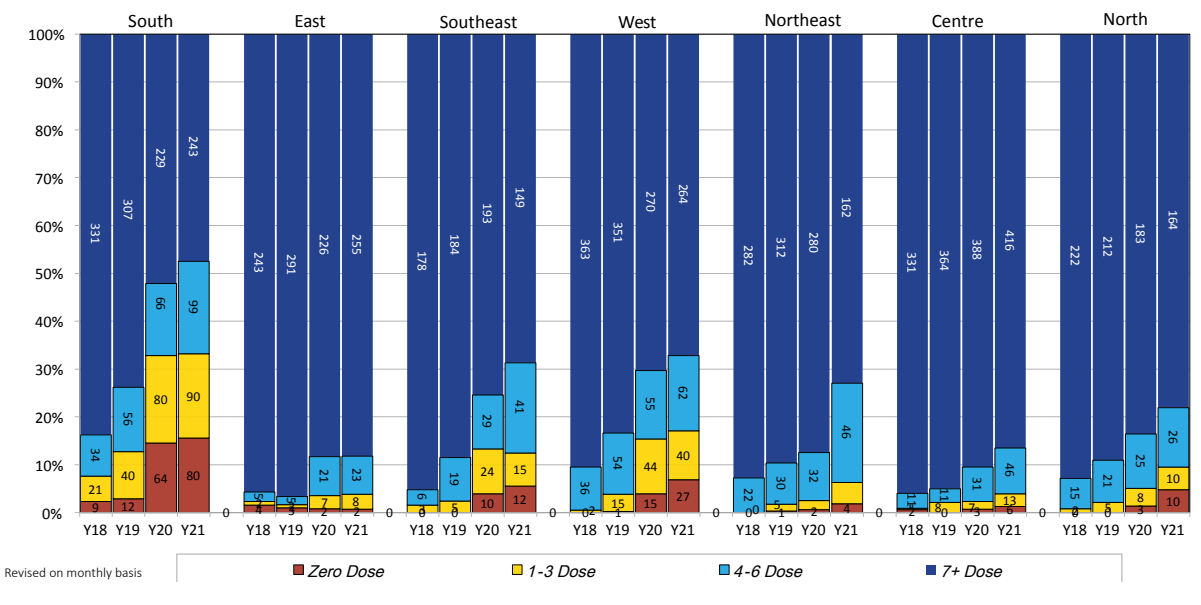
Generally, more than 45% of the target population in the country could not be reached for polio vaccination by house-to-house strategy in 2021. Importantly, all the target children in the critical South and East Regions could not be reached through house-to-house campaigns in November and December NIDs. This means that the areas in these regions that were able to do house-to-house campaigns till mid-2021, are no longer able to do so. The last full-scale house-to-house campaign in the entire East Region was implemented almost one year ago (in January 2021) and the same in South Region in early 2018. This indicates the ever-growing immunity gap and associated risks in this region.

Figure 3: Campaign Implementation Modality - November & December 2021 NIDs



Clustering of refusals in the South and South East Regions is contributing to already low population immunity due to the inability to implement house-to-house campaigns and for quality issues in the areas with house-to-house campaigns. Due to all these factors, the campaigns have not been achieving the coverage required to reach eradication. The available surveillance data on the vaccination status of AFP cases indicates an increase in population immunity gap across the country due to suspension of campaign for an extended period, particularly in the South Region, in areas where house-to-house campaigns have not been implemented for a significant period.

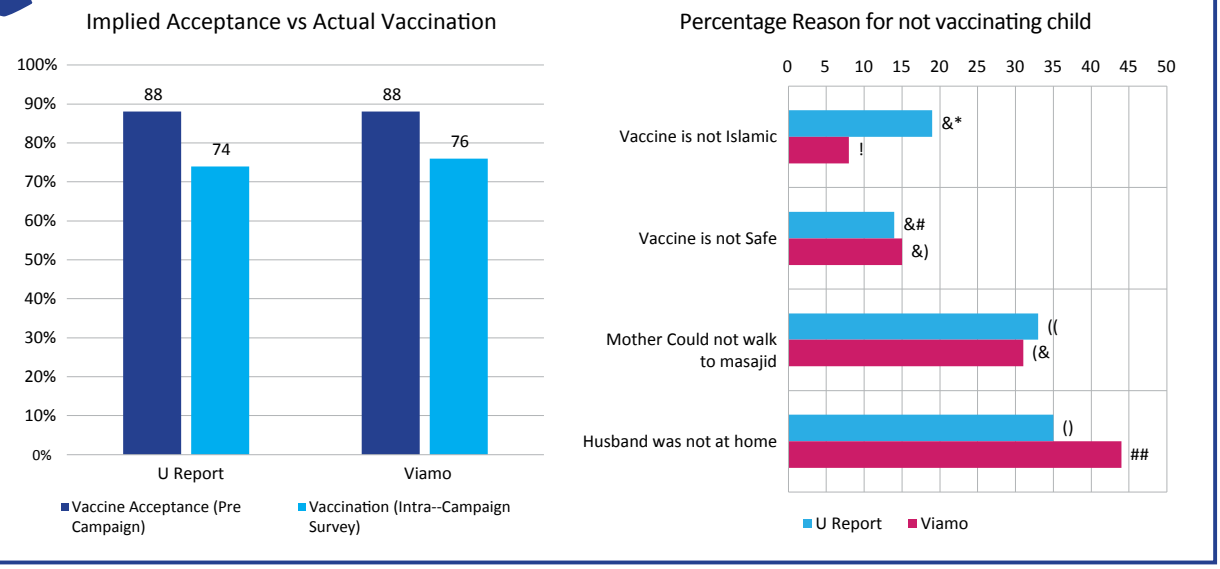
Figure 4: Vaccination status of Non-Polio AFP cases 6-59 Months- Region



Throughout 2021, the programme continued its efforts to address vaccine acceptance issues through a wide variety of community engagement and social mobilization activities such as engagement of religious leaders, grandmothers, and local authorities. Region-specific approaches were adopted, ICN network was streamlined and tailored to local needs, and partnerships with local communities including working with grandmothers, husbands, religious leaders, media engagement, and authorities were strengthened. Further details are available in the section on Communication.

UNICEF introduced the use of U-report and Viamo remote surveys to understand community perception, awareness, and acceptance of polio vaccinations during November and December campaigns in 2021. U-report and Viamo are telephone-based surveys that push out short questionnaires in various provinces/localities. While U-report has registered users, Viamo is random surveys to telephone subscribers. Data from community surveys using U-report and Viamo platforms during campaigns in November and December 2021 show that majority of respondents implied they would vaccinate their children during the campaign. However, not all responders eventually presented children to be vaccinated. Most common reasons for not vaccinating child during the campaign included husband not being at home and mother could not walk to the mosque. The programme has used this data to inform communication and community engagement gaps and appropriate deployment of frontline social mobilizers especially for surveys conducted pre-campaign.

Figure 5



During 2021, the programme took several measures to improve the reach and quality of vaccination campaigns, with special focus on hot spots in the South and East Regions (Kandahar city, Lashkargah, Nangarhar, Kunar). There was varying success in different regions, given the ongoing challenges and the evolving political situation. While female participation among polio workers initially improved in high-risk areas of South and East Regions, it deteriorated from mid-2021. After concerted efforts, the programme could improve women participation as vaccination volunteers during the campaigns in the South Region. Overall, the percentage of women participating in campaigns in the South Region increased to 30.8 percent in January but dropped in the November 2021 NIDs. Although the campaign modality impacted women's participation, 998 women social mobilizers (24% of the total number) were involved as campaign-based social mobilizers for both M2M and H2H. Out of 108 Provincial and District communication Officers, 15% (16) are women (as of January 2022).

The use of a slightly modified re-visit strategy to maximize coverage of missed children continued successfully in Kandahar city and parts of Loya-wala in Kandahar province during the first half of the year. As previously noted, both the South and East Regions could not implement house-to-house campaigns during the second half of 2021. The coverage through fixed site vaccination was far below the benchmark required for eradication (at least 90% verified by finger marking and preferably higher in thickly populated areas).

Technical support is being extended by field PEI staff to the BPHS+ for the monitoring of health facilities and reporting of issues relevant to immunization. In most parts of the country, PTTs continued vaccination of children and rationalization exercise were done focusing the PTTs on areas with unreached children.

The programme decided to vaccinate all <5 years children visiting the health facilities across the country by the available vaccinators in the health facilities and the required instruction was shared with BPHS NGOs. In addition, 480 female vaccinators were recruited in health facilities in the East, South, and West Regions to vaccinate all visiting children less than 5 years of age with OPV and missed EPI doses for other antigens.

Section 3:
Key Challenges and Risks

The programme has identified the following significant challenges/risks to stopping poliovirus transmission in Afghanistan: 1) continued inconsistent access for vaccination to all children; 2) Programme management transition; 3) Inability to perform house-to-house campaigns; 4) Sub optimal campaign quality; 5) stagnating number of refusals especially in the South East Region; 6) high population mobility; and 7) chronically low routine immunization coverage in polio high risk provinces.

- **Continued inconsistent access for vaccination to all the children**

An overarching and most critical challenge for the programme has been the inability to reach all children consistently. A significant number of children remained missed due to one reason or the other over the years, allowing the poliovirus to continue transmitting. More details are mentioned in the chapter on epidemiology and in the section “inability to perform house-to-house campaigns” below.

- **Programme management transition**

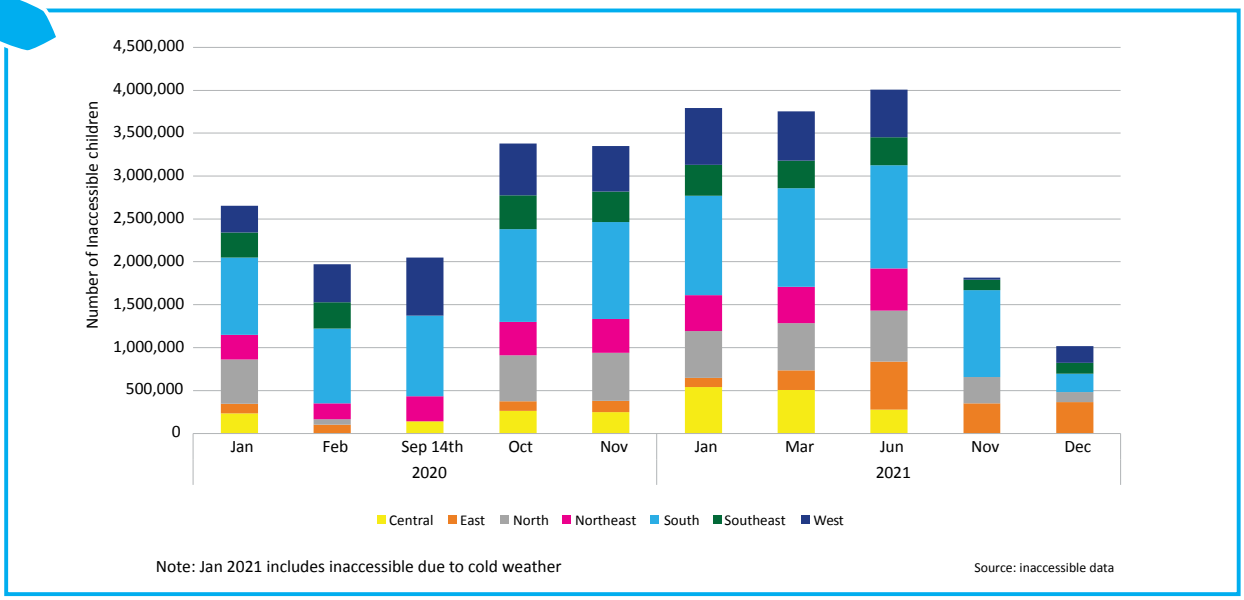
Afghanistan saw a major political evolution around mid-2021, with transition of authorities in August, including the change of management of polio eradication programme. While the country is facing a significant humanitarian crisis, it is a challenge to maintain adequate focus on polio eradication efforts. The current situation puts the gains made and progress in serious jeopardy, if not addressed urgently. The National EOC functional review is in final stages and efforts are underway to put in place and fully functionalize the National EOC by the end of the first quarter of 2022.

- **Inability to perform house-to-house vaccination**

As described earlier, the number of unreached children continued to increase significantly from May 2018 due to a continued ban on house-to-house vaccinations in most parts of the South Region because of security concerns from the Taliban. During 2019, the programme faced a complete ban on vaccination for approximately six months that was partially lifted in late September 2019, with the exception of Taliban-controlled areas. In 2020, the ban continued and expanded to areas in other regions including the North, North East, Central Regions. It is important to note that the critical areas in the South Region were under the ban for nearly three years, affecting around one million children, leading to significant drop in the population immunity and significantly heightened risk of further intensification and geographical spread of WPV-1 as well as cVDPV2. During the first half of 2021, more than three and a half million children could not be reached across the country during each of the NIDs implemented.

Though campaigns resumed in November 2021, after being suspended from July to November, more than 4.5 million children could not be reached through house-to-house strategy during November and December 2021 NIDs. Matter of concern is that around three million target children could be in the critical South and East Regions of the country, which has been the hotbed of poliovirus circulation, could not be reached through house-to-house modality.

Figure 6: Children missed due to limited campaign modality

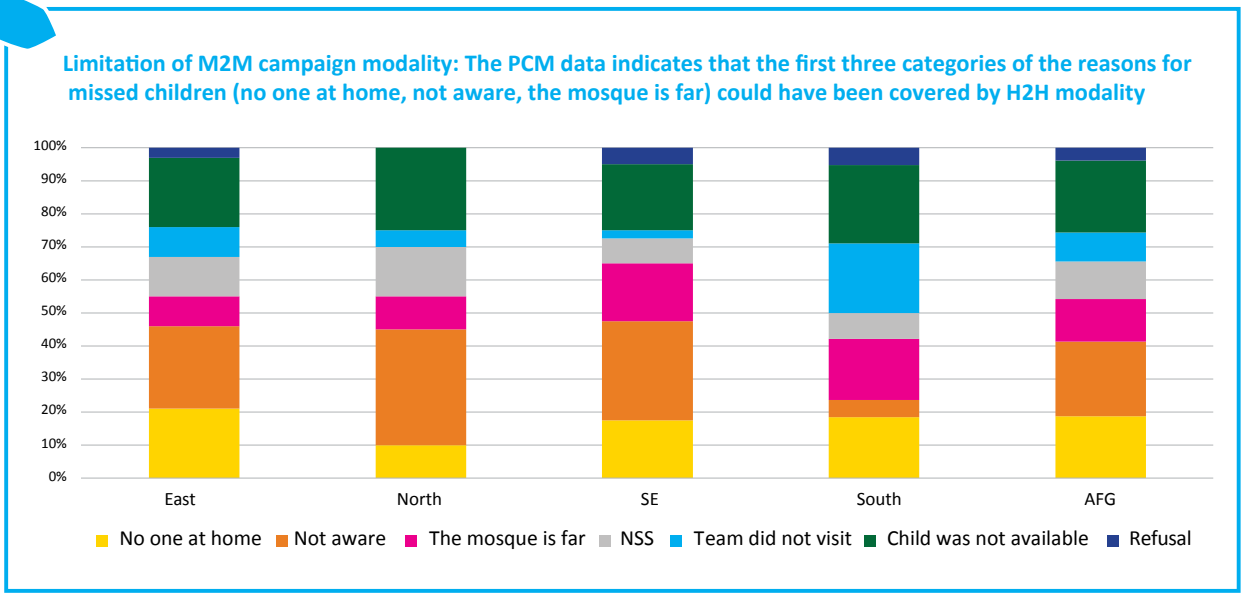


Note: Jan 2021 includes inaccessible due to cold weather

Source: inaccessible data

The below graph shows the reason for children missing vaccination for three main reasons - (i) No one at home to take the child to the vaccination site; (ii) Caregiver not aware of the campaign; and (iii) Vaccination site is far - could have been avoided if house-to-house modality was implemented.

Figure 7: Missed children by Reason & Region, Dec 2021 (areas where H2H modality was not followed)

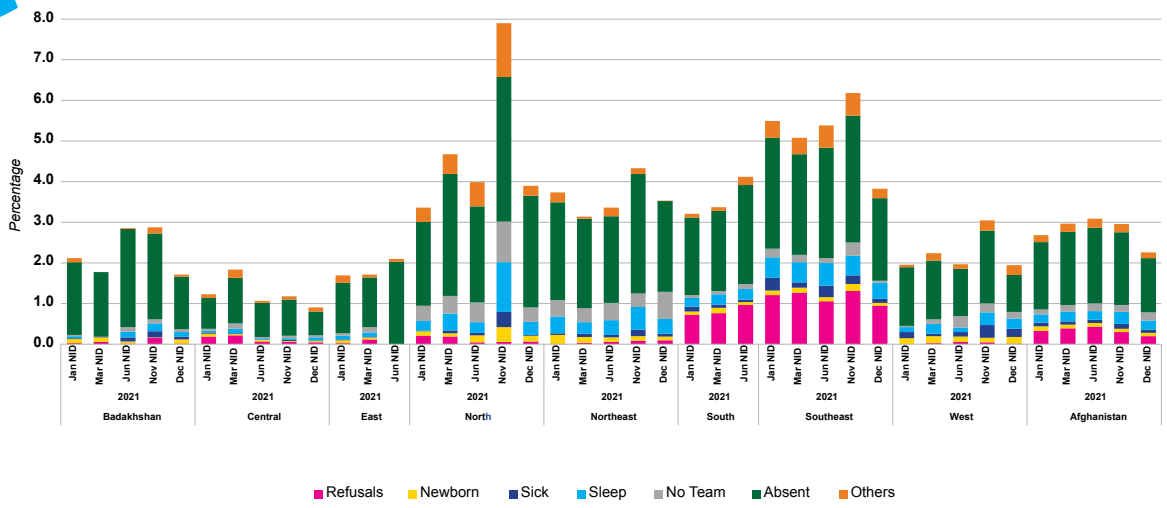


- **Sub-optimal campaign quality**

The programme continues to face the challenge of compromised quality SIAs largely due to accountability issues. Although the overall campaign quality in some areas is adequate, in-depth data analysis indicates that the quality of SIAs is not uniform at the sub-district level. This is particularly true for the critical areas of the South Region, including Kandahar city and Lashkargah.

Improving programme quality is one of the top priorities to eradicate polio which is prioritized and will be focused on in the NEAP. The post-campaign independent monitoring data from December 2021 NIDs indicates approximately 3.5% missed children in the South Region, 2% in the East, 5.5% in the South East, 3.8% in the North East and 3.5% in the North. 'Child absence' and 'refusal' were the primary reasons (please see the graph below).

Figure 8: Missed children by Reason & Region, Jan 2020 – Jun 2022



- *Absent and refusal (south & southeast) are the main reason for the children being missed however there is slight decline in the number of refus al in southeastern region*
- *November and December rounds were not conducted house to house in all south, East and two provinces of southeast*

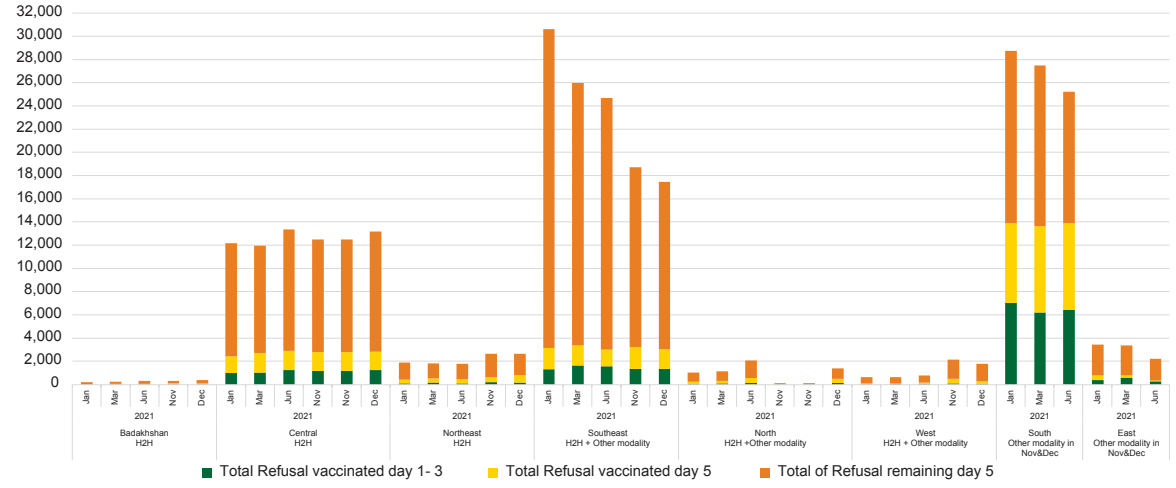
Source: *PCM H2H data*

Reports from the field indicate problems in the selection of polio health workers at the forefront and other staff, lack of women vaccinators, training, supervision, capacity building, timely payment, monitoring, sub-optimal accountability, limited data use, gaps in follow-up actions in between SIAs, failed LQAS lots with lack of investigation and corrective measures, sub-optimal implementation of revisit strategy and appropriate micro-plans implementation. Interference in the selection of polio health workers at the forefront/ staff from many sources continues to be a challenge. Selection committees are either not sufficiently empowered, are influenced or lack commitment to follow the guidelines.

- **Stagnating number of refusals**

Clusters of refusals**,** particularly in and around Kandahar (South Region) as well as in the South East Regions (Khost and Paktika provinces) are a matter of concern. Persisting high number of chronically refusing families continue to be reported from the South and South East Regions where the number of refusals ranges from 25,000 to 28,000 in the South, and from 24,000 to 30,000 in the South East. The highest concentration of refusals is reported in Kandahar city and surrounding districts and Paktika province in the South East. The graph below shows the trend in refusals in 2021, though there is no mechanism to identify refusals if house-to-house modality is not followed.

Figure 9: Reported coverage, Remaining Refusal by region, By campaign – 2021



Source: Reported Administrative data

The key reasons for refusals continue to be religious objection, campaign fatigue, contents of the vaccine, and lack of other health and development services, particularly in the marginalized and underserved communities in the South Region. Part of such refusals also exist in areas of Helmand, Kandahar and Uruzgan provinces where there was active WPV-1 circulation in 2020 and cVDPV2 circulation in 2021.

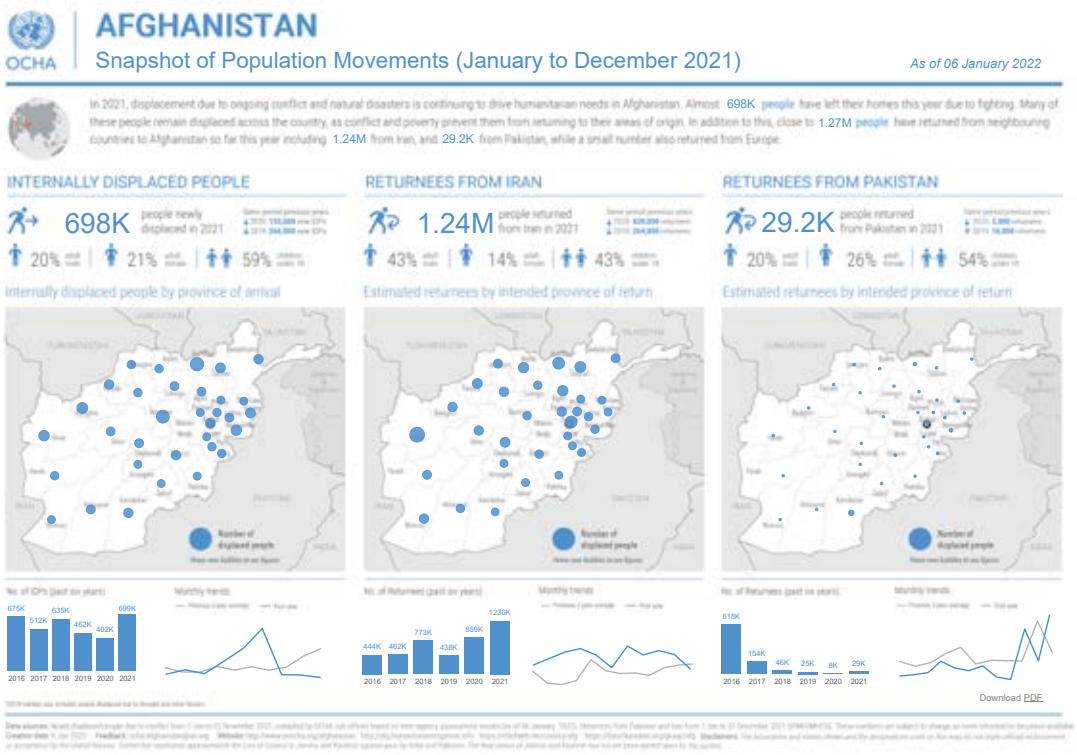
Reports also indicate that the use of non-local staff, involvement of young male volunteers and lack of women vaccinators/social mobilizers add to the challenges around community acceptance for polio vaccine. These is exacerbated by community fatigue, multiple door-knocking, staff capacity and low staff motivation which pose additional challenges that will be focused on during 2021. With the decrease in the participation of women volunteers in campaigns, which dropped nationally from 17.8 % in January to 10.9 percent in November and more particularly in South, the programme assumes that the number of refusals is likely to substantially increase.

- **High Risk Mobile Population moving between Afghanistan and Pakistan**

Continued cross-border population movement between Pakistan and Afghanistan due to strong socio-cultural ties, trade and commercial reasons continues to constitute a significant challenge for the programme both in terms of difficulty to reach such populations - for SIAs and surveillance - as well as leading to shared poliovirus circulation within the one epidemiological block. This movement is not just limited to border areas and areas that are demographically close to the borders, but also to areas far from borders due to a variety of reasons. The four main groups identified by the programme and that will continue to be focused include:

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

The below snapshot of population movement shared by OCHA Afghanistan shows that the number of returnees from Pakistan in 2021 was 29,200 while from Iran it was 1.24 million. There were also 698,000 internally displaced people mostly concentrated in the East, North, West and Central Regions.



Source: OCHA Afghanistan

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

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

Routine EPI is one of the main strategies of polio eradication. High EPI coverage always provides a strong base for population immunity to minimize the risk of polio. The RI coverage continues to be very low in polio high-risk provinces, particularly in the South. The latest AHS survey (2018) indicates very low Penta-3 coverage in the polio high-risk provinces with the most intense polio transmission: Helmand less than 20%, Kandahar about 30% and Uruzgan less than 5%. Vaccination status data for non-polio AFP cases shows that nationally 14% of non-polio AFP cases aged 6-59 months were un-immunized or under-immunized in routine immunization in 2021. In the South, the percentage is 33%. The situation in the high-risk provinces is alarming: the percentage of un-immunized or under- immunized children in Kandahar is 11%, Helmand 41%, Uruzgan 53% and in Farah 30%. These Figures indicate the need to scale up efforts to improve EPI services in these provinces, including the birth OPV dose strategy.

The contractual terms and conditions with NGOs are the same as they were in 2020. The NGOs working at the provincial/district level are supposed to cover the entire population of the province. With only US$5 per capita and a contractual target population of 50% of the total actual population (comparing to NID population), even a high-performing NGO only has resources for around half of the eligible children.

- **Update on progress with implementation of integrated services**

During the year, GPEI partners supported the implementation of integrated services for EPI strengthening with the following activities implemented in the South with direct or indirect support from the polio programme: of the planned 115 new BPHS plus facilities to be established, 80 are established and functional; 260 vaccinators deployed for outreach vaccinations; 49,169 zero-dose children received vaccinations; 21 mobile health and nutrition teams launched and functional delivering basic health services in white areas; 18 WASH facilities in health and communities established providing services to over 15,000 people; and, 27,422 children under five received polio vaccination after target age was raised to <5 years from <1 year.

Challenges during the year included no access to 'white areas' (geographical areas and population pockets missing due to inconsistent distribution of health facilities), insufficient budget, very few health facilities as well as governance and accountability issues, and poor monitoring and supervision. With more than a million new births every year in Afghanistan, there is a growing immunity gap. Reaching newborns is an operational and communications challenge, with factors such as the cultural practice of keeping newborns inside the house for 40 days from birth and the absence of women vaccinators also add to the reasons for sub-optimal coverage of newborns. Reaching newborns requires emphasis and monitoring during training and implementation of the EPI service as well as during house-to-house and transit points vaccinations. Moreover, appropriate communication strategies need to be designed and utilized, accordingly. Timely administration of OPV-0 through routine immunization will positively impact on stopping transmission. Additionally, timely EPI vaccination with IPV will help reduce paralytic disease from WPV-1 and cVDPV2.

Section 4:

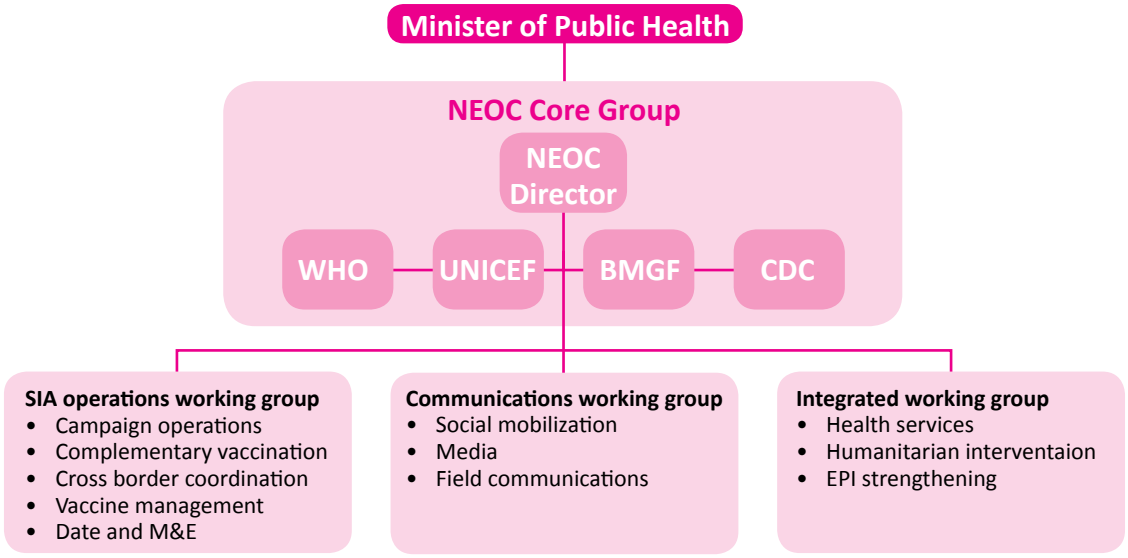
Development and operationalization of NEAP 2022

The ongoing inability to implement house-to-house vaccination campaigns throughout the country for almost three years is leading to continued drop in the immunity against polio. Afghanistan also saw a political transition around mid-2021. Keeping in view the current epidemiology and challenges, and programme management situation, the National Emergency Action Plan for polio eradication was updated for 2022 using a consultative approach at the national and sub-national levels. The regional and provincial polio teams were consulted and brainstorming sessions conducted on progress made and lessons learnt in 2021, current challenges as well as adjustments needed in the current strategies and new interventions required to expedite progress towards achieving eradication. The NEAP document incorporating feedback from regions and partners was shared with the TAG and relevant partners, and guidance of the TAG and other experts was incorporated.

Appropriate and high-quality implementation of the approaches and activities in the NEAP 2022 hold the key for further building upon the progress in 2021 and stopping WPV-1 transmission and cVDPV2 outbreaks. The programme will take the following actions:

Improving the implementation mechanisms through strengthened and focused leadership and management from the Emergency Operation Centres

In 2021, the GPEI commissioned an independent review of the National EOC, which had been in place since 2016. The review highlighted critical room for improvement in functioning and staffing to make the decision-making processes and coordination among implementing partners more efficient. The review identified concerns such as overstaffing and lack of cohesion across government and partners leading to slow and ineffective decision making. In response to the review findings, the GPEI worked with the Ministry of Public Health during the last quarter of 2021 to restructure and refresh the National EOC. Through this process, a clear purpose and streamlined deliverables were identified for the with a focus on coordination and working as one team. In addition, a simplified structure was developed with clear roles for all partners and staff.



The revised structure, purpose, and deliverables of the National EOC were finalized at the end of 2021. The focus has been on recruiting National EOC staff positions, establishing working groups, and working as One Team within the Core Group. The NEOC is targeting to be fully functional in terms of staffing and working groups by the end of March 2022. The National EOC will also lead a similar process of refreshing and restructuring regional EOCs during the first quarter of 2022. This process will rely heavily on the work done on National EOC restructuring as a similar purpose and deliverables are applicable to the regional EOCs.

Overall programme management at the regional and provincial level

The regional EOCs will coordinate all the activities related to polio eradication including routine EPI strengthening in line with the NEAP, to achieve the goal of stopping the WPV-1 transmission. The REOCs will provide technical support to the PHDs and REMT/PEMTs through the PEI partners, maintain liaise with them and guide them to implement all components of PEI in a quality manner, especially SIAs and routine EPI. In the regions with no regional EOC, the above regional level functions and coordination will be undertaken jointly by the in-country GPEI partners.

In the provinces, the PHDs in coordination with the regional level, will support the REMT/PEMTs in implementing PEI activities. The PHDs will ensure support of all health department functionaries

including REMT/PEMT and staff of the BPHS/EPHS NGOs for implementation of SIAs as well as for effective functioning of AFP surveillance in the province. The PHDs will also liaise with the Provincial Governor's office for ensuring inter-sectoral collaboration between PEI and other line departments.

The PHD will lead organizing the provincial task force meetings under the chairmanship of the Provincial Governor planning and implementation of SIAs. The PHD in coordination with the GPEI partners will ensure that the meetings of the provincial task force are held in an effective way, and any support required from the line department (e.g., police/security department, education department, Hajj and Auquf department) is obtained through the provincial task force and Provincial Governor. The GPEI supported staff at the national, regional, and provincial will facilitate and support the technical and programmatic decision making while maintaining coordination across all the levels.

Implementation of plan

Under the management of the new leadership and restructured National EOC, the NEAP workplan will be jointly developed with precise and clear roles and responsibilities of the MoPH and polio eradication partners. The NEAP implementation will be tracked by the National EOC's core team to monitor the progress towards the plan's objectives while exercising necessary accountability under the mechanisms in vogue.

Costing

The GPEI in-country partners under the leadership of the National EOC are responsible to cost the NEAP interventions in consultation with the MoPH leadership and GPEI global partners. While financial Resource Requirement/budget estimates for 2022 have already been submitted to GPEI, there are some amendments in the SIAs plan that are currently under discussion and unfunded *(as of 04 March 2022)*.

Programme review and tracking the Progress for Polio Eradication at the national and global levels

National Level

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

Global level

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

Section 5:
Goals

- Stop transmission of wild poliovirus across the country by end-2023
- Effectively respond to and stop any WPV-1 outbreaks in the non-reservoir areas and prevent the spread to currently polio-free areas
- Stop all cVDPV2 outbreaks by end-2023

Section 6:
Objectives

The NEAP 2022 has the following objectives:

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

Section 7:
Key risks identified for 2022

The programme considers the following as major risks to stopping endemic WPV-1 transmission and cVDPV2 outbreaks in Afghanistan:

- Inability to implement house-to-house vaccination campaigns across the country resulting in widening immunity gap, generally in the whole country and specifically in the reservoir and high-risk regions/areas.
- Programme management challenges, relating to the recent political transition in the country with possibility of inability to get the EOC up and running by March 2022.
- Competing priorities of responding to simultaneous WPV-1 and cVDPV2 transmission.
- Risk of further seeding with mOPV2/tOPV use.
- Interruptions/limitations that may result due to subsequent COVID-19 waves.
- Ongoing population movement between Pakistan and Afghanistan making it challenging to consistently reach these populations groups and posing a risk of continued cross-border transmission.
- Misinformation about polio vaccinations by influential persons leading to hesitancy and refusals among community members.
- Multiple challenges faced by the Government in running the line departments, addressing unprecedented humanitarian crisis, revamping health care system as well as in fully obtaining the GPEI support due to ban/restrictions on government funds and sanctions globally.

Section 8:
Strategies/Strategic Interventions

This section describes the programme's overall strategic approach as well as summary of key interventions planned during the year 2022. The country went through a political transition in 2021, and the dynamics for implementing vaccination campaigns also evolved on the ground. Generally, the access for polio vaccination campaigns improved during the second half of 2021. However, the desired reach for vaccination required for eradication could not be achieved. The current epidemiology (as of end 2021) seems very encouraging but given the inconsistent reach and quality of SIAs, the risks are paramount and if high quality SIAs are not implemented during 2022, WPV-1 spread is imminent. There is also risk of cVDPV2 resurgence in the absence of uniform and consistent high-quality house-to-house campaigns everywhere in the country.

The key strategies to build upon progress in 2021 and utilize the opportunity of the current epidemiology are outlined below:

- Review and update the epidemiological risk categorization and continue focus on the high-risk districts identified in NEAP 2022.
- Sharpen and improve the polio programme management by reviewing and appropriating the EOCs at the national and sub-national level.
- Implement five NIDs and two SNIDs in 2022 with bOPV. The plans for bOPV SIAs will be periodically reviewed during the year and adjusted as per the evolving epidemiology. The programme is planning an intensified SIAs plan in 2022, considering the current historic opportunity to stop WPV-1 transmission in the Afghanistan-Pakistan epidemiological block Moreover, the programme has recently gained access to 2.6 million children who were inaccessible for almost four years and reaching them with polio vaccine multiple times will help rapidly boosting the immunity gap. The programme will also plan to rapidly implement house-to-house campaigns in the areas currently vaccinating through mosque-to-mosque modality, as soon as the opportunity arises.
- Aggressive case response strategy to new WPV-1 cases/isolates (see section below on conducting SIAs).
- Plan and implement case response vaccination rounds with type-2 containing vaccines in line with the global SOPs, as per the evolving cVDPV2 epidemiology.
- Prepare the country for introduction on nOPV2 to possible future in response to cVDPV2 outbreaks.
- All vaccination campaigns to be implemented through house-to-house strategy, with focus on achieving uniform high quality to address the current significant immunity gap, especially in the polio reservoirs and high-risk areas. Special attention on reaching newborns and young children and achieving high vaccination coverage among the high-risk populations.
- Review, update and optimize the communication/community engagement and social mobilization strategies to adapt to the evolving context for improved community acceptance and demand for polio vaccine.

- Take all necessary measures to maintain sensitive surveillance for polioviruses to ensure detecting poliovirus transmission anywhere in the country. Continue desk and field monitoring/reviews, consider an independent/external field review during 2022, as feasible.
- Maintain PEI's support to strengthen routine immunization with focus on polio high risk areas
- Maintain accountability for all the programme components under clear guidelines on identifying and responding to underperformance.
- Review the implementation and impact of the integrated health services towards building population immunity in 2021, and further fine-tune/improve the planning and implementation (in the light of lessons learnt) of these services in high-risk areas of Kandahar, Helmand and Uruzgan provinces of the South.
- Ensure incorporation of gender related analysis in all programme components, with focus on high-risk communities/localities. Sex disaggregation will be ensured in the information/ data sets on SIAs and surveillance to generate evidence for planning and decision making at all levels. Ensure inclusion of clear parameters in the programme's human resources policy at all levels to ensure gender equality as well as ongoing supportive supervision of female workers/staff.
- Focus on enhancing women's inclusion in supervisory and mid-managerial positions, as feasible, to support further increase in women's participation as polio health workers at the forefront.
- In line with the GPEI's zero tolerance for sexual misconduct in polio eradication operations, the polio eradication programme in Afghanistan will ensure protection of the beneficiary populations and of the personnel working for polio eradication from sexual exploitation, abuse, and harassment. This will include necessary orientation/training, screening of personnel, accessible mechanisms for reporting of potential allegations and a victim centered response approach to any sexual exploitation and abuse allegations while working in close collaboration with the UN mechanisms. Any allegations will be immediately reported through the appropriate organizational channels and investigated and responded to, accordingly.

Below is a brief description of the key interventions planned as well as the measures to improve quality of the programme activities.

8.1 Conduct supplementary immunization activities

The programme plans to implement 5 NIDs and 2 SNIDs in 2022 using bOPV. Four of the 5 NIDs are planned during the first half of the year during the low transmission season (*see annex for the SIAs schedule/scope*). bOPV may be appropriately replaced by tOPV in case some parts of the country are affected by outbreaks/intense transmission of cVDPV2 and/or if the risk assessment shows very low immunity against type-2 poliovirus. The areas that can convert from the mosque-to-mosque to house-to-house strategy may be considered for additional OPV doses, based on the risk assessment and local context.

The programme will maintain coordination with Pakistan to synchronize the major SIAs, when feasible. Since the WPV-1 and cVDPV2 transmission intensity has significantly decreased in 2021, the programme will maintain a very aggressive stance for responding to new WPV-1 and cVDPV2 detected from any source. The aim will be to implementing three bOPV vaccination rounds in synch with planned bOPV rounds, preferably within eight weeks of the onset of the last WPV-1 case/collection of last WPV-1 environmental samples. For cVDPV2, two response rounds will be implemented using a type-2 containing vaccine, following the detection of a new cVDPV2 or cVDPV2 breakthrough transmission. The scope of case response campaigns will be decided as per the epidemiology and risk assessment.

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

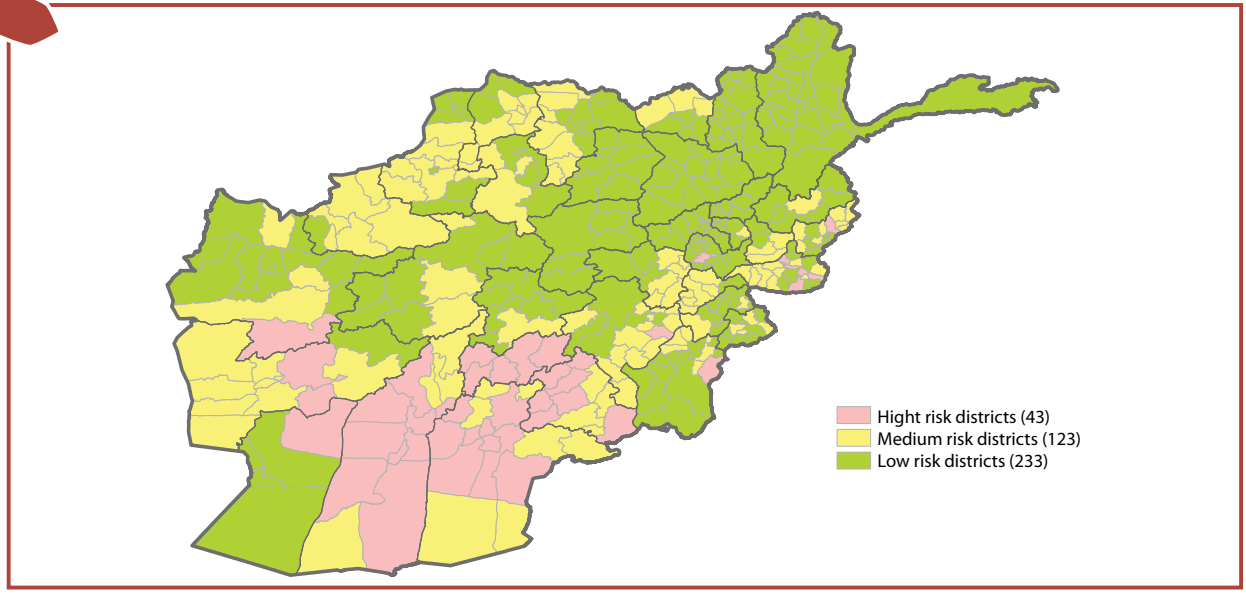
The polio programme and national EPI will work together to add bOPV to planned campaigns of other antigens (e.g., measles) and multi-antigen campaigns in high-risk areas in the light of the evolving WPV and cVDPV epidemiology. Polio eradication assets/staffs will be engaged in monitoring such campaigns as feasible, with focus on reservoir and high-risk areas.

8.2 Focus on high-risk provinces and districts

Access for vaccination has been inconsistent since 2018, with some areas unreached for vaccination for nearly three years (especially in the South Region). Despite overall improvement in access since November 2021, house-to-house campaigns could not be implemented in almost half of the provinces in the country, including in the critical South and East Regions. This prolonged lack of access for vaccination has led to low population immunity against WPV-1. Hence, the programme considers all districts that are not able to implement house-to-house campaigns, as high-risk for programmatic purposes. Population immunity against type-2 poliovirus has generally improved after implementation of campaigns with type-2 containing vaccines in 2021. However, these campaigns could not be implemented everywhere through house-to-house strategy and hence there may be population pockets with low type-2 immunity, indicating risk of resurgence of type-2 poliovirus transmission.

Based on polio epidemiology, lack of/inconsistent access for house-to-house SIAs and other epidemiological factors (population immunity, presence of refugees/IDPs, in-country and cross border travel patterns etc.), 43 districts of the country have been flagged as high-risk, 123 as medium risk and 233 districts as low risk for sustaining poliovirus transmission (*see annex for risk categorization list*). Since 2017, 94% of polio cases have been reported from the 166 medium and high-risk districts, 70% from 43 high-risk districts alone. Seven provinces have been flagged as high-risk, namely Kandahar, Helmand, and Uruzgan in the South, Nangarhar and Kunar in the East, Paktika in the South East and Farah in the West. The provinces also accounted for more than 79% of polio cases since 2017. It is important to note that inability to implement house-to-house campaigns in some critical parts of the country - notably the South - has been persisting for almost three years. The programme will continue to periodically review and adjust the risk categorization, as per the evolving epidemiology.

Figure 11: Risk categorization, Afghanistan PEI, 2022 (as of 25 Jan 2022)



The programme will lay special focus on the high-risk districts as per the revised categorization in NEAP 2022, including adjustment of SIAs schedule and scope, enhanced technical and programmatic support for operations and social mobilization, targeted supportive supervision, and monitoring from the provincial and national levels as well as support from the Ministerial and higher levels on administrative and accountability related aspects.

The programme will also enhance focus on the areas with the most recent detection of WPV-1 (North East) and areas having ongoing population movement with the core reservoirs (northern and southern cross border corridors) and WPV-1 infected areas.

8.3 Improving SIAs quality

Afghanistan is currently witnessing an unprecedented positive epidemiological situation that represents a very good opportunity to stop WPV-1 transmission. This is a paramount prospect, given the encouraging epidemiology in the neighbouring Pakistan as well. To maximally utilize this opportunity, the programme aims to continue and innovate targeted interventions to reduce and bring the proportion of missed children to 3% or less at district and cluster level in high-risk areas and achieve proportion of passed LQAS @ 90% above 90%. Every LQAS lot below 90% threshold will be considered as failed.

The programme will take a focused and meticulous approach towards reaching missed children. Close supervision of vaccination teams during the SIAs will be ensured to pick up and address any performance issues immediately. In polio reservoirs and high-risk areas, supervision and monitoring will be enhanced during the SIAs from the regional and national levels. The reasons for missed children will be regularly disaggregated and investigated during and after each vaccination round, aiming to identify the root causes during the campaigns and/or in between the vaccination rounds. Communities will also be engaged in activities to address refusal before the campaign through the influencers and trusted groups at all levels. The regional and National EOCs will continue to focus on improving the conduct and quality of end-day/evening meetings during the campaigns, to be maximally utilized for improving the implementation quality by providing necessary support and exercising necessary accountability. Any issues not resolved during the campaigns will be examined and mitigating measures will be taken during the preparation phase of the subsequent rounds to minimize the number of missed children. The National EOC will also hold regular post campaign review meetings (engaging the regional/provincial teams) to ensure that the feedback and lessons learned are documented and used for quality improvement.

The programme will review and adjust guidelines for recording various types of refusals for targeted interventions. The programme will plan for better understanding and disaggregating the recoverable children (who return to their houses within the period of campaign) and non-recoverable absent children (who do not return within campaign) to ensure every child available for vaccination is reached through appropriate approaches. Focus on recorded as “newborn, sick, sleeping (NSS)” will be sharpened to identify and address the core reasons for missing these children with special attention to gender related barriers. Special attention will be laid in trainings and supervision, on reaching the newborns as well as identifying and vaccinating guests, sick and sleeping children. Continued monitoring of process indicators such as team composition, team performance and supervision indicators will be used to address gaps affecting the quality of campaigns. Also, the monitoring and coverage data of revisits will be analyzed in a disaggregated manner to identify and address implementation issues.

The programme will enhance focus on effectively reaching newborns and infants during vaccination campaigns, including during revisit and catch-up phases. Recording of newborns/ infants by ICN in between the campaigns will be further streamlined to support the vaccination teams on reaching such children. Relevance of ICN has been revisited and reconFigured to largely campaign based in areas with low burden of missed and refusal children. During and between campaigns, full-time mobilizers/communication supervisors (still referred to as ICN) will prioritize community engagement and communication work including with influencers in polio high-risk areas especially those with high burden of missed and refusals. These cadres will also support monitoring BPHS activities (10-15% of their time).

There will be enhanced emphasis on importance of vaccinating newborns and infants during training and monitoring. High-risk areas will be prioritized for efforts to increasing women's participation as vaccinators, supervisors, and monitors in order to reach young children more effectively. The women's participation will also be considered for the long-term engagement activities at the district level and mosques catchment areas to support the campaign activities. Transit vaccination teams including cross-border teams will also be specifically trained on appropriate approaches to families and to vaccinate newborns/infants. The programme will work towards strengthening referral mechanisms to enroll and follow up newborns for essential immunization and other essential health services to gain trust of communities. Communication strategies will focus on engaging women, men, and communites at large on the importance of newborn vaccination through dedicated messages on the overall child vaccination, combined with complimentary promotional items in high-risk areas. The programme will continue to strive towards supporting the identification of white (areas not covered by any health facility for routine immunization)' and underserved areas at village level and coordinating for inclusion in the outreach schedules.

The programme's ICN will continue to focus on areas at risk of misinformation and high number of missed children/refusals in the country. The ICN will be optimized to ensure quality community engagement that goes beyond house-to-house visits into engaging influential persona, identifying and tracking of children who missed vaccinations, complimenting the work of vaccination teams/ volunteers.

The programme will continue efforts to increase women's participation as polio health workers at the forefront through special gender strategies and incentives. For the areas where campaigns are conducted by house-to-house modality, continued emphasis will be placed on overall efforts to reduce missed children based on analysis of non-vaccine reasons and subsequent action plans and appropriate messages uses. ICN in high-risk areas will continue to report and track missed children and report on emerging rumors in clusters and on silent refusals, and propose actions. Though mosque-to-mosque modality is not ideal to stop polio transmission in Afghanistan, the areas that implement campaigns using this modality will be supported with efforts to track and address refusals and to mobilize communities to bring children to vaccination sites. The tracking and catch-up activities for missed children in such settings are not operationally feasible.

A "No Tolerance Policy" for campaign quality gaps will be adopted, utilizing the programme accountability mechanisms at all levels. Any quality gap will be treated as priority for analyzing and addressing the reasons. Appropriate steps will be initiated as per the accountability mechanism in vogue, aimed at improving the programme implementation quality. The accountability to Affected Population approach will be used to ensure consultation with the community about the service quality. The National EOC will ensure transparent data/information reporting, with zero tolerance for data/information misreporting/fudging. Persistence of any issues in resolving quality gaps will be immediately taken up by the National EOC until appropriate steps are taken from the national level. The programme will focus on fundamental elements of campaigns which include microplanning, selection of polio health workers at the forefront, trainings, monitoring and supervision, locally appropriate social mobilization activities and data quality and utilization. Interventions listed below aim to address these fundamental components of the programme.

8.3.1 Polio health workers at the forefront

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

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

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

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

8.3.2 Training and ongoing mentorship

Appropriate training of health workers at the forefront will be among the key focuses, aiming to improve the quality of campaign implementation. For all training content, basic inter-personal communication skills, gender awareness and community engagement will be streamlined. The following interventions will be carried out under close supervision at the national level:

- The National EOC will review the implementation of the training manual during the first quarter of 2022, tease out the lessons learnt and accordingly take measures to improve training quality. Any required revisions will be made in the training manual by end-March 2022. Emphasis will be to ensure simplicity in the trainings with focus on identification and recording of all eligible children, ensuring vaccination of newborns and guest children, and recovering missed children by the end of the campaign. Trainings will also focus on interpersonal communication skills, community engagement and communication strategies at the household level as well as on gender-related barriers, to ensure high quality vaccination during house-to-house campaigns. The trainings will also include building the basic skills on field problem solving, refusal recording and reporting at household and community level.

- Trainings in high-risk districts by senior programme staff themselves, rather than team supervisors.

- Effective use of training monitoring data to take corrective measures.

- Direct oversight on the functioning of training committees in high-risk provinces and ensuring their effectiveness.

- On-the-job training will be introduced to assist the FLWs to improve the quality of their work.

8.3.3 Microplanning

With more and more areas able to implement house-to-house campaigns, the programme will ensure review, revision and updating of micro-plans before each campaign, including thorough field validation, as needed. Mechanisms to monitor the revision of micro-plans by each supervisor will be ensured with special focus on high-risk provinces/districts. In addition, key components of microplanning such as team/supervisor/coordinator workload and team composition will be tracked for each campaign.

The programme will monitor the need for any major micro-plan revision based on the findings of campaign monitoring and sex disaggregated data analyses. If there is need - based on significant evidence - targeted micro-plan revision/validation exercises will be carried out between campaigns under the supervision of the regional/provincial and National EOCs. Areas that became accessible for house-to-house campaigns after an extended period will be prioritized for thorough field review and validation of micro-plans.

8.3.4 Revisit/catch up vaccination of missed children

To effectively address the two major reasons for missed children - i.e., absent and refusals - the programme will carry out the below key interventions:

- The daily revisit strategy will be strengthened by enhancing and improving the quality of supervision by first level supervisors of vaccination teams as well as monitoring by higher levels. The vaccination teams, after finishing the day's assigned area, will revisit households with missed children on the same day. The revisit and missed children catch up will continue during the three days of the campaign, as operationally feasible in areas where campaigns are conducted under the house-to-house modality. The children not reached during the three days of the campaign will be followed up on fourth/revisit days.

- The revisit strategy will be flexible for high-risk areas, and decisions can be taken locally to revisit/missed children for two days by splitting the vaccinations teams, if operationally feasible (no additional resources allocated for such adjustment).

- The national and regional EOCs will continue to monitor and make necessary changes for timing and modality as well as aim to streamline the work division among the vaccination teams/volunteers and ICN (whereas ICN role continues to focus on vaccine promotion and community engagement rather recovery and vaccination of missed children).

- The programme's subnational refusal committees will continue to engage with the regional and National EOCs, as appropriate, and continue developing strategies/actions to address issues of refusals and make recommendations to campaign teams before, during, and after every campaign.

Focused Revisit Strategy for SIAs in 2022

- Focus on recording and following the missed children in pre-campaign trainings (hands-on, role plays)
- Ensure recording of all the missed children during the first visit to the households (focus during intra-campaign supervision and monitoring)
- Revisit/follow up for missed children on the same day (day 1 to day 3)
- Revisit/follow up for missed children recorded on the previous day, if operationally feasible (day 1 to day 3)
- At the end of day 3, proper compilation of missed children and planning for follow up on day 4
- Close supervision and monitoring of the vaccination teams on revisit day/s
- Track all children vaccinated at fixed sites/ health facilities on day 4, who were reported missed by vaccination teams or whose caregivers report no team visited the household

8.4 Integrated service delivery: special focus on the high-risk areas of the South Region

The South Region of Afghanistan, particularly the provinces of Helmand, Kandahar and Uruzgan, have remained poliovirus reservoirs for almost a decade. In 2019 and 2020, over 75% of all polio cases nationally were reported from these three provinces. These provinces have consistently reported low routine immunization coverage with a high number of zero-dose children and low coverage of penta-3 in Uruzgan (5%), Helmand (17%), and Kandahar (30%) [2018 Afghanistan Health Survey].

Despite improving polio epidemiology, the situation in 2021 remained concerning given the persistent inability to conduct high quality campaigns. The prevailing malnutrition situation in the South further exacerbates inherent vulnerabilities for intense transmission of poliovirus, compounded by ongoing population movement and dismal access to health services including essential vaccination. The South has consistently been exposed to decades of conflict, insecurity, poverty, and access limitations. Nearly one million children (70% children under five in Uruzgan and Helmand and about 20% of children in Kandahar) are unvaccinated due to the inability to implement high quality house-to-house polio campaigns for more than 3 years, leading to a substantial immunity gap.

The MoPH will ensure continuation and further strengthening of the current support of EPI to PEI in Kandahar, Helmand and Uruzgan. Integration of polio and routine EPI in these provinces is one of the priorities of MoPH to enhance the synergy between the two programmes so that coverage is boosted and immunity developed in high-risk and underserved communities.

WHO and UNICEF will oversee delivery of basic package of health service via the Sehatmandi project through June 2022. During the second half of 2022, UNICEF will oversee delivery of the BPHS under the Humanitarian Emergency Response project.

There are areas that remain out of reach for health facilities (white areas) and chronically missed polio vaccinations during the three year bans on campaigns. To mitigate the risk of polio virus transmission in these white areas of the South, the programme will use the integrated services approach to bring basic health services including polio vaccinations to these vulnerable communities.

Purpose of integrated service delivery

The programme seeks to implement integrated services for EPI strengthening in the South (polio high-risk jurisdiction with multi-layered deprivations) to complement the delivery of the BPHS in white areas, improve routine immunization services (PEI-EPI synergy), and gain community trust and confidence. The integrated services package comprises of basic health interventions including provision of health services through BPHS+ health facilities, vaccinations through mobile health clinics, WASH services, community-based education, and nutrition services. All

these aim at increasing and sustaining polio vaccinations and strengthening EPI especially in high priority areas at risk of polio virus introduction and transmission.

The overall objective of polio programme support for integrated services is to increase routine and polio immunization coverage among children aged less than two years and under five years, through continued assessment and strengthening of new vaccination service delivery points. This will help boost EPI coverage, sustain immunity for polio and ultimately contribute to improving the health status of target mothers and children.

Specific objectives:

- Strengthening EPI services to increase opportunities for delivery of polio vaccines particularly among youngest and most vulnerable children in white areas
- Strengthening and promoting community activities to increase participation, trust, and community demand for EPI services
- Promoting investment in other critical health, nutrition, and humanitarian programmes including WASH in high-priority areas to address inherent vulnerabilities and respond to community needs.

Key interventions for integration to mitigate polio risks and increase access to basic health services

To enhance polio eradication efforts, the programme needs to leverage convergence of services and the advantages of other delivery platforms such as WASH, nutrition services and education. These social service platforms have direct and indirect implications to the eradication efforts in Afghanistan. The purpose of integration is to ultimately increase EPI coverage including for polio vaccinations and reduce the number of EPI zero-dose children particularly in the South.

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

- Strengthening EPI, including monitoring of EPI fixed/outreach sessions, supporting EPI microplan updates, and conducting training sessions.
- Provision of complementary interventions as part of EPI fixed/outreach services (including SAM monitoring and referral, basic nutritional supplements, soaps). This will be the primary use of GPEI FRR funds allocated to integrated services in Afghanistan.
- Advocacy with health and humanitarian partners to increase investments (e.g., WASH and education) in the South.

The following activities will be included during integrated service delivery in the South:

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

- Establish 16 new health facilities (12 in Kandahar and four in Uruzgan).
- Establish 50 new mobile health and nutrition teams in polio high risk areas to increase access. to EPI services and improve immunity gap including for polio.

- Improve utilization of health/ immunization services through provision of pluses such as soaps, hygiene kits and baby blankets at health facilities in order to increase and sustain uptake of vaccinations.
- Improved routine immunization coverage through deployment of additional human and material resources (technical staff and outreach vaccinators, solar fridges) in polio high-risk areas.
- Strengthened capacity of existing HFs, through training, technical and financial support inclusive of training of new vaccinators for underserved and white areas.
- Strengthen community engagement and mobilization to engender participation, built trust, and confidence in vaccination and other health services.
- Expand the programme to South East Region considering the past polio outbreaks and large immunity gaps.

Nutrition: The following nutrition services will be integrated in consultation with service providers and communities.

- Integrate nutrition services into mobile health teams as well as CHCs, BHCs, MHTs.
- Provide deworming tablets to children 24-59 months.
- Provide therapeutic food (RUTF) for treatment of children 6-59 months with SAM and Ready to Use Supplementary Feeding to Moderate Acute Malnutrition.
- Distribute Vitamin A and Albendazole to children during national polio campaigns, as per the age policy in the national SIAs guidelines.
- Integrate polio vaccine messages and information into infant and young child education sessions for caregivers.

WASH: the polio programme will leverage the advantages that WASH services bring to communities. Clean and safe water being an essential and sought-after commodity in communities, the programme will work with WASH team to improve access to clean and safe water and good sanitation in polio high risk areas. The following WASH interventions are proposed in 2022:

- Establish 10 WASH facilities in health facilities
- Establish 20 WASH facilities in schools
- Establish 10 WASH facilities in polio high risk communities

Education: The programme will use prevailing education platforms to mobilize and create awareness of the importance of polio vaccinations in selected communities. This will include using education spaces as meeting locations and engaging teachers, especially women teachers, to educate caregivers on the importance of polio vaccinations. The following activities will be implemented in consultation with education stakeholders:

- Support functionality of 480 community-based education facilities
- Community discussions and awareness sessions in communities with community-based education facilities
- Train CBE teachers on engaging communities for vaccination services and tracking children who miss vaccinations
- Use teachers as interlocutors and influential persona to address issues of refusals in communities.

Provision of polio promotional items: The programme will use promotional items to increase uptake and reduce dropout of children for polio and routine vaccinations. These promotional items will be distributed through health facilities, mobile health teams, and where applicable during campaigns.

The following promotional items will be bundled with vaccinations:

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

Coordination and management of PEI activities in polio high-risk areas: In the South, UNICEF offices including outposts in Helmand and Uruzgan, are strategic facilities to facilitate coordination of integrated services with stakeholders. The EPI programme will lead the effort to strengthen EPI in the South and the polio programme will support and work closely with the EPI programme to contribute to this.

Expected Results i) achieve at least 50% coverage of all antigens among children aged less than one year and sustain immunization of all antigens at district level by the end of 2022; ii) achieve at least 90% OPV3 coverage among children aged less than 5 years in 2022; and iii) Measles cases reduced to less than the expected rate in selected districts (or 1 case per 1 million populations) by end 2022.

8.5 Advocacy, Communication, Community Engagement and Social Mobilization

The programme will leverage strategic communication interventions for awareness and commitment from all stakeholders at national and subnational level including from communities for a polio-free Afghanistan. This will involve creating awareness, improving community's knowledge on vaccine importance, and changing people's perceptions towards polio vaccine with the aim to ensure polio vaccination is widely accepted amongst different communities in Afghanistan. Successful implementation of these intervention will require in-depth understanding of the community issues and the environment in which the polio programme operates.

Despite multiple challenges faced by the programme in 2021, polio communication interventions successfully promoted and maintained general vaccine acceptance across the country albeit twin outbreak of WPV and cVDPV2, ongoing COVID-19 pandemic and the country's political transition which led to temporary suspension of polio activities.

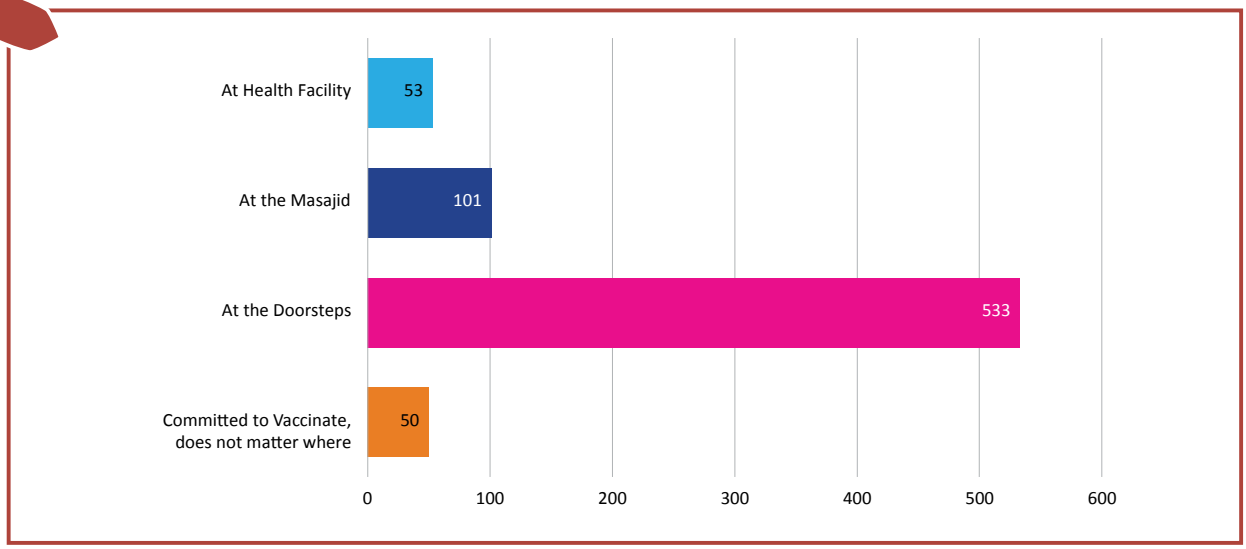
The programme seeks to achieve the following communication and social mobilization objectives:

- Increase engagement by focusing on community consultation and strengthen community participation to improve vaccine acceptance especially in cross-border communities
- Improve evidence generation activities by collecting real-time data on vaccination perception, refusal, and rumor tracking
- Build the capacity of community groups for engagement and social mobilization during the campaign

8.5.1 Main Pillars of work for Community Engagement and Social Mobilization

The programme will adapt community engagement and social mobilization work around four key pillars to empower communities and increase participation; engage religious leaders and influential persons; increase awareness around polio vaccinations, enhance attention to risk communication and community engagement, social norms and social cohesion, social mobilization for SIAs, behaviour monitoring as well as enhance accountability to affected communities. While these interventions will be implemented across the country, more emphasis will be placed on polio high-risk districts and areas previously inaccessible to the programme.

Figure 12: For future vaccination campaigns, where would you like your children to be vaccinated?



Pillar 1: Risk Communication and Community Engagement

The programme will engage stakeholders, partners, and communities in a transparent and two-way manner to increase awareness about the inherent risks of poliovirus outbreaks especially in the context of multiple humanitarian crises in Afghanistan. This engagement to communicate risks of poliovirus outbreaks will entail:

- Embed outbreak preparedness and response in communication strategies and plans
- Raise community awareness about poliovirus outbreaks to trigger early alerts in case of suspected outbreaks

- Establish community level rumour and refusal tracking systems
- Improve interpersonal skills of polio health workers at the forefront (ie, ICN, female vaccinators) to effectively communicate the risks of poliovirus transmission.

Pillar 2: Social Norms and Social Cohesion

Social norms and traditional beliefs characterize the rich culture in Afghanistan and inform the individual's decision-making process around uptake of polio vaccination especially for women in households. The following actions will be taken to address practices that impede polio vaccinations:

- Analyse religious perspectives to understand prevailing practices for and against vaccinations; map available resources, human and material; and strengthen leadership networks to identify influential persona for the programme.
- Conduct an appreciative inquiry approach with stakeholders (religious and community leaders) to collaboratively define roadmap for sustained uptake of vaccinations, reduction of missed children including refusals, and a polio-free Afghanistan.
- Conduct norms analysis to understand gender dynamics in communities and households, positive practices, and entry points for community awareness and engagement for polio vaccinations.

Pillar 3: Social Mobilization for Supplementary Immunization Activities

The programme will bring together stakeholders and communities to raise awareness on risks of poliovirus outbreaks, potential misinformation, and polio vaccination activities including campaigns, complementary vaccination activities, and routine vaccination outreaches. Various channels including mass media, social media, print and interpersonal communication such as house or mosque visits will be used.

Social mobilization interventions will be aligned with SIA modality.

For house-to-house modality, activities will be focused on strengthening knowledge of the caregivers at among households in order to increase vaccine acceptance. Pre-campaign community engagement activities will focus on the clusters with a high number of missed children and aim to identify the key reasons for children missing vaccinations and for caregivers refusing vaccinations.

For mosque-to-mosque campaigns, religious leaders will be rallied to facilitate mobilization by announcing campaigns at the mosque and communities. Campaign-based social mobilizers will conduct street announcements to bring more caregivers to the vaccination sites. Pre-campaign media announcements will also be used to raise awareness on the importance of polio vaccinations. Proposed activities will include:

- Community Polio Days
- Orientation Sessions for FLWs about the safety of the vaccine
- Friday calls and announcements in mosques
- Community and educators' meetings at madrassas
- Megaphone street announcements
- FVM and ICN education and consultation sessions

Pillar 4: Behaviour Monitoring and Accountability to Affected Populations

Under this pillar, the programme will seek to enlist beneficiary participation in the planning implementation and monitoring of polio communication and community engagement activities. Specific approaches will include:

- Establishing information sharing and communication channels (daily radio shows, grandmother meetings and madrassa discussions) so that communities understand the importance of polio vaccinations and make informed decisions regarding vaccinations.
- Using hotlines and other tools (Viamo surveys and U-reports) to capture community voices and provide feedback about polio vaccination services.
- Engaging duty bearers at all levels creating awareness about their roles and responsibility to communities about polio vaccinations.
- Regular monitoring of community behaviour through listening and analysis of community conversations.

8.5.2 Thematic Areas

The programme will leverage the following thematic areas to expand the depth and reach of polio social mobilization and community engagement activities, improving community participation in eradication initiatives.

Coordination and expand partnerships including with communities

To increase engagement with community groups (especially religious leaders and civil societies), coordination mechanisms and partnerships both formal and informal at central and provincial levels will be strengthened by implementing the following:

- Regular engagement with partners including communities through meetings, discussions, consultations on activities that address vaccine refusal and facilitate uptake of vaccinations
- Quarterly review meetings with stakeholders at subnational level to improve communication and engagement strategies
- Participate in cross-border activities to address challenges and leverage opportunities with the Pakistan programme
- Create information hub to share best practices at all levels
- Integrate polio messages in all community engagement and social mobilization interventions
- Activate partnerships with universities to create awareness about polio and campaigns in 2022 and conduct independent surveys/in-depth studies to understand the reasons for missing vaccinations
- Engage private entities in community awareness and participation in polio eradication activities
- Update training tools and information to be shared with partner universities (when open) and NGOs.

Gender

Women and girls are critical caregivers targeted by the polio engagement activities. Although the programme has involved women and girls at all levels, the security situation and social barriers have limited their role. The programme will focus on the following activities to mainstream gender approaches into programming and decision making.

- Strengthen gender training on gender related barriers and gender activities among all the partners
- Design messages and activities to promote the role of women and men in eradicating polio in Afghanistan
- Conduct follow-up research focusing on social norms analysis.

Innovation

In consultation with community groups and polio health workers at the forefront (i.e., female vaccinators and ICN), and based upon an understanding of the local norms, community initiatives will be supported to create innovative interventions. The initiatives aim to address the lack of motivation and polio message fatigue. These initiatives are designed to make the polio outbreak visible and a national concern.

The proposed ideas are as follows:

- A paralyzed character sharing the journey with polio by focusing on daily life experiences
- Define a national/local model to promote polio messages among households and communities
- Promote UNICEF's Aisha character as an example for fighting poliovirus in Afghanistan.

8.5.3 Communication and Advocacy Strategies

The programme's communication team will work to incorporate voices of all stakeholders for a comprehensive and fit-for-purpose strategies. The strategies will include:

- Developing context-specific national and subnational communication plans with participations of all stakeholders
- Plan of action for the introduction of nOPV2, which will require tailored communication preparedness measures including:
    - Communication preparedness and response strategy for the introduction of vaccine, contextualizing of the existing global nOPV2 Q&A for easy interpretation by local media
    - Develop crisis communication response protocol for the regions based on the mapped potential crisis including nOPV2 scenarios
    - Develop multimedia products with integrated messages including health, polio, and hygiene key messages to ensure relevant vaccine concerns are addressed
    - Produce communication and information materials to increase outreach and promote polio messages.

8.5.3.1 Mass Media Engagement

Polio awareness remains critical to successful implementation of campaigns across the country. The following will be implemented:

- Mapping and developing media partnerships including in areas previously not accessible to maintain consistent awareness and community trust.
- Review media engagement plan for effectiveness and deploy monitoring mechanisms to ensure timely broadcast placement of polio communication products on all media buy channels.
- Media roundtable discussions in the districts and rural setup will be intensified to engage and increase community participation in the discussions regarding their children's health and polio immunization.
- Key influencers, including religious leaders, community leaders and medical experts will be engaged in these discussions to address a variety of issues around polio and routine immunization.
- Ensure campaign monitoring systems and media impact assessments are implemented for better analysis and planning to achieve the required results.
- Production of high-quality multimedia materials to address programme challenges including missed children, refusals, rumors/misinformation and other priorities to influence behavior change towards vaccine uptake.

8.5.3.2 Digital Media engagement and other Innovations

Recent U-Report survey data (December 2021) showed that 31% of Afghan communities learned about the campaign through social media. This is a clear indication that social media engagement

is playing a critical role in creating awareness as well as disseminating key polio messages. Key digital media engagement actions will include:

- Develop social media strategy and strengthen digital approaches to increase engagement across all platforms to amplify vaccine acceptance.
- Use a dedicated software for social listening and to analyze social media trends, identify traffic, track rumors and design appropriate messages to counter them.
- WhatsApp groups will be utilized within the social mobilization network to disseminate messages as well as track rumors/misinformation.
- Polio website remains the key reference point for all polio programme information. It is designed to act as a resource centre with polio information/updates, eradication strategies and success stories, achievements, and challenges. Localizing the website in 2022 will be a top priority to ensure the information can easily be accessible in the local languages (Pashto and Dari).

8.5.3.3 Crisis Communication

Crisis communication training was conducted at national and regional level in 2021. In 2022, support will be provided to all EOCs to ensure a well laid out crisis communication response protocol is developed and could be utilized to mitigate all polio related crisis communication issues. In addition, mapping for potential crisis scenarios will be done as part of the preparedness for the introduction of nOPV2 vaccine.

8.5.3.4 Partnerships and Advocacy Interventions

- New partnerships with organizations such as sports associations and other influential organizations will be established to play a critical role in vaccine acceptance.
- Advocacy with key decision-makers will be scaled up to influence policy and leadership at national and provincial level and involve high level religious scholars and Islamic institutions.
- Continue to build capacity of journalists to better understand polio and vaccines through media orientation/training sessions and enhance their reporting skills on polio and health related issues.
- Initiate media awards to motivate journalists to produce polio stories addressing vaccine uptake issues and maintain polio at the top of the news agenda.

8.5.3.5 Cross-border communication interventions

Moving to 2022, cross-border communication initiatives with Pakistan need strengthening to address high risk mobile population movement between the two countries. This will include.

- Development of synchronized communication materials for the border crossing points
- Engaging media with extensive reach along the borders to create polio awareness
- Engaging known influencers on both sides of the border to influence vaccine acceptance
- Initiate social listening approaches along the border to understand the rumors/ misinformation circulating and prepare for appropriate response.

8.5.4 Islamic Advisory Group (IAG) initiatives

In 2022, NIAG as part of the Communication Working Group of the National EOC will continue to work with religious influencers through capacity building and knowledge sharing regarding polio vaccination, routine immunization, and child health in Islam. The following interventions will be pursued:

- Advocacy meetings with religious leaders, scholars, and mosque imams in order to advocate for polio eradication, routine immunizations, and child health, raise community awareness, create demand for vaccination, and tackle refusals based on religious misconceptions
- Advocacy meetings with community influencers to support SIAs and facilitate access for campaigns to reach all target children, through house-to-house vaccination strategy
- Visits to madrassas to highlight importance of vaccination and immunizations in Islamic Shariah and ensure support for polio vaccination campaigns
- Training of NIAG provincial focal points and religious scholars on vaccination, routine immunization, and child health from Islamic perspective
- Religious scholars training on interpersonal communication skills to advocate for polio eradication and routine immunization, raise community awareness, create demand for vaccination and tackle refusals based on religious misconceptions
- Support trainings for polio field staff, polio health workers at the forefront and health facilities personnel and participate in the monitoring of SIAs
- Train final-year students of medicine and Shariah in select universities as well as senior madrassa students on the importance of polio vaccination, routine immunizations and child health from the religious and health perspectives using the curriculum developed by the IAG in collaboration with Al-Azhar University, the WHO and UNICEF. The curriculum will be available in Dari and Pashto in early 2022
- Training of FLWs on the Fatwa book content for informed discussions during household visits and community meetings
- Coordination with Ministry of Religious Affairs and Ministry of Education and Higher Education
- Engagement of at least one faith-based NGO to support NIAG activities in polio eradication and mother and child health
- Dissemination of messages on importance of vaccinations and mother and child health from Islamic perspective through IEC materials and social media.

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

Despite low level of WPV-1 transmission in 2021, there is continued transmission between Afghanistan and Pakistan, evidenced by the epidemiology and genetic analysis of the isolated viruses. This highlights the continued significance of mobile populations travelling across the border and within the countries in sustaining and spreading poliovirus transmission.

Under the NEAP 2022, the mapping and vaccination activities for these mobile populations will the further strengthened, and relevant staff at national and provincial EOCs will follow the implementation of agreed strategies related to HRMPs, with enhanced focus on newborns and infants.

In addition:

- The programme will continue to collaborate with other UN agencies, organizations, and line departments for detailed information about IDPs and will immediately plan vaccination activities in response to any significant development in dynamics of IDPs. The programme will also focus on effectively reaching the IDPs during the nation-wide and sub-national vaccination campaigns and ensure that they are included in the micro-plans and focused during the intra-campaign supervision and monitoring.
- SNIDs will continue to include HRMP settlements in non-endemic/high-risk areas.
- Continuous mapping and cross border information sharing about movements of nomads will be carried out with vaccination strategies (nomad specific campaign in the South East Region and special transit teams along nomad movement routes in South, South East and West).
- Cross border:
    - The programme will continue to vaccinate travelers of all age groups crossing the border with Pakistan at Torkham. The programme will consider strengthening all age vaccination on the southern border crossing point at Friendship Gate
    - Regular assessment of informal crossing points will continue (at least at quarterly frequency), and cross border vaccination teams rationalized accordingly
    - The programme will continue vaccination at all cross-border points and international airports
    - Regular coordination with Pakistan polio eradication team for mutual information sharing on any major population movement and ensure preparation for vaccination on such instances
    - Vaccination of travelers as per IHR will continue for all age groups.
- Returnees:
    - Through regular coordination with UNHCR, IOM and DoRR, the programme will monitor the flow of returnees to Afghanistan and adjust vaccination teams in the repatriation centres as required
    - All major congregations will be identified and special vaccination opportunities provided
    - The programme will exercise all possible flexibilities while endeavoring to reach cross border resettling families during and outside the campaigns, with the core aim of “consistently reaching and vaccinating the children” in such families.

8.7 Maintaining sensitive surveillance

In continuation of previous years' efforts, Afghanistan maintained a sensitive and quality AFP surveillance system across the country in 2021, irrespective of access for SIAs. Most importantly, surveillance activities including AFP case reporting and stool sample processing continued despite the challenges during the political unrest around mid-2021. While there was a slight decline in AFP case reporting during that time, the system restored its full capacity within a short period of time.

Throughout the year, evaluation of the functionality of the surveillance facilities and prioritization of those has been continued. Hence, the number of zero reporting sites in the country increased from 2,951 in 2020 to 3,040 in 2021, active surveillance sites from 1,694 to 1,827, and reporting volunteers from 41,676 in 2020 to 45,066 in 2021. Active surveillance sites are visited by surveillance officers weekly, fortnightly and monthly based on priority. Completeness of active surveillance sites visits by surveillance officers (PPOs) was 95% across the country. Similarly, surveillance sites in all provinces achieved completeness benchmark of submitting Zero reports. Currently, all districts are accessible for surveillance activities. All these efforts resulted in upholding the indicators of non-polio AFP rate and percent AFP cases with adequate stool specimens above the target benchmarks in all the provinces in 2021.

The programme took the initiative of exploring the feasibility of adding more environmental surveillance sites to cover more areas based on polio epidemiology. Currently, Afghanistan is collecting environmental surveillance samples from 26 sites in all the seven regions of the country, in 15 major population centres of 13 provinces. In line with global guidelines as recommended by the TAG, the programme adopted a more rationalized approach for collecting stool samples from healthy children and collecting three contact samples instead of five for every AFP case with inadequate stool samples.

Besides facility-based surveillance, the programme has an extensive community based functional surveillance. People from wide spectrum of categories including faith healers, traditional healers, religious leaders, shrine keepers, vaccinators, community health workers, and midwives, are identified and included in this network of reporting volunteers. A certain number of reporting volunteers are enlisted with one AFP Focal Point who provides orientation regarding identification and reporting of AFP cases and, importantly, maintains regular communication. In addition, reporting volunteers are periodically visited and or communicated with over the telephone by surveillance officers.

An external surveillance review was initiated by GPEI in 2021. An extensive desk data review was completed and field interviews will be done during the first quarter or early second quarter of 2022. The programme is developing an action plan to implement the recommendations of the surveillance review (to be finalized by end of Quarter 1, 2022). Implementation status of the recommendations will be regularly tracked, at least once quarterly. An internal surveillance review is planned during the second half of the year. Last year's internal review was postponed firstly due to security unrest and, secondly, prioritizing the supplementary vaccination rounds following gaining nationwide access for vaccination in the second half of the year. It is important to note that internal surveillance reviews are completed on annual basis targeting high-risk regions and provinces. The programme continued to send AFP case specimens to RRL-Islamabad without interruption during 2021, including the period leading up to and during the political transition in August.

Considering Afghanistan and Pakistan as one epidemiological block for polio eradication, the Afghanistan programme maintains close coordinationwith the Pakistan programme at both national and provincial levels on operational and technical aspects, including information sharing on surveillance, cross notification of AFP cases, communication, population movement, and SIAs as well as coordinated response to poliovirus detection. To facilitate cross border activities joint corridor action plans are developed and are being implemented for all three corridors. A total of twelve AFP cases were cross notified between the two countries in 2021.

AFP surveillance activities are actively guided by National Rapid Response Team, composed of senior technical persons from different polio partners including MoPH. Similarly, Regional Rapid Response Team are active at regional level. Only one visit was completed by NRRT towards North East Region in 2021. In addition, a functional ERC is working relentlessly to classify, in a timely manner, inadequate AFP cases with residual paralysis even after 60 days of onset. In 2021, ERC convened ten meetings and classified 147 AFP cases.

The programme will further strengthen its surveillance guided by the GPEI Strategy 2022-2026 in order to meet the objective "improve detection and response through sensitive surveillance". Though Afghanistan has achieved all the surveillance indicators' standards, there is evidence of some gaps in sensitivity in terms of early detection of AFP cases at the subnational level, especially the hard-to-reach areas. In 2022 and onwards,

the programme prioritizes the addressing of any subnational surveillance gaps in underperforming districts by improving active surveillance and enhancing community surveillance especially the areas previously inaccessible for SIAs and the districts with high WPV-1 reported cases. The programme plans to take key steps in 2022 to sustain and further improve surveillance sensitivity and quality:

- Desk review of in-depth data analysis will be carried out at regular intervals to track surveillance activities, particularly to understand the opportunities and challenges of areas that were previously inaccessible for SIAs, to identify the causes of underperforming districts and understand linkages of origins of reported VDPV and or isolated polio viruses (if any). The programme will continue to work on further understanding the origin of isolated long-chain polioviruses and the areas in which they may be circulating.

- Focus will be given to active surveillance and zero reporting, and reviewing the current frequency of active visits and reprioritizing health facilities accordingly to change from monthly visits to fortnightly or weekly visits if needed by Quarter 2. In addition, field surveillance officers will also explore probable inclusion of new facilities either for active surveillance visits and or zero reports. All of these efforts will be based on reported and/or missed cases in past years, previously inaccessible districts both for SIA and surveillance, WPV reported districts, and functionality of available health services. The completeness and timeliness will be monitored regularly at subnational level and quarterly at national level. There will be health facility visits by regional and national level supervisors to monitor the active surveillance and zero reporting functionality.

- The community surveillance reporting volunteers' workforce will be systematically reviewed by mid-2022 to assess its functional presence, contact/ networking with focal persons and contributions. Regular communication with surveillance officers (PPOs, DPOs) will be strengthened and monitored. The programme will continue conducting AFP cases contact analysis on biannual basis with the objective of including those reporting volunteers who have missed reported the cases.

- Engage with the Hub/EMRO to review and update the surveillance protocols or documents and align them with global standards and Strategy by Quarter 3. These documents will include case investigation forms, detailed case review forms, ERC processes, hot case assessments and contact sampling.

- The 26 environmental surveillance sites situated in 13 provinces will continue to cover all the seven regions of the country. Frequency of sample collection from different sites and expansion of the number of sites to other areas will be continuously evaluated based on the evolving epidemiology and risk. If needed, the programme will perform ad-hoc environmental surveillance in high-risk areas.

- To ensure the quality of environmental surveillance, the programme will regularly monitor indicators by site and conduct supervision of sample collection and handling.

- Cross border coordination with Pakistan on surveillance activities will be continued and further strengthened for timely measures of cross notified cases. A team of national and sub-national surveillance staff will participate in an exchange visit in both the countries with the objective of better understanding the system across the border and replicate the best practices.

- To improve knowledge and capacity building, all surveillance officers and supervisors (PPOs, ARPOs, and RPOs) and focal points will receive comprehensive refreshers training on AFP and VPD surveillance during second and third quarter of the year.
- Special focus will be paid to the feasibly of including women in the surveillance team
- In addition to the current practice of verification of a certain percentage of AFP cases by supervisors, supervision and monitoring at national and regional level will be reinforced and the findings reviewed at national level during the biannual surveillance review meeting.
- Review of the existing AFP surveillance ERC will be carried out with the help of national and international surveillance experts to inform further strengthening measures in second half of the year.
- Revitalizing involvement of NRRT in the timely investigation of any polio cases, positive isolates from environmental surveillance, and other needed activities according to SOPs.
- Existing protocol to send AFP stool specimens and environmental samples to RRL-Islamabad daily will continue.
- Three contact samples strategy for AFP cases with inadequate stool samples will be continued.

Section 9:

Enhancing EPI/PEI convergence in high-risk districts

The programme will continue to make collaborative efforts to mutually benefit PEI and EPI in polio high-risk areas. The approaches initiated in 2020 and 2021 will be continued to further enhance and promote the EPI – PEI convergence, mainly focusing the polio reservoirs, high risk and difficult to reach areas and populations.

In 2022, the National EPI plans to continue enhancing routine and polio immunization coverage among children under 1 and under 5 years respectively through focused strategies and interventions.

The National EPI and Polio EOC will jointly plan and implement the following:

- Multiantigen campaigns with focus on polio endemic and high-risk provinces and provinces where the vaccination coverage is low (based on the 2021 reported coverage)
- Periodic Intensification of Routine Immunization targeting areas and populations at high risk and reported low vaccination coverage
- Continued PEI-EPI collaboration and field convergence to support the monitoring of routine immunization in the health facilities and outreach
- Monthly reporting, referral, and follow-up of zero-dose children between PEI and EPI across the country
- Use polio resources including the surveillance network for other vaccine preventable disease surveillance
- Develop aligned communication strategy that covers PEI and EPI services and for the introduction of new vaccines in order to enhance demand for both PEI and EPI.

The key objective include:

- Providing all vaccines to all unreached children aged less than 24 months and TD to all women of child-bearing age
- Providing MCV to children aged 9-59 months and OPV to children aged 0-59 months
- Expand vaccination beyond the traditional target groups, based on risk and considering operational feasibility
- Increase community demand for immunization
- Ensure that unreached populations are reached in every selected district in 2022
- Ensure vaccine, immunization, and injection safety
- Improve and strengthen vaccine-management systems

- Provide integrated service delivery with information, education, communication and social mobilization
- Evaluate PIRI/campaign and strengthen national immunization programs.

National EPI Communication related intervention to strengthen PEI

One of the important strategies for polio eradication is the strengthening of the routine EPI programme and ensure polio different serotypes are included in the routine EPI schedule from zero OPV till OPV4 and two doses of IPV.

National EPI's Communication section successfully implemented religious leaders training project for almost 24,000 religious Figures (mullahs) across the country alongside visuals/IEC materials including posters, leaflets, folders with influential messages, billboards and banners to increase uptake. Spots in national and local radios/TVs were aired on both routine and polio vaccination activities, incorporating the addressing of polio eradication queries. One of the best examples is "bring children less than two years old to the nearest health facilities for routine EPI vaccine and vaccinate all children less than five years old in each round of Polio Campaign".

The main intervention planned in 2022 is conducting IPCI training for 3,000 people in 34 provinces, including health professionals, EPI managers, supervisors, regional trainers, vaccinators, community health supervisors and community health workers. Good routine EPI coverage along with reducing high dropout rates, missed opportunities and eventually strengthening routine EPI coverage is expected as a result which is fundamental for polio eradication and in turn leads to control EPI targeted diseases and outbreaks.

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

The National EPI will continue supplying OPV for children aged less than five years to all health facilities in all 34 provinces throughout 2022. This is expected to help boost the population immunity against polio.

The current support mechanisms of PEI support to EPI will be maintained by WHO and UNICEF PEI field staff. WHO and UNICEF PEI field staff will spend 20% of their time in supporting EPI. There will be further focus on strengthening:

- Supportive supervision and monitoring of EPI with focus on outreach and mobile sessions
- Support on improving EPI micro-plans
- Collated findings with basic analysis of PEI staff monitoring, including "Zero Dose AFP cases data" will be regularly shared with the National EPI as well as with NGOs, GCMU and PMU departments for planning and intervention *(see annex for monitoring SOPs)*.
- BPHS NGOs and PEMTs are expected to share information on actions taken for issues identified by the polio programme
- Systematic engagement of ICN in creating demand for vaccination
- Coordination between BPHS NGOs, polio eradication partners and PEMT/REMT will be enhanced using the EOCs.

Section 10:

Effective vaccine management and cold chain operations for PEI

In 2021, the programme ensured 100% availability of all polio vaccine antigens for polio eradication activities in the country. Vaccine types used during the year for SIAs were tOPV (for four campaigns in January, March, November, and December) and bOPV (for one campaign in June). Vaccine wastage rate was on average 13% during the year for all types of vaccines.

In 2022, the programme will prioritize the following interventions:

- On quarterly basis review and update the target population for vaccine forecasting in accordance with recommendations and schedules of SIAs. This will be implemented in staggered manner to avoid overstocking.
- Ensure timely supply of vaccine to support NEAP 2022 SIA schedule and all other activities including integrated services.
- Facilitate timely delivery of offshore vaccines and in-country distribution to the field as per vaccine management SOPs (in coordination with supply division, national and provincial EPI teams).
- Ensure basic programme trainings at all levels (PEI/EPI) includes vaccine/ cold chain management and regular monitoring of stocks as part of training agenda.
- Strengthen vaccine management at field cold stores and at service delivery points, facilitate stronger vaccine management in districts through regular trainings for vaccinators and cold chain technicians, and regular and timely reports on vaccine utilization and leftovers.
- Ensure accountability for non-routine vaccines (mOPV2, nOPV2, and tOPV) in a timely manner. This will include implementation of standard operation procedures related to the accountability framework, appropriate use of vaccine management forms and electronics tools, continuous monitoring of wastage rates, and maintaining functional vaccine vial disposal committees.
- Facilitate introduction of nOPV2 by providing necessary logistics management tools, procedures, terms of reference, guidelines and appropriate training on vaccine handling, management, and accountability.
- Ensure quarterly update of active and passive cold chain equipment and monthly vaccine stock inventories.

Section 11:

Ongoing Monitoring of the Evolving COVID-19 Pandemic and Mitigation Measures

The COVID-19 pandemic remains a global reality after almost two years. The programme will continue to monitor the evolving COVID-19 situation in the country and make necessary adjustments, as appropriate. The programme will plan and take required mitigating measures to optimally implement the NEAP 2022 strategies. The National EOC will continue to consider providing necessary support to the pandemic response, as and when required, while ensuring that NEAP 2022 activities are not compromised.

Section 12:
Monitoring

The NEAP 2022 will regularly assess implementation of strategies and take immediate corrective measures, identifying bottlenecks, facilitating resolution of the same so that the programme leadership and the other oversight bodies are given an early indication of the progress or gaps in achievement of objectives. The National EOC will ensure systematic use of key performance indicators to inform strategic and operational interventions. Special focus will be maintained to improve pre-campaign management (including FLW recruitment and micro-plans validation) and corrective measures during the campaign through local problem-solving mechanisms with necessary support from higher levels.

The key areas and constituent activities that will be prioritized for the ongoing monitoring of NEAP 2022 are:

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

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

Detecting every poliovirus transmission chain in a timely manner and investigating appropriately

- Conduct internal and external AFP surveillance reviews
- Weekly data review at national and sub-national levels
- Maintain the high-quality standards of both AFP and environmental surveillance
- Expand environmental surveillance sites where possible
- Conduct annual refresher training for PPOs and DPOs as well as sensitization of reporting volunteers
- Smooth transition from the traditional Information for Action surveillance system to the new web-based integrated system

Improving data processes and systems

- Fast track the establishment of the Afghanistan Polio SIA Information Management System
- Credible and timely SIA data (sex disaggregated) is essential for assessing risks and guiding improvements in the programme. Existing deficiencies greatly impede the ability to adjust improve quality. Increase accountability at all levels to ensure that all shared SIA data is valid, timely and complete (e.g., timely sharing of administrative data)
- Simplifying data process (where necessary) by removing un-utilized data tools/variables
- Conduct rigorous and regular data audits (both internal and external) to ensure programme data is reliable and decisions based on programme data are objective.

Ensuring that communication and community engagement strategies yield impactful results

- Ensure shifts in communication strategies result in improved community mobilization and trust in the areas where house-to-house strategy is implemented
- Assess the impact of the revamped communication and community engagement strategies on the refusals in the South
- Document the effectiveness and utilization of mass media and social media in addressing emerging issues from messages circulating in mass/social media
- Ensure the programme is developing context specific and evidence-based communication approaches and IEC materials
- Develop and implement field reviews and conduct capacity building by the core national and regional EOC communication teams
- Ensuring effective management of vaccine logistics and cold chain
- Review and update vaccine forecasts for 2022 in accordance with the proposed SIA calendar

- Conduct trainings on vaccine management for all regional, provincial, and district workers on a regular basis
- Due to the continued use of Sabin type-2 containing vaccines – ensure the accountability and vaccine management SOPs are disseminated and implemented at the lowest level

Providing support to and improving the coordination with EPI program

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

12.1 SIAs monitoring

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

Pre-campaign phase

FLW selection

- All efforts to ensure that team composition is as per SIA minimum standards and both vaccination team members are local (living in the same team area) and trained, at least one team member is literate, and one team member is female.
- The programme will strengthen accountability of FLWs through regular performance-based review and will take necessary actions which will include removals based on objective documented criteria.
- The programme will endeavor to increase the proportion of women FLWs (supervisors, vaccinators, social mobilizer, ICM) and mid-level managers. The National EOC will also ensure an enabling environment for recruiting and sustaining women workers at all levels. This activity will be closely monitored, and the progress tracked.

FLW Training

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

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

Intra-campaign phase

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

Post campaign phase

- The outcome monitoring following SIA campaign includes PCM, LQAS and out-of-house finger mark survey conducted to assess the coverage and quality of the vaccination activity, to identify missed or poorly covered areas, reasons for missed children, and take immediate and future corrective actions (e.g. recovering missed area, vaccinating missed children, improving microplanning for the next round particularly missed areas, and replacing inappropriately selected teams/supervisors).
- Post campaign monitoring checklist has been modified following November 2021 NID to include monitoring in the context of alternative modalities like site-to-site and mosque-to-mosque.
- LQAS will be conducted in all areas of the country irrespective of the modality of campaigns as it is increasingly important to assess the quality of campaigns and effectively address the same.
- To improve the reliability of PCM and LQAS the programme will continue to validate the PCM and LQAS for data quality assurance and to identify poor performing clusters for corrective interventions.

- The programme will continue to conduct joint investigation of failed lots by a team comprising representatives from WHO, MoPH, UNICEF and other partner organizations at the provincial level. The investigation aims to identify the root causes of missed children, act by recovering the area and planning remedial action. The national team will investigate lots that fail more than 2 times in successive campaigns.

- Financial accountability will be exercised with zero tolerance for any misappropriation.

Third party monitoring

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

- to identify why children are missed to guide future action
- to spot problems with implementation and guide corrective measures
- in LQAS and PCM third party monitors are chiefly deployed including university students, teachers, NGO staff or private sector health workers (not directly involved in the implementation of the campaign). It should be ensured that the monitors speak the language of the community and have been properly trained
- In all areas of the country, post campaign monitoring will be conducted house-to-house irrespective of the modality of campaign as it precisely identifies missed children and direct teams to missed houses/areas, documents information on reasons for missed children/ refusals, and reduces bias by random selection of areas.

12.2. Improving data systems

Afghanistan Polio Information Management System, an online data collection, collation and analysis tool including polio dashboards is currently being field tested to improve the efficiency of data management and utilization in the country. Following the testing, APIMS will be rolled out across the entire country by the end of 2022.

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

The programme will conduct a capacity building exercise for regional and provincial data staff. On the other hand, the programme will continue to implement validation mechanisms to ensure data quality and completeness. The programme will have no tolerance for any negligence or falsification of data.

12.3. NEAP monitoring

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

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

A similar review mechanism will also be adopted at sub-national EOCs and at provincial headquarters. National EOC will continue to participate in reviews carried out in endemic or infected regions/provinces.

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

A mid-term review of the NEAP implementation status and effectiveness of strategies will be carried out in mid-2022 and necessary mid-course correction and adjustments will be made, as needed.

12.4 Monitoring and Evaluation of communication and ISD activities

The overall guiding principle for monitoring and evaluation of planned immunization and surveillance activities for polio eradication include:

- Increased quality of all polio eradication activities including campaigns, AFP Surveillance, communication, community engagement, and routine immunization
- Increased programmatic access and reach with a focus on continuously missed children in high-risk areas
- Provision of timely and quality information, including spatial analysis, for decision making
- Documentation of the polio eradication activities and lesson learnt

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

For communication and community engagement

- Analysis and feedback from local assessments and exit interviews
- Trend of reported and converted refusals by SIAs implemented during 2022
- Supportive supervision, including concurrent monitoring, using real time data collection on the Open Data Kit platform
- KAP surveys
- Solicit feedback (including in-person questionnaires at service points, group discussions, telephone surveys) from caregivers and polio health workers at the forefront on the reach and uptake of polio vaccinations
- Media monitoring

For vaccine management and cold chain operations

- Vaccination utilization including wastage rate

For integrated services

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

Section 13:
Annexures

Annexure I:	SIA Plan 2022
Annexure II:	List of High, Medium, and Low risk districts (Risk Categorization)
Annexure III:	Minimum standards for SIAs
Annexure IV:	SOPs for Polio Staff to Support Routine Immunization
Annexure V:	ISD Update June 2022

Annexure I:

SIA plan 2022

Start date	SIA scope	Target
Jan 17	NID	9,999,227
Feb 21	NID	9,999,227
Mar 21	NID	9,999,227
May 23	NID	9,999,227
June 28	NID	9,999,227
July 25	SNID	5,248,473
Sept 19	NID	9,999,227
Oct 17	NID	9,999,227

Annexure II:

List of High, Medium, and Low risk districts (Risk Categorization)

High Risk Districts	
PROVINCE	DISTRICT
FARAH	BAKWA
FARAH	BALABULUK
GHAZNI	ANDAR
HILMAND	GARMSER
HILMAND	LASHKARGAH
HILMAND	NAD-E-ALI
HILMAND	NAHR-E-SARAJ
HILMAND	NAWA-E-BARAKZAIY
HILMAND	NAWZAD
HILMAND	REG
HILMAND	SANGIN
HILMAND	WASHER
HIRAT	SHINDAND
KABUL	KABUL
KANDAHAR	ARGHANDAB (K)
KANDAHAR	DAMAN
KANDAHAR	GHORAK
KANDAHAR	KANDAHAR
KANDAHAR	MAYWAND
KANDAHAR	PANJWAYI
KANDAHAR	SHAHWALIKOT
KANDAHAR	SPINBOLDAK
KANDAHAR	ZHERAY
KUNAR	SHIGAL WA SHELTAN
NANGARHAR	ACHIN
NANGARHAR	BATIKOT
NANGARHAR	BEHSUD
NANGARHAR	JALALABAD
NANGARHAR	MUHMAND DARA
NIMROZ	KHASHROD
PAKTIKA	BERMEL
URUZGAN	CHORA
URUZGAN	DEHRAWUD
URUZGAN	KHASURUZGAN
URUZGAN	SHAHID-E-HASSAS
URUZGAN	TIRINKOT
ZABUL	ARGHANDAB (Z)
ZABUL	DAYCHOPAN
ZABUL	KAKAR
ZABUL	MIZAN
ZABUL	QALAT
ZABUL	SHOMULZAY
ZABUL	TARNAK WA JALDAK

Medium Risk Districts	
PROVINCE	DISTRICT
BADGHIS	BALAMURGHAB
BADGHIS	JAWAND
BADGHIS	MUQUR
BADGHIS	QADIS
BADGHIS	QALA-E-NAW
BALKH	CHARBULAK
BALKH	CHEMTAL
BALKH	DAWLATABAD
BALKH	KESHENDEH
BALKH	SHOLGAREH
BALKH	SHORTEPA
BALKH	ZARI
DAYKUNDI	GIZAB
FARAH	ANARDARA
FARAH	FARAH
FARAH	GULESTAN
FARAH	KHAK-E-SAFED
FARAH	LASH-E-JUWAYN
FARAH	PUSHTROD
FARAH	QALA-E-KAH
FARAH	SHIBKOH
FARYAB	ALMAR
FARYAB	BILCHERAGH
FARYAB	DAWLATABAD
FARYAB	GHORMACH
FARYAB	KHWAJASABZPOSH
FARYAB	PASHTUNKOT
FARYAB	QAYSAR
FARYAB	SHIRINTAGAB
GHAZNI	ABBAND
GHAZNI	AJRESTAN
GHAZNI	DEHYAK
GHAZNI	GELAN
GHAZNI	GIRO
GHAZNI	KHWAJAUMARI
GHAZNI	MUQUR
GHAZNI	NAWA
GHAZNI	QARABAGH
GHAZNI	RASHIDAN
GHAZNI	WAGHAZ
GHAZNI	WALIMUHAMMAD-E- SHAH
GHAZNI	ZANAKHAN
GHOR	CHARSADRA
GHOR	DOLAYNA
GHOR	PASABAND
HILMAND	BAGHRAN
HILMAND	DEH-E-SHU
HILMAND	KAJAKI
HILMAND	MUSAQALAH
HIRAT	ADRASKAN
HIRAT	KUSHK
HIRAT	PASHTUNZARGHUN
JAWZJAN	AQCHA
JAWZJAN	DARZAB
JAWZJAN	FAYZABAD
JAWZJAN	KHANAQA
JAWZJAN	MARDYAN
JAWZJAN	MINGAJIK
JAWZJAN	QUSHTEPA
JAWZJAN	SHIBERGHAN
KANDAHAR	ARGHESTAN
KANDAHAR	KHAKREZ
KANDAHAR	MARUF
KANDAHAR	MIYANSHIN
KANDAHAR	NESH
KANDAHAR	REG
KANDAHAR	SHORABAK
KAPISA	ALASAY
KHOST	MANDOZAYI
KHOST	NADIRSHAHKOT
KHOST	SABARI
KHOST	TEREZAYI
KUNAR	BARKUNAR
KUNAR	CHAPADARA

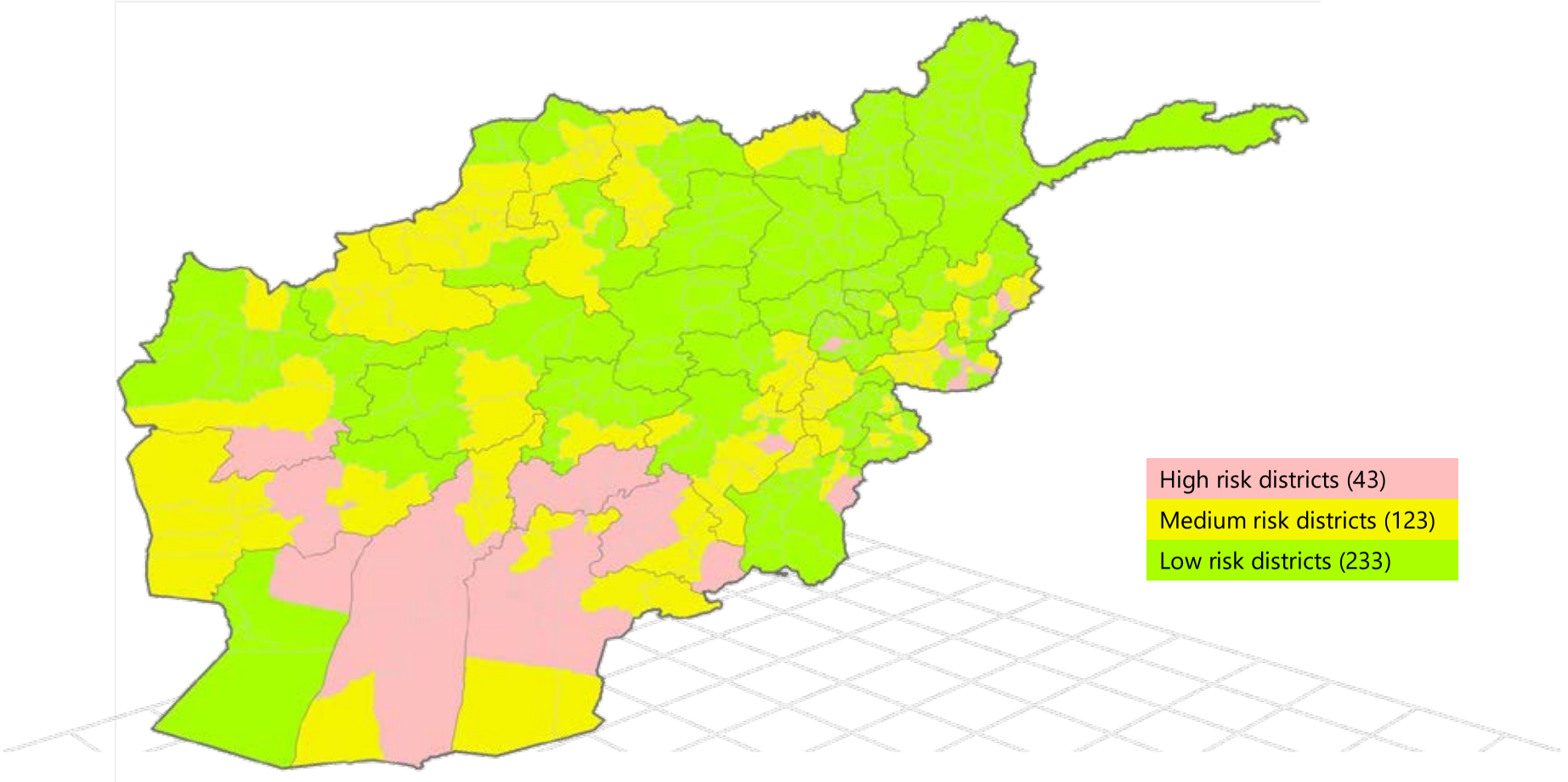
Low Risk Districts	
PROVINCE	DISTRICT
BADAKHSHAN	ARGHANJKHWA
BADAKHSHAN	ARGO
BADAKHSHAN	BAHARAK
BADAKHSHAN	DARAYEM
BADAKHSHAN	DARWAZ
BADAKHSHAN	DARWAZ-E-BALLA
BADAKHSHAN	ESHKMESH
BADAKHSHAN	FAYZABAD
BADAKHSHAN	JORM
BADAKHSHAN	KESHEM
BADAKHSHAN	KHASH
BADAKHSHAN	KHWAHAN
BADAKHSHAN	KOFAB
BADAKHSHAN	KOHESTAN
BADAKHSHAN	KORAN WA MONJAN
BADAKHSHAN	RAGHESTAN
BADAKHSHAN	SHAHR-E-BUZORG
BADAKHSHAN	SHAKI
BADAKHSHAN	SHIGHNAN
BADAKHSHAN	SHUHADA
BADAKHSHAN	TAGAB
BADAKHSHAN	TESHKAN
BADAKHSHAN	WAKHAN
BADAKHSHAN	WARDUJ
BADAKHSHAN	YAFTAL-E-SUFLA
BADAKHSHAN	YAMGAN
BADAKHSHAN	YAWAN
BADAKHSHAN	ZEBAK
BADGHIS	ABKAMARI
BAGHLAN	ANDARAB
BAGHLAN	BAGHLAN-E-JADID
BAGHLAN	BURKA
BAGHLAN	DAHANA-E-GHORI
BAGHLAN	DEHSALAH
BAGHLAN	DOSHI
BAGHLAN	FERENG WA GHARU
BAGHLAN	GUZARGAH-E- NUR
BAGHLAN	KHENJAN
BAGHLAN	KHOST WA FERENG
BAGHLAN	KHWAJAHEJRAN
BAGHLAN	NAHRIN
BAGHLAN	PUL-E- KHUMRI
BAGHLAN	PUL-E-HESAR
BAGHLAN	TALA WA BARFAK
BALKH	BALKH
BALKH	CHARKENT
BALKH	DEHDADI
BALKH	KALDAR
BALKH	KHULM
BALKH	MARMUL
BALKH	MAZAR-E-SHARIF
BALKH	NAHR-E- SHAHI
BALKH	SHARAK-E-HAYRATAN
BAMYAN	BAMYAN
BAMYAN	KAHMARD
BAMYAN	PANJAB
BAMYAN	SAYGHAN
BAMYAN	SHIBAR
BAMYAN	WARAS
BAMYAN	YAKAWLANG
DAYKUNDI	ASHTARLAY
DAYKUNDI	KAJRAN
DAYKUNDI	KHADIR
DAYKUNDI	KITI
DAYKUNDI	MIRAMOR
DAYKUNDI	NILI
DAYKUNDI	SANG-E-TAKHT
DAYKUNDI	SHAHRESTAN
FARAH	PURCHAMAN
FARYAB	ANDKHOY
FARYAB	GARZIWAN
FARYAB	KHAN-E-CHAR BAGH
FARYAB	KOHESTAN
FARYAB	MAYMANA

KUNAR	DANGAM
KUNAR	GHAZIABAD
KUNAR	NARANG
KUNAR	NARI
KUNAR	NURGAL
KUNAR	WATAPUR
KUNDUZ	DASHT-E-ARCHI
KUNDUZ	EMAMSAHEB
KUNDUZ	QALA-E-ZAL
LAGHMAN	ALINGAR
LAGHMAN	MEHTARLAM
LAGHMAN	QARGHAYI
LOGAR	BARAKIBARAK
LOGAR	CHARKH
LOGAR	KHARWAR
LOGAR	KHOSHI
LOGAR	MOHAMMADAGHA
LOGAR	PUL-E- ALAM
NANGARHAR	CHAPARHAR
NANGARHAR	HESARAK
NANGARHAR	KAMA
NANGARHAR	KHOGYANI
NANGARHAR	LALPUR
NANGARHAR	PACHIERAGAM
NANGARHAR	SHERZAD
NANGARHAR	SHINWAR
NANGARHAR	SURKHROD
NURISTAN	PORUNS
PAKTIKA	MATAKHAN
PAKTIKA	NAKA
PAKTIKA	SAROBI
PAKTIKA	SHARAN
PAKTIKA	URGUN
PAKTIKA	YOSUFKHEL
PAKTYA	CHAMKANI
PAKTYA	ZURMAT
SAR-E-PUL	KOHESTANAT
SAR-E-PUL	SAYAD
SAR-E-PUL	SOZMAQALA
WARDAK	CHAK
WARDAK	JAGHATU
WARDAK	JALREZ
WARDAK	MAYDANSHAHR
WARDAK	NERKH
WARDAK	SAYDABAD
ZABUL	ATGHAR
ZABUL	NAWBAHAR
ZABUL	SHAHJOY
ZABUL	SHINKAY

FARYAB	QARAMQOL
FARYAB	QORGHAN
GHAZNI	GHAZNI
GHAZNI	JAGHATU
GHAZNI	JAGHURI
GHAZNI	MALESTAN
GHAZNI	NAWUR
GHOR	CHAGHCHARAN
GHOR	DAWLATYAR
GHOR	LAL WA SARJANGAL
GHOR	SAGHAR
GHOR	SHAHRAK
GHOR	TAYWARAH
GHOR	TOLAK
HIRAT	CHISHT-E-SHARIF
HIRAT	FARSI
HIRAT	GHORYAN
HIRAT	GULRAN
HIRAT	GUZARA
HIRAT	HERAT
HIRAT	INJIL
HIRAT	KARUKH
HIRAT	KOHSAN
HIRAT	KUSHK-E-KOHNA
HIRAT	OBE
HIRAT	ZINDAJAN
JAWZJAN	KHAMYAB
JAWZJAN	KHWAJADUKOH
JAWZJAN	QARQIN
KABUL	BAGRAMI
KABUL	CHAHARASYAB
KABUL	DEHSABZ
KABUL	ESTALEF
KABUL	FARZA
KABUL	GULDARA
KABUL	KALAKAN
KABUL	KHAK-E- JABBAR
KABUL	MIRBACHAKOT
KABUL	MUSAYI
KABUL	PAGHMAN
KABUL	QARABAGH
KABUL	SHAKARDARA
KABUL	SUROBI
KAPISA	HISA-E- AWAL-E- KOHE
KAPISA	HISA-E- DUWUM-E- KOH
KAPISA	KOHBAND
KAPISA	MAHMUD-E- RAQI
KAPISA	NEJRAB
KAPISA	TAGAB
KHOST	BAK
KHOST	GURBUZ
KHOST	JAJIMAYDAN
KHOST	KHOST(MATUN)
KHOST	MUSAKHEL
KHOST	QALANDAR
KHOST	SHAMAL
KHOST	SPERA
KHOST	TANI
KUNAR	ASADABAD
KUNAR	CHAWKAY
KUNAR	DARA-E-PECH
KUNAR	KHASKUNAR
KUNAR	MARAWARA
KUNAR	SARKANI
KUNDUZ	ALIABAD
KUNDUZ	CHARDARAH
KUNDUZ	KHANABAD
KUNDUZ	KUNDUZ
LAGHMAN	ALISHANG
LAGHMAN	DAWLATSHAH
LOGAR	AZRA
NANGARHAR	DARA-E-NUR
NANGARHAR	DEHBALA
NANGARHAR	DURBABA
NANGARHAR	GOSHTA
NANGARHAR	KOT

NANGARHAR	KUZKUNAR
NANGARHAR	NAZYAN
NANGARHAR	RODAT
NIMROZ	CHAKHANSUR
NIMROZ	CHARBURJAK
NIMROZ	KANG
NIMROZ	ZARANJ
NURISTAN	BARG-E- MATAL
NURISTAN	DUAB
NURISTAN	KAMDESH
NURISTAN	MANDOL
NURISTAN	NURGERAM
NURISTAN	WAMA
NURISTAN	WAYGAL
PAKTIKA	DILA
PAKTIKA	GOMAL
PAKTIKA	GYAN
PAKTIKA	JANIKHEL
PAKTIKA	OMNA
PAKTIKA	SARRAWZAH(SARHAWZAH)
PAKTIKA	TURWO (TARWE)
PAKTIKA	WAZAKHAH
PAKTIKA	WORMAMAY
PAKTIKA	YAHYAKHEL
PAKTIKA	ZARGHUNSHAHR
PAKTIKA	ZIRUK
PAKTYA	AHMADABA
PAKTYA	ALIKHEL (JAJI)
PAKTYA	DAND WA PATAN
PAKTYA	GARDEZ
PAKTYA	JANIKHEL
PAKTYA	LIJA AHMAD KHEL
PAKTYA	SAYEDKARAM
PAKTYA	SHAWAK
PAKTYA	ZADRAN
PANJSHER	BAZARAK
PANJSHER	DARA
PANJSHER	KHENJ (HES-E- AWAL)
PANJSHER	ONABA(ANAWA)
PANJSHER	PARYAN
PANJSHER	RUKHA
PANJSHER	SHUTUL
PARWAN	BAGRAM
PARWAN	CHARIKAR
PARWAN	GHORBAND
PARWAN	JABALUSSARAJ
PARWAN	KOH-E- SAFI
PARWAN	SALANG
PARWAN	SAYDKHEL
PARWAN	SHEKHALI
PARWAN	SHINWARI
PARWAN	SURKH-E- PARSA
SAMANGAN	AYBAK
SAMANGAN	DARA-E- SUF-E- PAYIN
SAMANGAN	DARA-E SUF-E-BALA
SAMANGAN	FEROZNAKHCHIR
SAMANGAN	HAZRAT-E- SULTAN
SAMANGAN	KHURAM WA SARBAGH
SAMANGAN	RUY-E-DUAB
SAR-E-PUL	BALKHAB
SAR-E-PUL	GOSFANDI
SAR-E-PUL	SANCHARAK(SANGCHARK)
SAR-E-PUL	SAR-E-PUL
TAKHAR	BAHARAK
TAKHAR	BANGI
TAKHAR	CHAHAB
TAKHAR	CHAL
TAKHAR	DARQAD
TAKHAR	DASHT-E- QALA
TAKHAR	ESHKASHEM
TAKHAR	FARKHAR
TAKHAR	HAZARSUMUCH
TAKHAR	KALAFGAN
TAKHAR	KHWAJABAHAWUDDIN
TAKHAR	KHWAJAGHAR
TAKHAR	NAMAKAB
TAKHAR	ROSTAQ
TAKHAR	TALOQAN
TAKHAR	WARSAJ
TAKHAR	YANGI QALA
WARDAK	DAYMIRDAD
WARDAK	HESA-E- AWAL-E- BEHS
WARDAK	MARKAZ-E-BEHSUD

Risk categorization



Annexure III:

Minimum standards for SIAs

Component	Indicator
Vaccinator selection	Both vaccinators in each team are local and resident of the area as in the team microplan The vaccinator is literate - at least 7th standard or equivalent (enough to write and read) Increment in number of female vaccinators selected
Social Mobilizer selection	Social mobilizer is local (resident in area of work and accepted by community) Completed 7 years of basic education or completed high school and able to read and write in local language Age > 25 years Preference in selection of females as much as possible
Supervisor selection	At least 80% members of selection committee are in agreement with selection 100% supervisors are local from the same cluster 100% supervisors are literate - at least 12th standard (enough to understand/use all SIA forms and to compile reports) Increment in number of female supervisors selected
District coordinator selection	All members of selection committee are in agreement with selection 100% coordinators are local for the district 100% coordinators are literate - at least 12th standard (enough to understand/use all SIA forms and to compile reports)
Trainings	ToT organized for trainers before each campaign At least 95% training attendance in vaccinator trainings 100% attendance in supervisor and district coordinator trainings 100% sessions monitored in high-risk districts, 60% in medium-risk districts and 25% in low-risk districts Training material and logistics available in at least 95% monitored sessions Presence of provincial PEI staff from all stakeholders in every supervisor training Presence of regional PEI staff from all stakeholders in every district coordinator training

Component	Indicator
Implementation & Monitoring	ICM conducted in 100% clusters in High-risk districts > 95% missed children found by ICM recorded on the back of tally sheet in all clusters PCM conducted in 100% clusters in high-risk districts, 50% in medium and low-risk districts PCM coverage should be >95% in all monitored clusters Out of house survey should be >95% in all monitored clusters Proportion of passed LQAS @ 90% should be above 90%
Data validation and use	5% ICM, 5% PCM and 10% lots validated ICM, PCM, LQAS, out of house finger mark coverage, reported coverage data compiled, verified for accuracy and the complete data should be submitted timely (within 10 days of completion of campaign) All data streams - ICM, PCM, LQAS and reported coverage analysis used in post campaign review

Annexure IV:

SOPs for Polio Staff to Support Routine Immunization

Standard Operating Procedures for Polio Staff to Support Routine Immunization

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

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

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

1. Each Polio Provincial Officer (PPO) and District Polio Officers (DPO) should prepare monthly plan for monitoring the routine immunization sessions. One working day a week is an approximate equivalent of 20% of time; therefore, the monthly plan should include 4 visits to the immunization sessions (twice a month to the fixed centers and one each to the outreach/mobile activities combining these where possible with active AFP surveillance visits). Copy of plan should be shared with Provincial Health Coordination Committee (PHCC)/PEMT and BPHS partners.
2. During each monitoring visit of fixed, outreach or mobile session, PPO/DPO should conduct community coverage survey by visiting 10 households in the area selected at random and filling in the relevant checklist.
3. The observations and findings will be recorded in the supervisory checklists; feed-back should be provided to the vaccinators at the time of visit and completed check-lists should be shared with the WHO Offices, EOCs (where exist), PEMT, PHCC as well as relevant BPHS partner.
4. At each RI session (fixed, outreach or mobile), PPO should spend at least one hour to observe the vaccination practices, complete the checklist and possibly address the identified gaps in knowledge of vaccinators.
5. Subsequent visit to the same center should occur in the next 2 or 3 months depending on the number of RI facilities in the PPOs area of assignment; PPO/DPO should follow up on his/her findings in the subsequent visits to the facility.
6. EOC and WHO Country Office will be tracking completeness and timeliness of the report's submission at the dedicated dashboard and providing feed-back on these indicators.
7. Copies of the supervisory checklists should be sent to WHO Country Office for compilation and analysis, while another copy should be kept in office for records. The WHO country office will share the compiled reports with the Polio National EOC and the National EPI. Why integrated services (Context)

Annexure V:

ISD Update June 2022

Ministry of Public HealthNational Emergency Operation Center (NEOC) integrated services update, 2022

Why integrated services (Context)?

- Southern Region has been the historical reservoir for polio in Afghanistan
- ~1M children in the Southern Region and about 300 thousands children in southeast region had been inaccessible for polio campaigns (before transition)
- Low EPI coverage South (Penta3 coverage <40% in Kandahar, <20% in Helmand, <10% in Urozgan) and Southeast (Penta 3 coverage < 30% in Paktika)
- 40% of children live more than a one-hour walk from the nearest HF, severely limiting access (in all provinces of south and Paktika of southeast)
- Just 25% of households have *improved sanitary facilities, affecting basic hygiene
- Over 70, 000 children suffer from severe malnourishment in the Southern region

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

IMB report 2018

The IS are cross-sectoral approaches to improve health outcomes in Southern Region

- Improving service delivery through:
  - New district-level mapping and insights
  - New BPHS+ HFs and service delivery strategies
  - Additional human resources
- Improving demand and awareness through:
  - Provision of hygiene products, nutrition supplements, and baby blankets to mothers
- Improving community engagement through:
  - New community schools
  - Enhanced water and sanitation at HFs, schools and community centers

Progress to date (south region)

Program Area	What was in the plan	What was accomplished
Service Delivery	Establishment of 115 BPHS Plus health facilities(HF)	100 HFs established
	Deploy 72 mobile health and nutrition teams	76 teams established (53 in South and 23 in Southeast)
	Add 300 additional vaccinators to current HFs	240 vaccinators added (for one year/2021)
	Establish policy to vaccinate all children <5 who come to HFs	Policy established and implemented (Particularly in 3 provinces of south)
Demand Generation	Baby blankets and soap bars for EPI visits across all 200 HFs in inaccessible areas (36 months)	Available through Jan 2022
	Nutrition services available at all HFs in south	Services available at 231 HFs (66%) Supplied critical supplies (RUTF and micronutrients)
Community Engagement	Solar powered pumps/wells in the community	6685 targeted population got access to safe drinking water
	WASH at community centers	6765 latrine (71 communities at ODF)
	WASH at schools and health facilities (South)	WASH in 22 schools (56,492 students) WASH in 9 HFs (409700)
	Increase access and utilization of community schools	Accomplished at 680 schools

Routine Immunization and nutrition services through BPHS plus and MHNTs in south (Jan-May 2022)

171158 less than 5 years children received **OPV**

17522 less than 2 years children received **Penta 3**

135430 under 5 children screened for **malnutrition**

20316 children received measles 1

30589 under 5 children diagnosed and treated for MAM and SAM (22.5% GAM rate)

48115 pregnant mothers received ANC services

73353 children received baby blankets

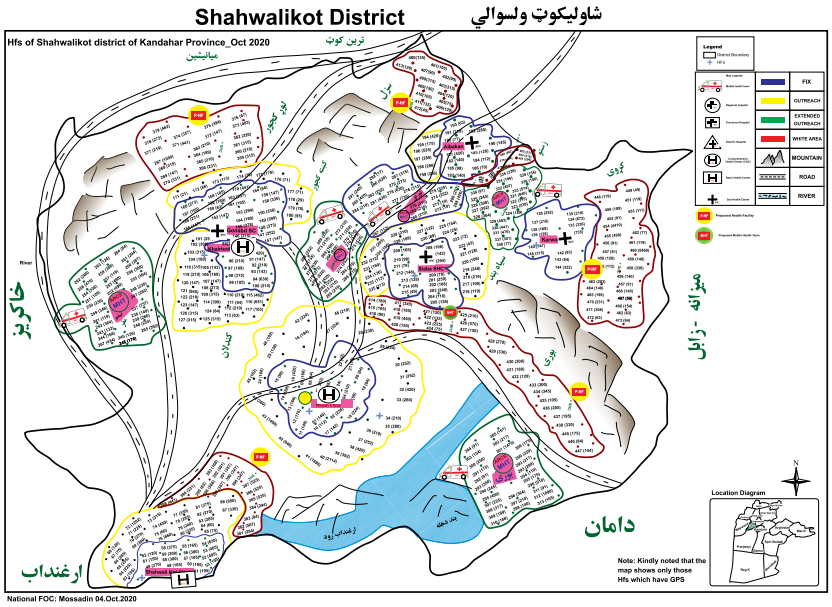
133920 under 5 children received soap (to boost uptake)

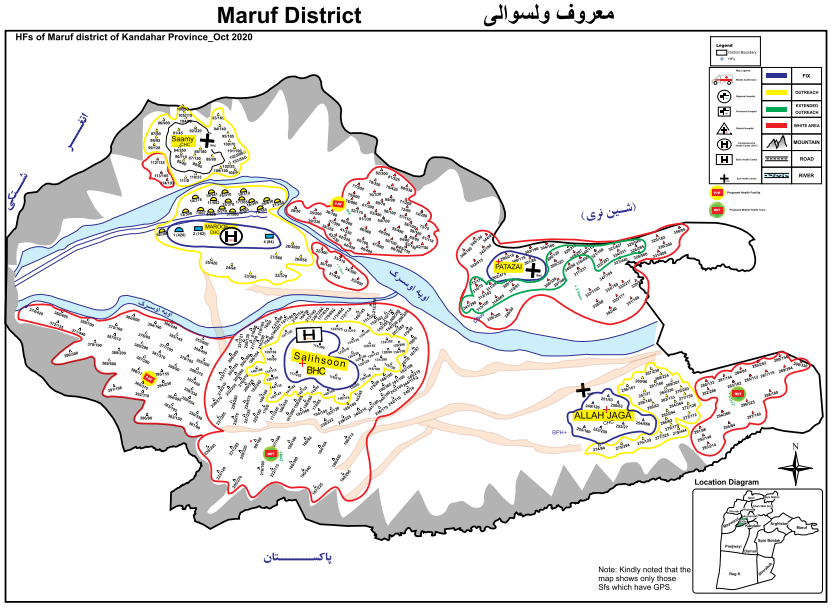
Southeast region (Jan-May, 2022)

Polio communication integration of service for 20222

- 23 MHNTs established by UNICEF in SER Since March 2022
- 50 Female mobilizer vaccinators deployed to 39 Health facilities in SER for supporting the routine immunization and community awareness raising.
- 20,601 males and 221,884 Females received Polio, health, nutrition, hygiene and sanitation education messages by FMVs .
- **91,032** U5yrs children received OPV vaccine and **19,168** 2yrs children received DTP3 via support of FMVs in health facilities.
- Key religious madrassas were supported with 142 book shelfs, 11000 Blankets, and stationary.

Mapping exercises in Kandahar, Helmand and Paktika provinces to find out white areas for health services



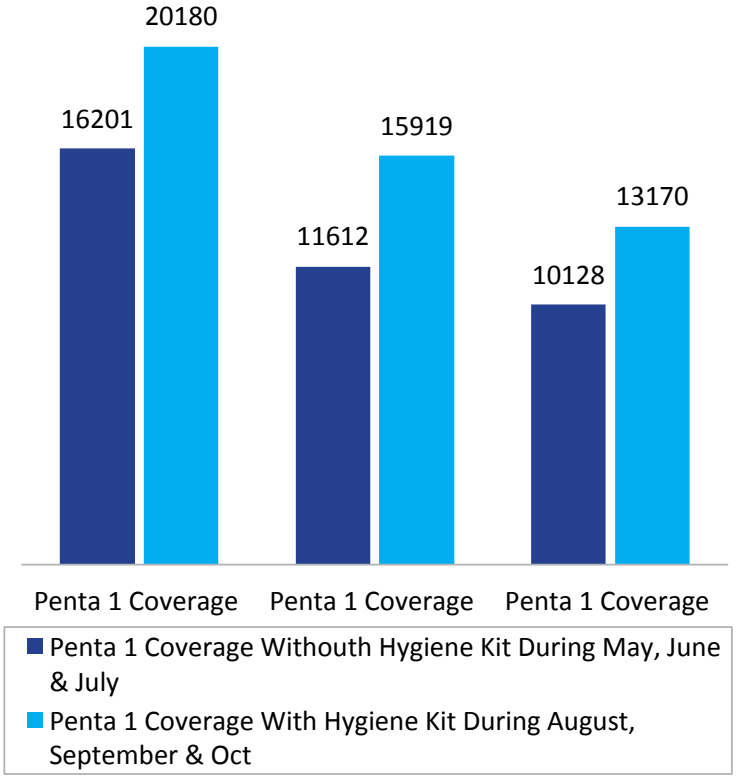


Updated mapping has helped to optimize EPI outreach and inform locations of new health facilities and mobile health teams

Source: NEOC mapping exercise

Provision of promotional material has helped improve demand for services

Number of children vaccinated in months with and without hygiene kit in 106 health facilities of Helmand province

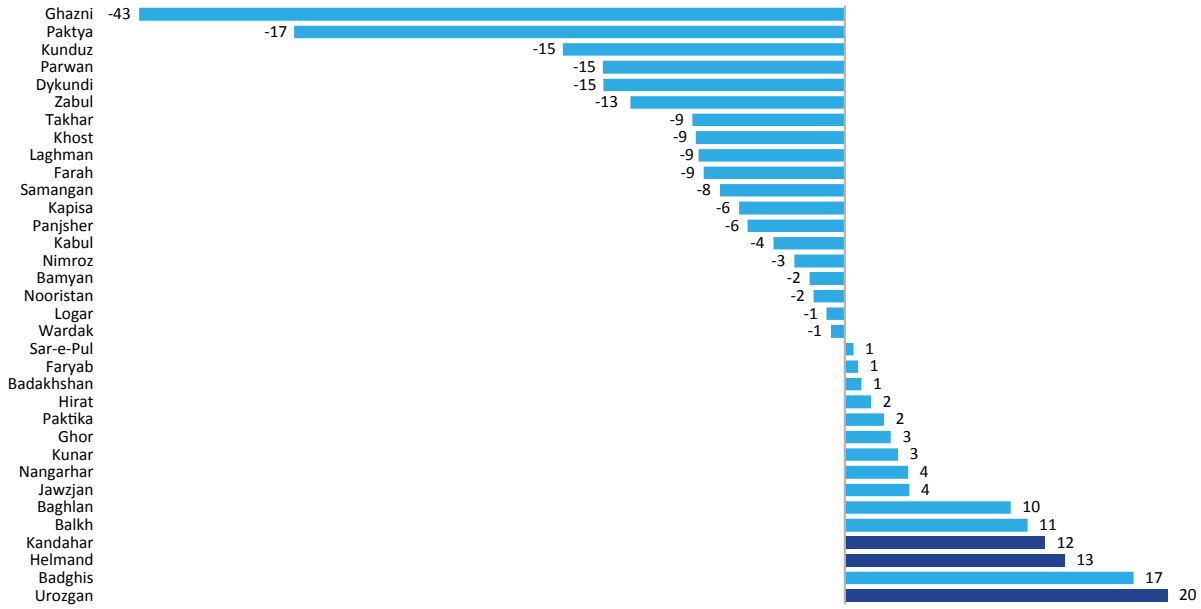


Source: NEOC

*Items: promotional item kits include baby blanket, hygiene kit, soap, and delivery kit

The three ISP provinces have seen some of the biggest improvements in Penta 3 performance from 2019 to 2021

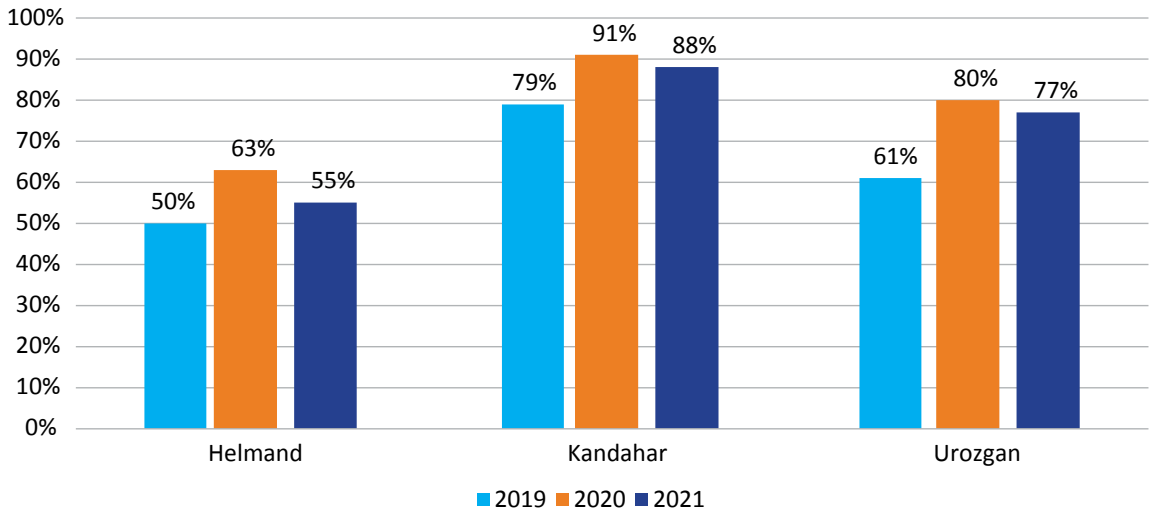
Change in Penta 3 coverage between 2019 and 2020 RI annual coverage; percentage points



Source: NEPI administrative data

Improved penta 3 coverage has continued to 2021

Penta 3 coverage % in last 3 years (Kand, Helm and Uroz)



Paktika Province Summary (Mapping Exercise)

Variable	Number/ %
# of HFs	67 HFs (1 PH, 2 DH, 1 CHC+, 8 CHCs, 15 BHCs, 30 SHCs, 9 MHTs and one prison health center)
Number of villages	2756
Total population	1,224,397
Fix area village/population	731 (27%) /367051 (30%)
Outreach village/Population	1037 (38%) / (42%)
Mobile & extended outreach village/ population	288 (10%) / 117930 (10%)
White area village/population	700 **(25%)** / 228313 **(19%)**
Having safe drinking water	41 out of 67 (61%)
HFs in private/rented houses	32 out of 67 (with inadequate WASH facilities)
Electricity (solar or generator)	52 out of 67 (78 %)
Toilet (at least two toilets)	17 out of 67 (25%)
Having Outreach services	59 out of 67 (88%)
Having Outreach plan	53 out of 67 (79%)
Mean of Outreach days/month/HF	8 days
# of Fix center vaccinators	63
# of Outreach vaccinators	31
Cold chain minimum standard	58 out of 67 (87%)
Need HFs, MHT, outreach/additional vaccinators	23 HFs (3 BHCs, 15 SHCs, 5 MHTs) and 28 additional outreach vaccinators

Conclusions

- The components of the ISP that were delivered in 2020 and 2021 had a major impact on OPV coverage and polio immunity across Helmand, Kandahar, and Urozgan – especially in inaccessible areas.
- IS has been a key contributor to the reduction in polio transmission in these areas (no polio case in south for the last 19 months).
- Given the above, the ISP must be refined and streamlined for 2022 and expanded to South-east (**Paktika**).

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

We are determined to make it happen.