AFGHANISTAN POLIO ERADICATION INITIATIVE 2024 ANNUAL REPORT

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACRONYMS

AFP	Acute Flaccid Paralysis
AFR	Acute Fever Rash
aVDPV	Ambiguous Vaccine-Derived Poliovirus
BCU	Big Catch-Up Activities
BMGF	Bill And Melinda Gates Foundation
bOPV	Bivalent Oral Polio Vaccine
BPHS	Basic Package of Health Services
CDC	Centers For Disease Control
CR	Campaign Response
CSO	Civil Society Organization
CVA	Complementary Vaccination Activity
cVDPV	Circulating Vaccine-Derived Poliovirus
DCO	District Communication Officers
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunization
ERC	Expert Review Committee
ES	Environmental Surveillance
EV	Enterovirus
FMVs	Female Mobiliser/Vaccinators
GPEI	Global Polio Eradication Initiative
H2H	House-To-House
HRMP	High-Risk Mobile Population
IAG	Islamic Advisory Group
ICN	Immunization And Communication Network
IHR	International Health Regulations
IOM	International Organisation for Migration
IPV	Inactivated Polio Vaccine
ISD	Integrated Service Delivery
KP	Khyber Pakhtunkhwa
LQAS	Lot Quality Assurance Sampling
MAAC	Multi-Antigen Acceleration Campaign
MoPH	Ministry Of Public Health
NEAP	National Emergency Action Plan
NEOC	National Emergency Operation Center
NIAG	National Islamic Advisory Group
NID	National Immunization Day
NIH	National Institute of Health
NPEV	Non-Polio Enterovirus
OPV	Oral Polio Vaccine
PCA	Post Campaign Assessment
PCM	Post Campaign Monitoring
PCO	Provincial Communication Officers
PEI	Polio Eradication Initiative
PPO	Provincial Polio Officer
PSA	Public Service Announcements
PTT	Permanent Transit Team
REOC	Regional Emergency Operation Centre
RI	Routine Immunization
SBC	Social And Behavior Change

SIA	Supplementary Immunization Activity
SNID	Sub-National Immunization Day
TAG	Technical Advisory Group
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VDPV	Vaccine-Derived Poliovirus
VPD	Vaccine-Preventable Disease
WASH	Water, Sanitation, And Hygiene
WHO	World Health Organisation
WPV	Wild Poliovirus

Executive Summary

EXECUTIVE SUMMARY

Afghanistan has made significant progress toward polio eradication in recent years, demonstrating the capacity to stop indigenous poliovirus transmission on multiple occasions and in all regions of the country. However, two major outbreaks have posed setbacks to the programme in the past few years – the first in the East region starting in mid-2022 and the other in the South region from mid-2023.
In 2024, 25 children were paralyzed by polio, with most cases concentrated in the South region, and 113 environmental samples tested positive for poliovirus across the country. In mid-2024, nationwide house-to-house (H2H) vaccination campaigns, except in Kandahar City, achieved unprecedented protection for children, reaching 89% coverage in July 2024. However, this progress was short-lived, as H2H campaigns were halted in September 2024. The shift from H2H to site-to-site (S2S) vaccination campaigns poses a significant risk to progress, particularly in the South region, undermining the efforts to stop the ongoing WPV1 transmission.

Current epidemiology indicates a growing outbreak in the South region, with an increasing number of children susceptible to poliovirus and an immunity gap as result of years of limitations on campaign modality. Meanwhile, innovative programme improvements have led to a decline in the outbreak in the East region.

The programme continued to be guided by the National Emergency Action Plan (NEAP) to implement polio eradication activities across the country. Of the seven strategic objectives in NEAP 2024, four were fully achieved, two were partially achieved, and one was not achieved.

As mentioned, in 2024, 25 polio cases were reported, with 23 from 13 districts in Hilmand, Kandahar and Uruzgan provinces in the South region, and two from Kunar and Nuristan provinces in the East region. Additionally, 113 positive environmental samples were reported in 2024: 80 from the South region (47 from Kandahar, 29 from Hilmand, three from Uruzgan and one from Zabul), 21 from the East region (15 from Nangarhar, five from Laghman and one from Kunar), five from Kabul province in the Central region, one from Baghlan province in the Northeast region, two from the Southeast region (one from Ghazni and one from Paktya), and four from the West region (one from Badghis and three from Harat). In 2023, 62 positive environmental samples were reported: 47 from the East region, 12 from the South region, two from Kabul province in the Central region and one from the North region. While poliovirus transmission in the East region began to decline by late 2024, the South region remained Afghanistan's only area of endemicity, making it the programme's top priority for halting transmission. Afghanistan has not reported any case of VDPV since 2022; the last case of VDPV (aVDPV1) was reported in January 2022. Of the eight wild poliovirus genotypes circulating in Afghanistan in 2020, only one (YB3A) remained in 2024.

In 2024, PEI in Afghanistan conducted two NIDs, three SNIDs, and four SIAs, targeting endemic, outbreak, and reservoir areas of the country, considering the evolving epidemiology.

In 2024, the number of unreached children in Afghanistan increased from 0.13 million at the start of the year to around 0.55 million by year-end due to restrictions put by the authorities on the H2H campaign starting in October 2024. Although acceptance of polio vaccination remains high, refusal rates are rising. In the East region, the number increased from 4,233 in January to 8,288 in December, and in the Southeast region, from 5,561 in January to 22,659 in December. Overall, the national refusal rate rose from 34,468 in the March NIDs to 39,681 in the September NIDs, with the highest number (13,142) reported in Paktika province in December. The exact number of refusals in the South region cannot be ascertained due to the inability to document and the number of children who, in the absence of H2H campaigns, are not brought to mosques and other vaccination sites.

The presence of many unreached children due to restrictions on H2H campaigns continued to be a challenge to the programme. The inability to vaccinate children at the doorstep over an extended period has resulted in large scale immunity gaps across the South region, regarded as a significant reservoir for poliovirus.

Afghanistan's polio surveillance system continued to function well and meet global standards, providing evidence-based guidance for polio vaccination activities. The acute flaccid paralysis (AFP) surveillance network consisted of 2,079 active sites and 3,516 zero reporting sites, as well as more than 62,268 reporting volunteers. 43 environmental surveillance sites complemented this.

Extensive communication and advocacy activities were undertaken to support vaccine acceptance, including advocacy with religious leaders, local influencers, and health professionals. Social media platforms, the Polio Free Afghanistan website, the Islamic Advisory Group, and local media were also utilized to amplify pro-vaccination messaging. Social and Behavior Change (SBC) interventions, together with media engagement, played a pivotal role throughout the year.

FMVs (Female Mobiliser/Vaccinators) continued to conduct health education sessions and support routine immunization at health facilities. In addition, WHO PEI field staff continued to provide monitoring and referral support for immunization and other health services during surveillance visits. Access to routine immunization in Afghanistan continued to improve in 2024. Integrated health services, including routine immunization, played an important role in supporting polio eradication, particularly in the South. In partnership with providers of the Basic Package of Health Services (BPHS), routine immunization, including polio vaccination and essential maternal and child health, were promoted through different activities in 2024 to ensure a consolidated approach for health service provision. Activities included producing and distributing polio-branded materials such as hygiene kits, soap bars, and baby blankets, and providing services linked to education, WASH, and nutrition to raise awareness about vaccines and build community trust.

1. Oversight, Coordination, and Programme Management

OVERSIGHT, COORDINATION, AND PROGRAMME MANAGEMENT

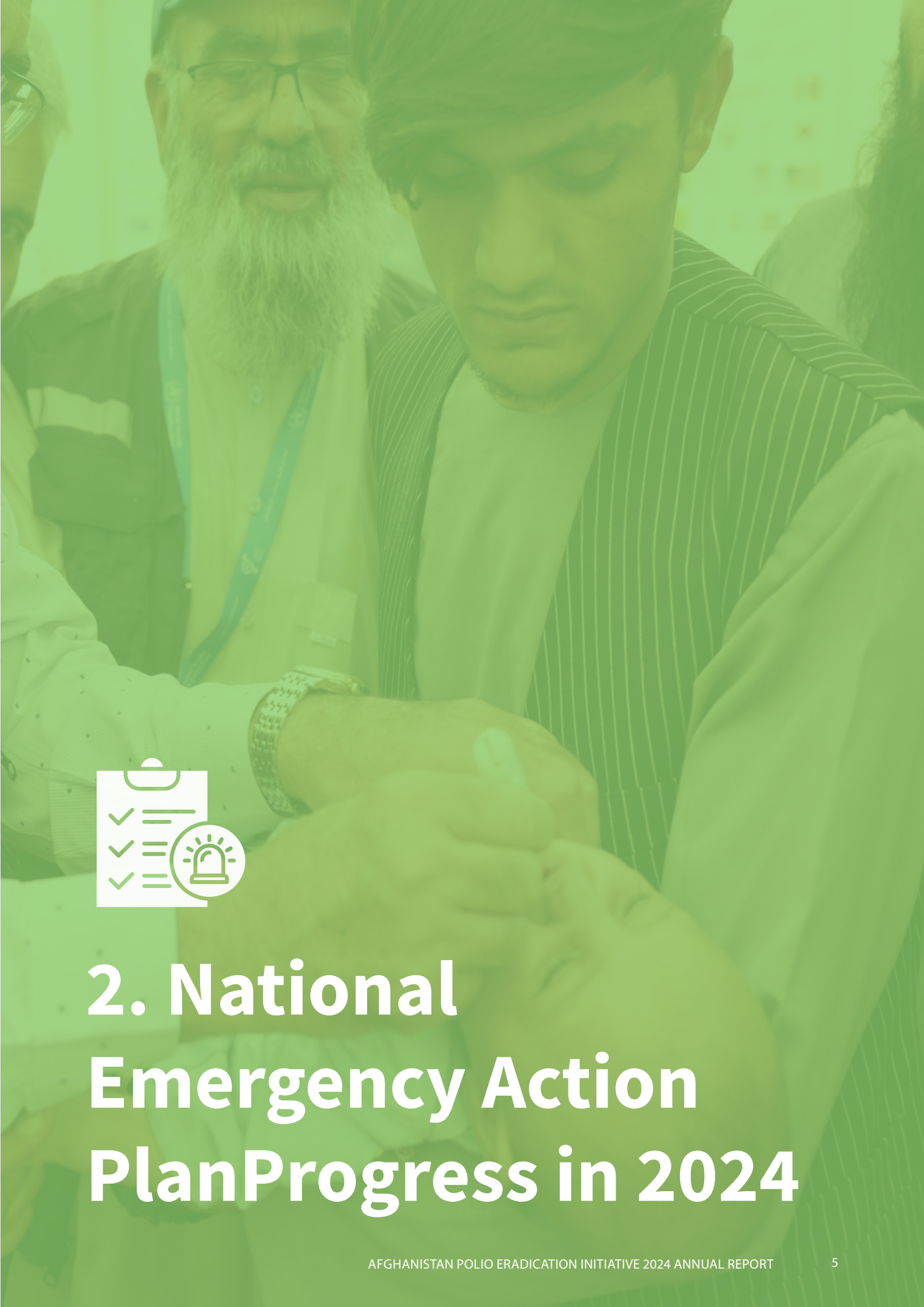
1.1. Governance and leadership

The National Emergency Operations Centre (EOC) continued its leadership role, supported by the Core Group, chaired by Director of the National EOC. Technical working groups on SIA, Data and M&E, Integrated Service Delivery (ISD), and communications are fully functional and playing an effective role in providing guidance and required policy-level direction to the programme.

1.2. Implementation and coordination

Under the leadership of the MoPH, the National EOC has the overall responsibility for the stewardship of all polio eradication activities in Afghanistan. With technical support from partners, the National EOC defines strategies for polio eradication, identifies high-risk areas, develops the necessary tools, evaluates the programme and tracks the performance of districts. The National EOC ensures that all strategies are shared with the provinces and undergo consultation before finalization.

The National EOC closely monitors the implementation of the NEAP and is supported by the four regional EOCs, one each in the West, South, East and Southeast regions, and two provincial EOCs in Helmand and Urozgan. The regional EOCs manage the daily operation of the PEI and coordinate and execute the strategies set at the national levelThe provincial EOCs in Helmand and Urozgan provide focused support in these epidemiologically important provinces.



2. National Emergency Action PlanProgress in 2024

NATIONAL EMERGENCY ACTION PLAN PROGRESS IN 2024

The NEAP guides the implementation of all polio eradication activities in Afghanistan. As per previous years, NEAP 2024 was developed through a consultative process involving the regions, stakeholders, and partners. The implementation of NEAP is monitored by the Core Group.

NEAP 2024 continued the seven strategic objectives for achieving polio eradication in Afghanistan. Of the seven objectives, four (57%) were fully achieved, two (29%) were partially achieved, while one (14%) was not achieved.

Table 1: Status of implementation of NEAP 2024 objectives

Objectives	Goal/Objective in NEAP 2024	Status
1	Interrupt polio transmission through improved campaign quality in Afghanistan.	Not Achieved
2	Maintain and enhance a sensitive and efficient surveillance system for the poliovirus in Afghanistan.	Achieved
3	Maintain a very aggressive stance for responding to new WPV-1 and cVDPV2 detected from any source.	Achieved
4	Strengthen outbreak response capacity with a timely and high-quality response.	Achieved
5	Improve cross-border collaboration with Pakistan.	Achieved
6	Implement strong social behavioral communications and change strategy.	Partially achieved
7	Strengthen vaccination activities in areas with populations of the lowest reach through targeting zero-dose children, multiantigen campaigns, and other interventions, including utilizing the GPEI humanitarian engagement in the South to reach all unreached children.	Partially achieved

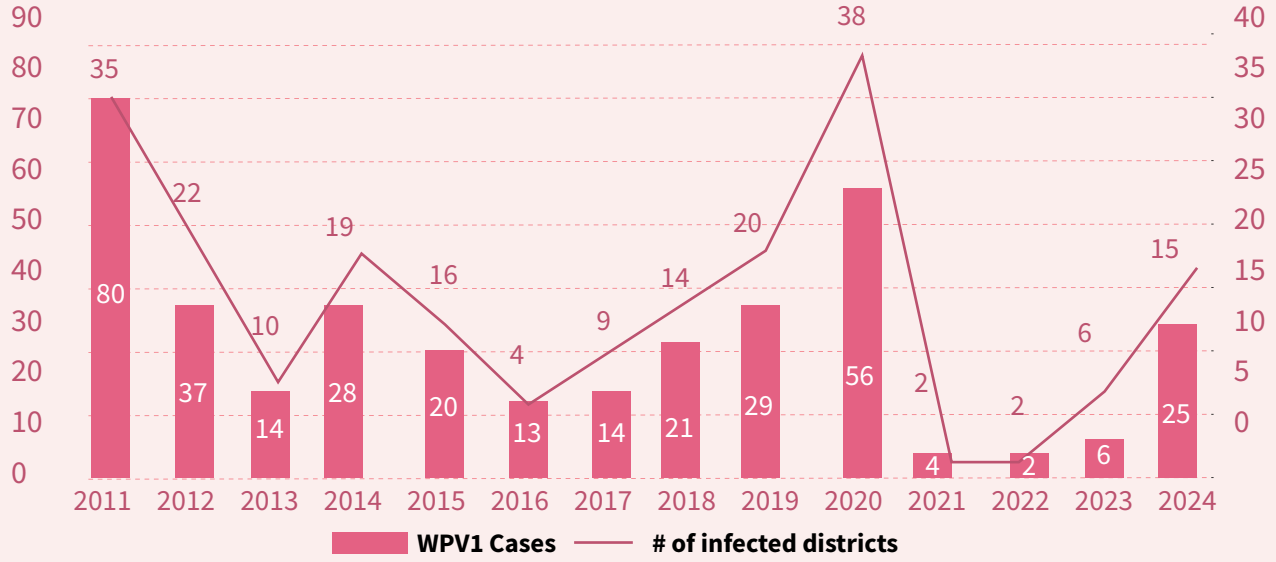
3. Epidemiology

EPIDEMIOLOGY

While 135 of Afghanistan's 400 districts have not reported a single case in past ten years, smaller pockets of the country in the South and East regions have been responsible for most positive detections of poliovirus and ongoing local transmission during this period. This is due to different socio-demographic features in different areas, and non-uniform programme performance in different parts of the country. The most important of these factors are: (1) population density; (2) campaign modality; (3) presence of HRMPs (High Risk Mobile Population); and (4) low routine EPI coverage.

Afghanistan reported 25 cases of WPV-1 in 2024, compared to six cases in 2023. Of these 25 polio cases, 23 were reported from 13 districts in Hilmand, Kandahar and Uruzgan provinces in the South region, while two were reported from Kunar and Nuristan provinces in the East region. Figure 1 shows the trend of confirmed polio cases and the number of infected districts from 2011 to 2024.

Figure 1: Confirmed Wild Poliovirus cases and polio-infected districts, Afghanistan 2011-2024



The South, a longstanding reservoir for WPV-1 transmission, had not report a polio case since October 2020. However, it detected a positive environmental sample in May 2023, and at least one positive environmental sample was reported monthly until the end of 2024. Poliovirus circulation re-established in the South and the first case of WPV1 was reported from the Arghestan district of Kandahar province in April 2024.

A total of 113 positive environmental samples were reported in 2024: 80 from the South region (47 from Kandahar, 29 from Hilmand, three from Uruzgan and one from Zabul), 21 from the East region (15 from Nangarhar, five from Laghman and one from Kunar), five from Kabul province in the Central region, one from Baghlan province in the Northeast region, two from the Southeast region (one from Ghazni and one from Paktya), and four from the West region (one from Badghis and three from Harat).

Genetic lineage indicated that all wild poliovirus isolates across the country in 2024, both from AFP and environmental samples, belonged to only one cluster (YB3A) compared to eight clusters in 2020.

The last case of VDPV (aVDPV1) was reported in 2022, while the last cVDPV case in Afghanistan was reported in July 2021.

4. Surveillance

4. SURVEILLANCE

A sensitive surveillance system remains the cornerstone of polio eradication efforts, guiding all other aspects of the programme. Afghanistan's PEI continues using both Acute Flaccid Paralysis (AFP) surveillance and environmental surveillance to detect and confirm WPV-1 cases and to monitor the circulation of WPV in the environment. Through designated field staff, the polio programme continues to conduct surveillance activities at all levels across the country.

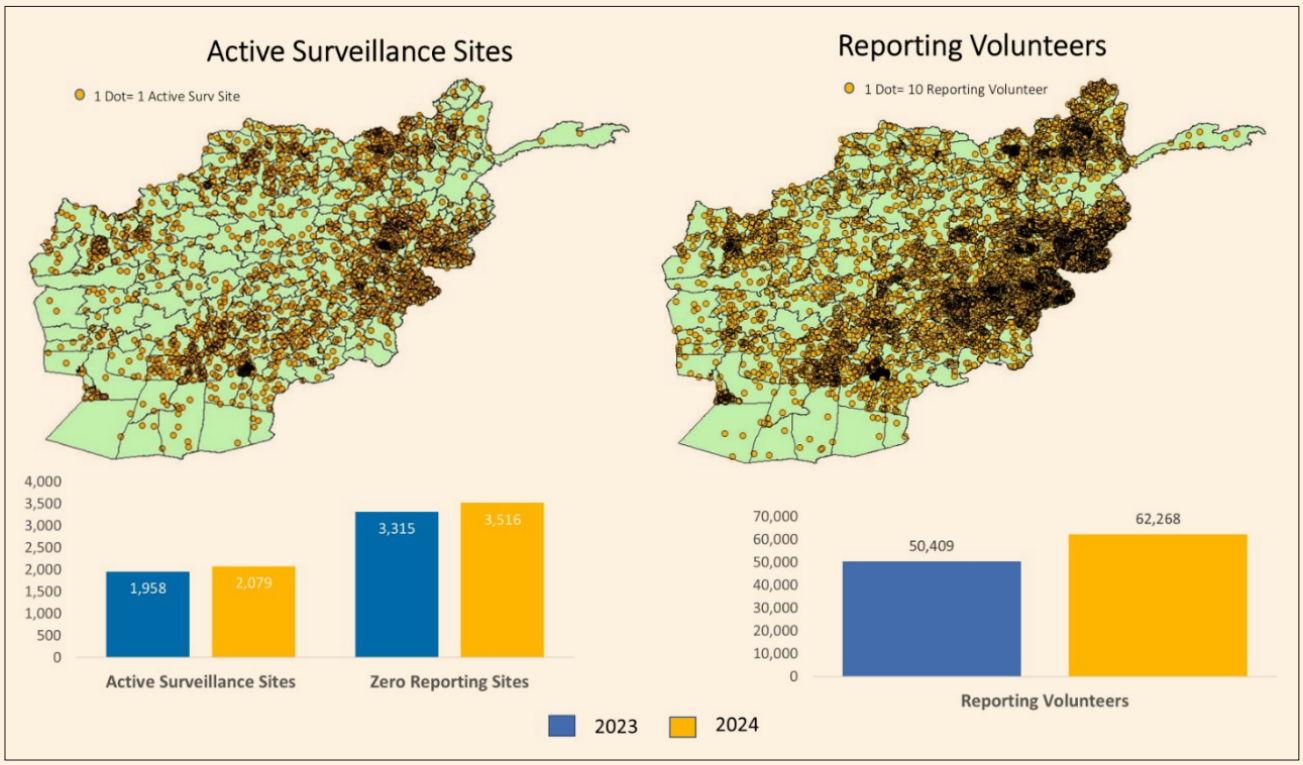
The AFP surveillance system continues to maintain high sensitivity for key indicators and to surpass global targets. The AFP surveillance network is active across the country and contributes to other disease reporting activities, such as measles and neonatal tetanus cases.

4.1. AFP surveillance

Afghanistan's AFP surveillance network includes major national, regional, and provincial-level hospitals, district-level health facilities, private practitioners and hospitals, physical rehabilitation centers, pharmacies, mid-level health workers, traditional healers, shrine keepers, and community volunteers. By the end of 2024, there were 2,079 active surveillance sites, up from 1,958 sites at the end of 2023. The number of zero reporting sites increased from 3,315 sites in 2023 to 3,516 in 2024. In 2024, the number of reporting volunteers rose from 50,409 in 2023 to 62,268 in 2024.

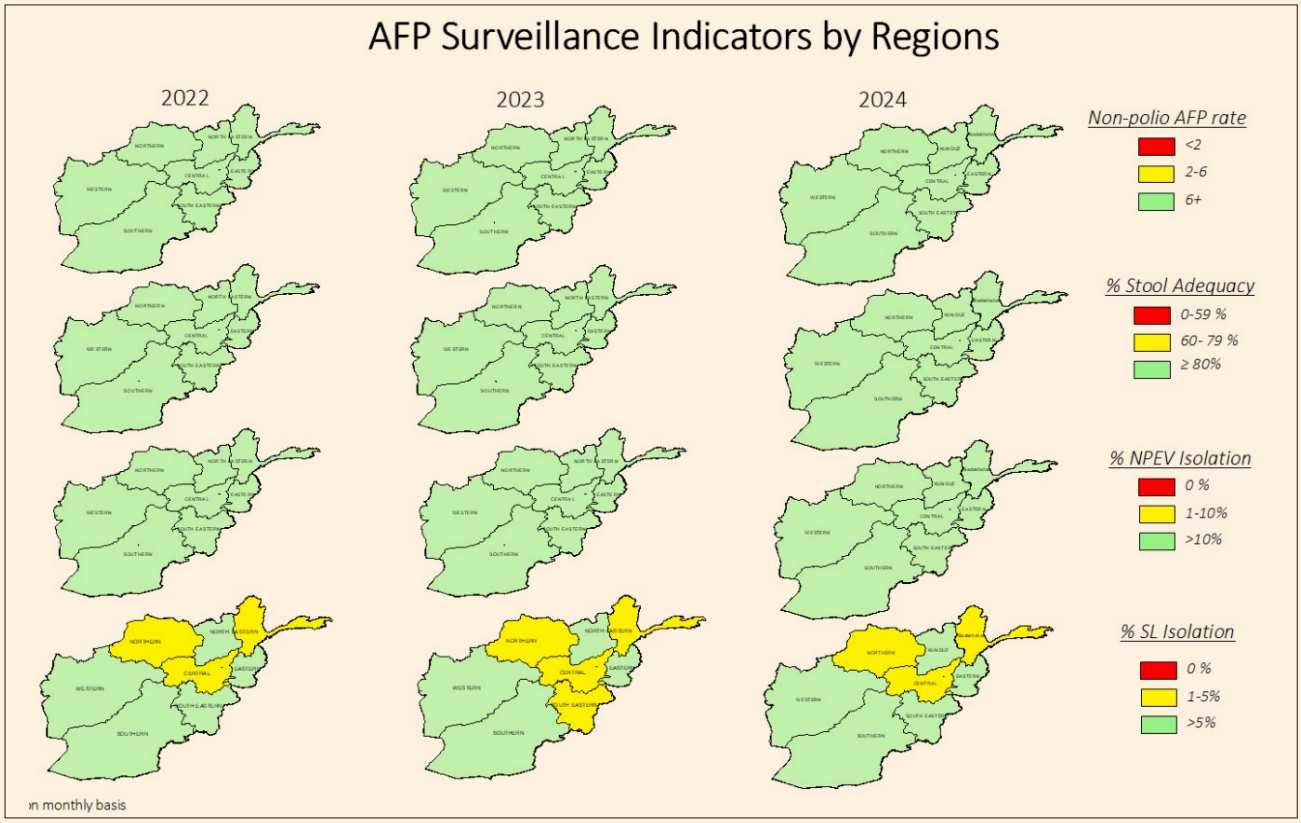
In 2024, the AFP surveillance system in Afghanistan reported 5,786 AFP cases with a non-polio AFP rate of 25 per 100,000 population below 15 years. This compares to 26 per 100,000 population below 15 years in 2023. The male-to-female ratio of AFP cases was 54:46 in 2024, which slightly changed from 56:44 in 2023.

Figure 2: AFP surveillance network in Afghanistan, 2023 – 2024



The stool adequacy rate in all regions was above 95% nationally, ranging from 92% (South) to 97% (Central region and Badakhshan Province). In 2024, the non-polio enterovirus isolation rate increased to 15% from 14% in 2023, while the Sabin-like virus isolation rate decreased to 5% from 6% in 2023. The figure below shows AFP surveillance indicators from 2022 to 2024.

Figure 3: AFP surveillance quality indicators in Afghanistan, 2022–2024



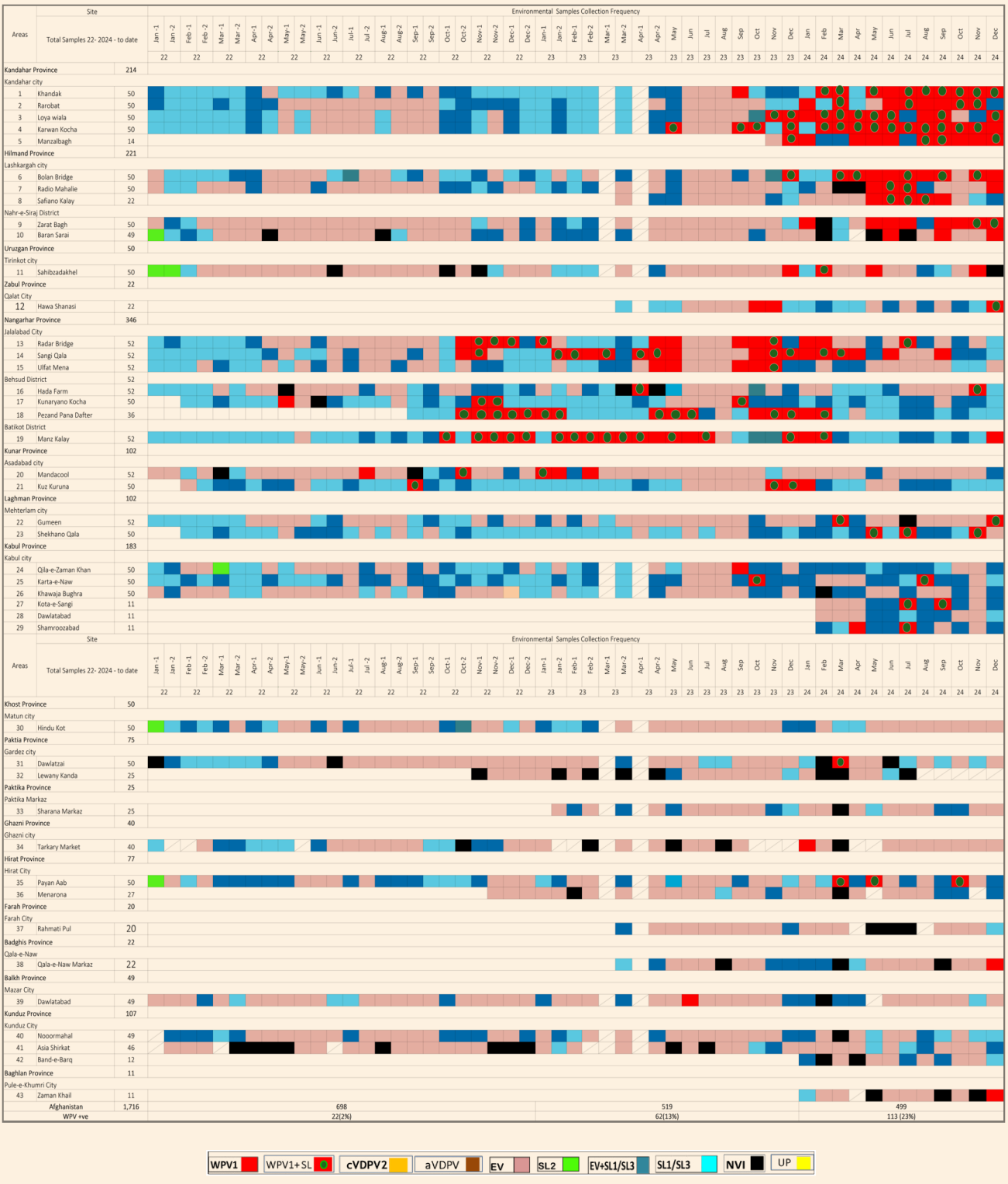
4.2. Environmental surveillance

The environmental polio surveillance system in Afghanistan supplements the AFP surveillance system, aimed at detecting wild polioviruses and vaccine-derived polioviruses in sewage and determine routes of transmission in the environment. In 2024, the number of sample collection sites increased from 38 in 2023 to 43. These sites are in all seven regions of the country, which are in 23 major population centers of 18 provinces of the country. The sample collection frequency continued monthly in 2024 to increase isolation of the virus in the environment. The programme continues to review the performance of environmental surveillance using globally defined sensitivity and quality indicators, and the performance levels have been satisfactory. Moreover, the programme also continues to monitor the drainage, sewage dynamics, and appropriateness of the collection points. Given the population size and population density at the regional and provincial level, the programme is confident that the current extent of the environmental surveillance system (in conjunction with the existing AFP surveillance network) in Afghanistan is sensitive to detect the polioviruses rapidly and timely.

Figure 4: Environmental surveillance sites in Afghanistan, 2024

In 2024, 113 ES-positive isolates tested positive for poliovirus out of 499 samples collected across Afghanistan, with 28 samples closely linked to ES-positive samples from the districts of Quetta, Chaman, Pishin, and Noshki in Balochistan; Dera Ismail Khan in Khyber Pakhtunkhwa; Lahore in Punjab; and Karachi in Sindh, Pakistan. The remaining samples were linked to local transmission in Afghanistan. The Afghanistan PEI programme reported its last VDPV2 strain in environmental sample in July 2021. The EV Isolation rate was >68% at the national level.

Figure 5: Environmental surveillance laboratory results, 2024



4.3. Review of surveillance

Afghanistan PEI programme conducted internal AFP surveillance reviews in 2024 in the Southeast, North, and Northeast regions. The main objectives were to assess whether the surveillance system is functioning adequately at all levels and across all geographic areas, whether information collection and documentation are adequate, and whether the information is being used to guide programme activities and to propose recommendations for improving AFP surveillance.

The key findings showed that the surveillance network in all the areas visited is robust, encompassing both public and private sectors. Active surveillance sites are classified as high, medium, or low priority, with surveillance staff visiting them at designated frequencies—weekly, fortnightly, or monthly. The review was comprehensive, including both formal and informal healthcare providers and traditional faith healers. There is effective communication among health staff regarding the implementation of all PEI activities, including AFP surveillance. The AFP surveillance data is used to enhance SIA's activities by identifying zero-dose or under-immunized AFP cases and poorly covered areas through area coverage surveys. All interviewed AFP focal points knew the AFP case definition in all the areas visited; they had records of surveillance documents, i.e., case investigation, sample collection, active surveillance, zero report, and linkage with the reporting volunteer network. The review team didn't find any missed AFP cases.

The review team concluded that there is a functioning, responsive, and sensitive surveillance system in place, with overall surveillance indicators well above international standards in most of the districts. There is no evidence of any missing AFP cases. Despite the current workload and limited staff, the regional team has established a highly effective and sustainable system. Significant efforts have been made to improve the surveillance system, and it is crucial to continue this work to maintain and further enhance its performance. However, there is still room for further strengthening monitoring, documentation, surveillance visibility, and linkage along with the network, and availing of referral booklet and posters, and stickers.

The GPEI hub, in coordination with the country team, conducted an independent external audit from 19 April to 15 May in the East and Northeast regions, involving a team of 19 independent reviewers. The audit team visited 22 districts, interviewed 26 district staff in person, and conducted desk reviews for two districts. They met members of the Expert Review Committees, validated surveillance and SIAs data quality, and monitored end-to-end processes. The team verified the vaccination status of six polio and 24 AFP cases. The external audit team monitored pre-, intra-, and post-campaign activities for the April 2024 SIA round.

The external audit team concluded that Afghanistan's polio eradication programme in the East region is functioning and well-performing, achieving high vaccination coverage across most districts. However, the coverage at sub-district level and among a few high-risk mobile population groups seems not uniformly high to stop transmission. The programme needs to enhance the focus on lower coverage at the sub-district level through fine-tuning microplanning. A small increase in coverage would be critical and may need targeted approaches to ensure higher coverage among HRMP, including better refusal conversions, returnees, and population living along the border. While the strategy and process of monitoring are aligned with national guidelines, the programme needs to focus on selection and regular rotation of monitors. Adjustments to the communication strategy are also needed, considering the context of each cluster in high-risk districts. The programme must maintain the current momentum while recognizing that additional efforts are imperative to increase coverage by reaching HRMP, addressing refusals, and fine-tuning SIA's operations to interrupt the endemic WPV1 transmission.

The summary and conclusions by the external audit team from the surveillance activities were that the information provided by the programme on the vaccination status of polio cases in 2023 matched with findings of the audit team based on interviews of parents and child caregivers. The overall surveillance system for polioviruses, including AFP, facility and community-based, and environmental surveillance is functioning effectively in the East region. However, sequencing data and clusters of potential compatible AFP cases indicates gaps in surveillance sensitivity. The team recommended enhancing surveillance among mobile populations and along the Afghanistan-Pakistan border. They also proposed a refresher session for Afghanistan's National Expert Review Committee (ERC) focusing on compatible cases, regular training for AFP focal points, orientation of reporting volunteers, and continued monitoring of ES sites.

The external audit team also visited the Northeast region and, due to limited time for the field mission, prioritized SIA over surveillance. The team conducted the following main activities:

- Visited ten districts in the Northeast region with known movement to Pakistan, including seven in Kunduz and three in Baghlan province.
- Conducted qualitative and quantitative assessments of end-to-end AFP surveillance and SIA processes, and validated monitoring processes.

Held interviews and group discussions to identify high-risk areas and underserved populations. A two-member post audit mission visited Afghanistan from 29 September 2024 to 7 November 2024 to follow up on the implementation of the recommendations from the external audit. The mission confirmed substantial progress in implementing recommendations, particularly in micro-planning and mapping, updating team-level vaccination operations and SBCC, enhancing focus on migrant and mobile populations in border areas, and validating of PCM and LQAS data. Similar progress was observed in the follow-up implementation of AFP surveillance activities.

5. Supplementary Immunization Activities

SUPPLEMENTARY IMMUNIZATION ACTIVITIES

In 2024, PEI Afghanistan conducted two NIDs, three SNIDs and four SIAs. The SNIDs and SIAs targeted the endemic, outbreak and reservoir areas of the country considering the evolving epidemiology as per the recommendations of the Technical Advisory Group (TAG) on polio eradication in Afghanistan (see Table 2).

Table 2: SIAs conducted in 2024

Type of SIA	Month	Target	Vaccinated	Coverage %
SNID	Jan 2024	7,580,085	7,611,216	100.41%
SNID	Feb 2024	7,610,799	7,842,267	103.04%
NID	Apr 2024	11,181,434	11,307,699	101.13%
NID	Jun 2024	11,181,434	11,691,623	104.56%
SNID	Jul 2024	8,046,561	8,547,388	106.22%
SIA	Aug 2024	2,435,550	3,079,651	126.45%
SIA	Oct 2024	6,905,950	6,251,299	90.52%
SIA	Nov 2024	5,955,842	5,732,863	96.56%
SIA	Dec 2024	5,501,859	5,344,153	97.13%

Access to vaccination campaigns in Afghanistan has improved significantly since the political transition in August 2021. Although advocacy for H2H vaccination continued, S2S and mosque-to-mosque (M2M) campaigns were implemented in most districts of the South and Northeast regions until mid-2024. The Northeast region reverted to H2H campaigns for the SNIDs in December 2024.

In May 2024, the Afghan authorities allowed H2H vaccination campaigns across Afghanistan, except in Kandahar province due to security concerns. In August, H2H campaigns were also permitted in Kandahar province, except in Kandahar City.

This was a breakthrough for the polio programme, as H2H campaigns remain the gold standard for polio eradication and was the campaign modality in all countries to-date. This was especially an important step forward for the South region where campaigns had long been restricted to M2M or S2S modality with limited reach. Unfortunately, in September 2024, an official notification restricting the H2H vaccination came from the authority and vaccination campaigns have since been limited to S2S modality country wide. This increases the likelihood of missing a significant number of children, including the most vulnerable under one year of age. Campaign monitoring data shows lower coverage in implementing mosque- or site-based modalities compared to H2H. Nevertheless, the polio programme remained focused on optimizing the S2S modality to protect as many children as possible and reversing the course of the current poliovirus outbreak.

Figure 6: Campaign modality, 2024

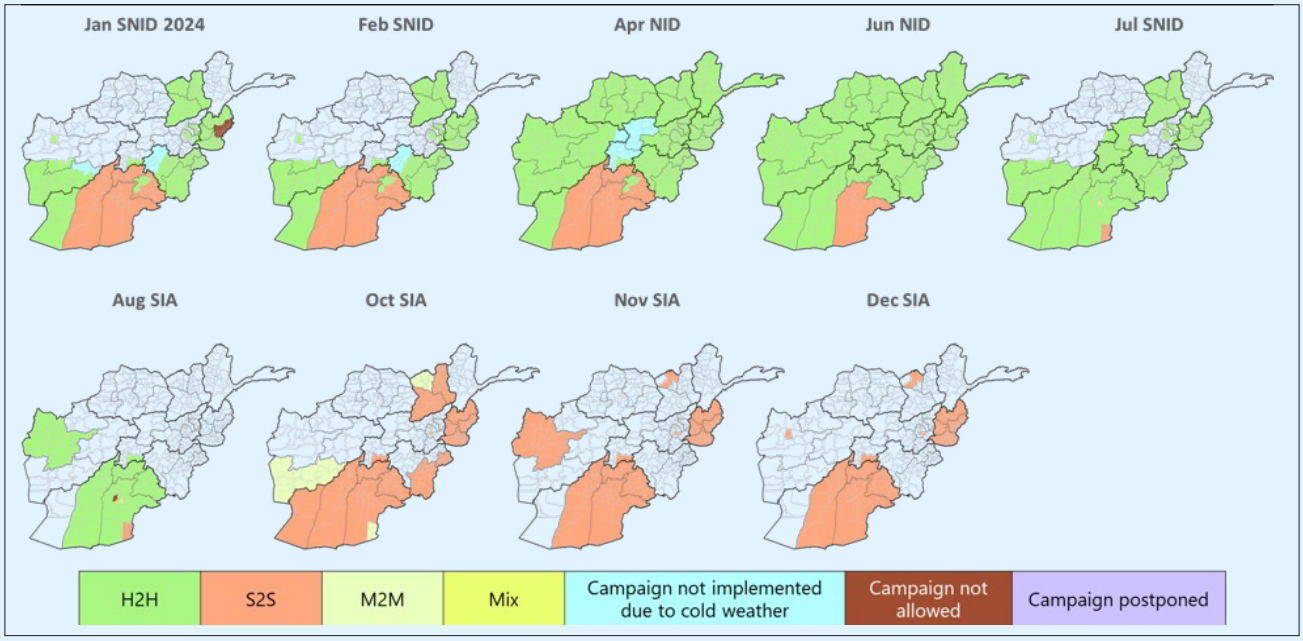


Table 3: SIAs modality (% of clusters), NIDs and SNIDs, 2024

Modality	SNID Jan24	SNID Feb24	NID Apr24	SNID Jun24	SIA JUl24	SIA Aug24	SIA Oct24	SIA Nov24	SIA Dec24
H2H	73%	80%	85%	96%	99%	95%	0%	0%	0%
Other Modality	27%	20%	15%	4%	1%	5%	100%	100%	100%

5.1. SIA quality

High-quality Supplementary Immunization Activities (SIAs) are key to interrupting the circulation of wild poliovirus in endemic areas and preventing the introduction of the virus to non- endemic areas. To ensure high quality of SIAs, particularly in polio reservoirs and high-risk areas, supervision and monitoring were strengthened by deploying additional monitors to South and East regions where there was active circulation of the virus and to all the high-risk areas.

The programme used lot quality assurance sampling (LQAS) during all NIDs and SNIDs in 2024 to assess the quality of campaigns. Lots accepted at 90% and above are regarded as passed and anything below 90% are failed. The quality of SIAs was seriously compromised when restriction on H2H campaigns was imposed and the number of failed LQAS Lots increased exponentially.

Across all NIDs and SNIDs, 2,246 sampled Lots were surveyed in 2024. LQAS results before restriction on H2H campaigns showed 84% Lots passed. After the restriction was imposed, only 34% of lots passed, in Kandahar and Hilmand, high-priority provinces where H2H campaigns were not implemented for most of the 2024, more than 97% of lots failed. In contrast, in Kunduz, Kabul, Nangarhar, and Kunar, high-priority provinces where H2H campaigns were implemented before the restriction, lot pass rates were significantly higher. As outlined in Figure 8, Kunduz and Kabul provinces showed a sharp decline in campaign quality after restriction on H2H campaigns starting in October 2024.

Figure 7: National post campaign monitoring results, NIDs 2024

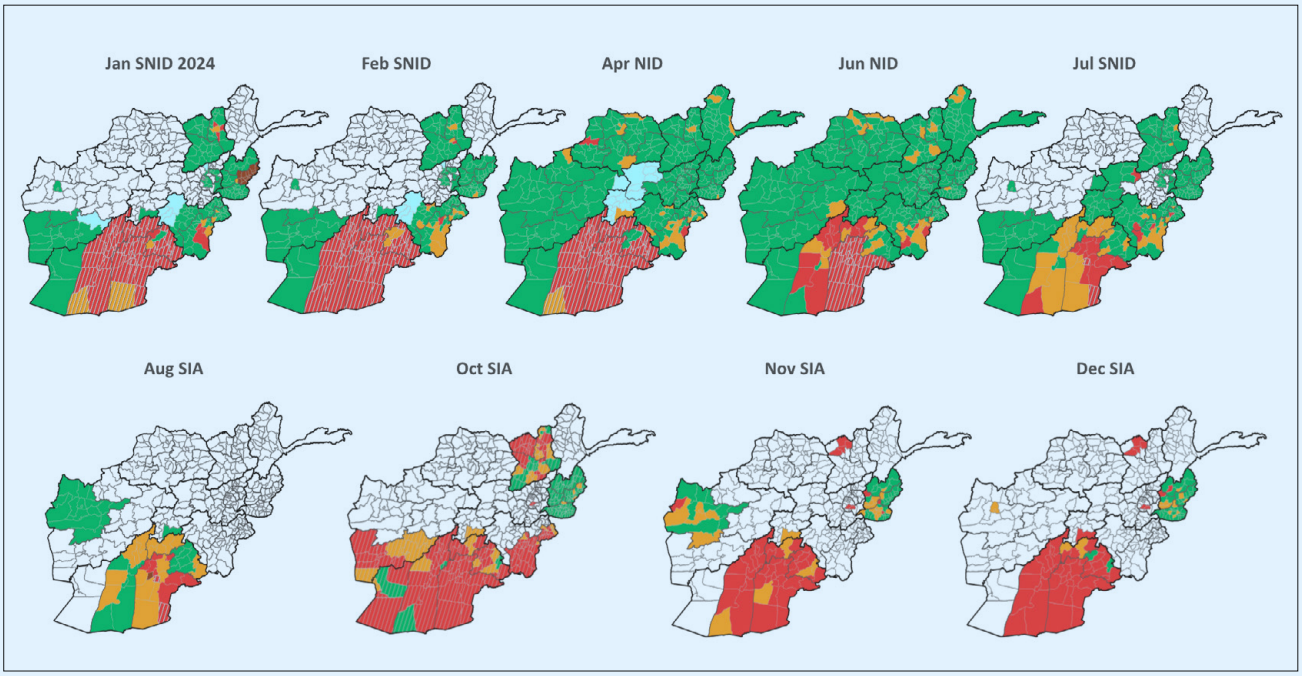


Figure 8: LQAs results in high-risk provinces during 2024 SIAs

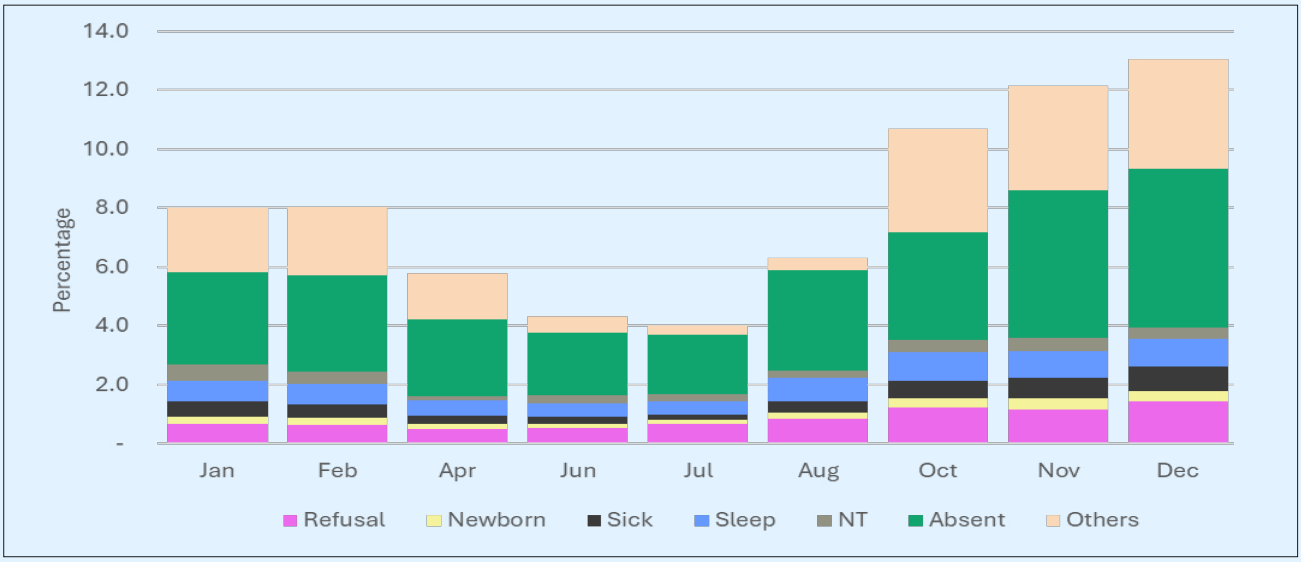
The reasons for missed children were regularly disaggregated and investigated after each campaign to identify root causes so that corrective measures could be taken. Following the investigation of the failed lots, both immediate and follow-up actions were implemented, including recovery and vaccination of missed children and improved microplanning, frontline worker selection, and training.

During each campaign, the regional and national EOCs conducted evening meetings to immediately address challenges and improve the quality of SIAs by providing support and exercising accountability.

For documenting feedback and lessons learned in improving the quality of subsequent SIA rounds, the National EOC held one post-campaign review meeting in January 2024 to review SIAs conducted in 2023 and another in March 2025 to review SIAs conducted in 2024, engaging both regional and provincial teams. The ICN was also used in the highest risk areas through active community engagement aimed at addressing missed children, particularly refusals. Campaign review meetings were also organized at the regional and provincial level after every campaign.

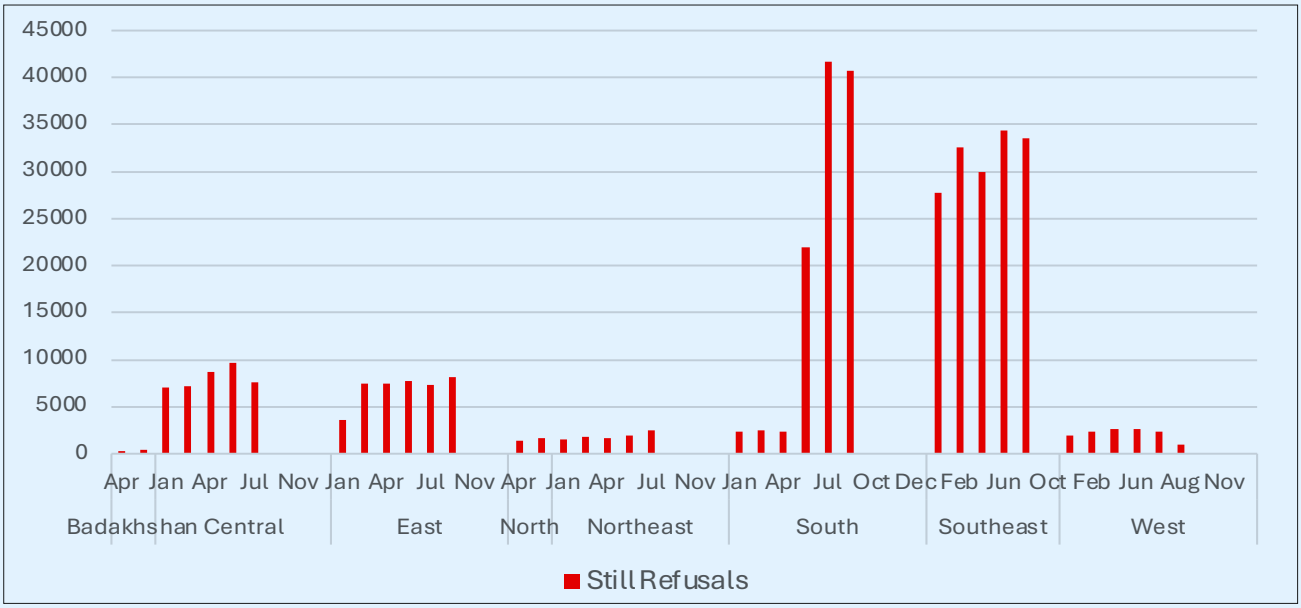
After each SIA, post campaign assessment (PCA) is conducted to identify actions to be undertaken for rectification of deficiencies in the next round to check the campaign coverage. PCA results in the 2024 NIDs showed that the proportion of missed children nationally ranged from 8% in January to 13% in December. According to PCA data, the main reason for missed children was absence during campaign (3.4%). Figure 9 demonstrates the reasons for missed children in 2024.

Figure 9: Reasons for missed children, post-campaign assessment in SIAs, 2024



The number of refusals increased in 2024, from 39,816 in the April NIDs to 63,993 in the June NIDs. The Southeast used to report the highest number of refusals in the country, but in July and August 2024, with the starting of missed children recording during H2H campaigns in Kandahar and Hilmand, the South region reported the highest numbers, with 41,667 and 40,705 refusals, respectively, in the July and August 2024 campaigns. The exact number of refusals in the South region could not be ascertained before the campaigns in July and August due to the inability to document the number of children who, in the absence of H2H campaigns, are not brought to mosques and other vaccination sites. It is alarming to note that number of refusals are showing an increasing trend in both Southeast and East regions. The number of refusals in Southeast increased from 27,704 in January to 33,488 in June 2024. In East, the increase was from 3,546 in January to 8,167 in October 2024.

Figure 10: Reported remaining refusals by region, by campaign – 2024



6. Complementary Vaccination Activities

COMPLEMENTARY VACCINATION ACTIVITIES

6.1. High Risk Mobile Populations (HRMPs)

Afghanistan and Pakistan share a long border and form a single epidemiological bloc for virus transmission. Given the large population movement within and between the two countries, HRMPs continued to be a key focus of the programme. HRMPs include long-distance travellers, communities that straddle the shared border or are close to it and who are very difficult to access due to conflict, insecurity, or remoteness, people with property on both sides of the border, returnees, refugees, displaced populations, nomads and seasonal migrants.

Based on need, the programme deployed transit teams on key nomad routes, conducted mapping of displaced populations, and ensured their inclusion in micro-plans. It also strengthened inter-sectoral collaboration with the Afghan Red Crescent Society, IOM, UNHCR, and other relevant agencies. HRMPs focal points were deployed in the West, Southeast, and East regions.

The risk of continued poliovirus circulation through the importation of the virus due to population movement highlights the need to explore additional ways to reach and vaccinate children. This has been achieved through the implementation of complementary vaccination activities. The strategies to reach HRMPs in addition to polio campaigns, include.

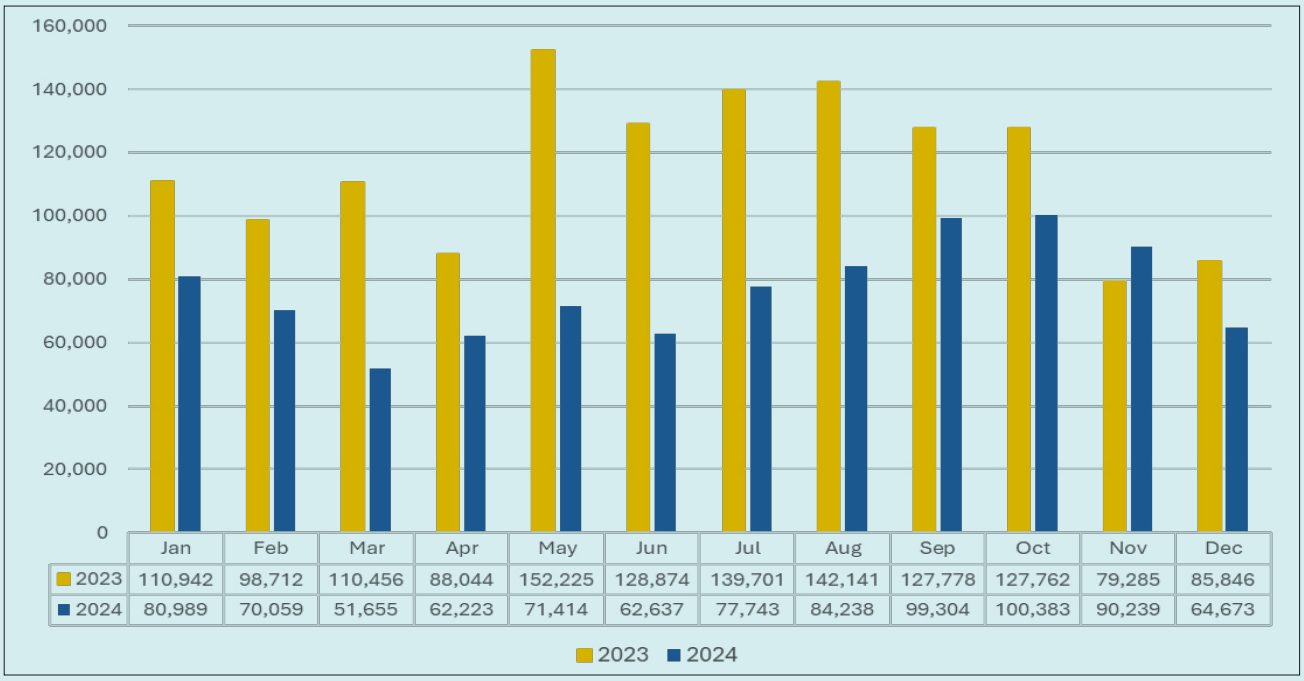
- Permanent Transit Teams providing a firewall for inaccessible or poorly covered areas by vaccinating cross-border travellers and HRMPs at strategically selected locations.
- Cross Border Teams providing bOPV to all age groups at Torkham (since March 2019) and Friendship Gate (since December 2023) border crossings. Children below 10 years are vaccinated at other border crossings.
- UNHCR/IOM Teams covering registered and unregistered returnees coming from Pakistan and Iran. Antigens, including bOPV and IPV, are provided at UNHCR centers and bOPV at IOM centers.
- IHR Teams providing bOPV to all travellers, irrespective of age, to Saudi Arabia and India.

The objective of complementary vaccination activities is to vaccinate children on the move and prevent WPV transmission from infected areas. In 2024, more than 11.9 million doses of OPV were given to children and adults by vaccination teams operating at border crossing points and by Permanent Transit Teams at repatriation centers and airports.

6.2. Cross Border Teams

Cross-border vaccination at the Torkham border has been mandatory for travellers of all age groups since 2019, while at the Friendship Gate border at Spinboldak it is mandatory since December 2023. With enforcement of travel restrictions through the cross- border points, the number of vaccinations decreased in 2024. Cross-border teams vaccinated 915,557 travellers compared to 1,391,766 in 2023.

Figure 11: Vaccination at border points, 2023 – 2024



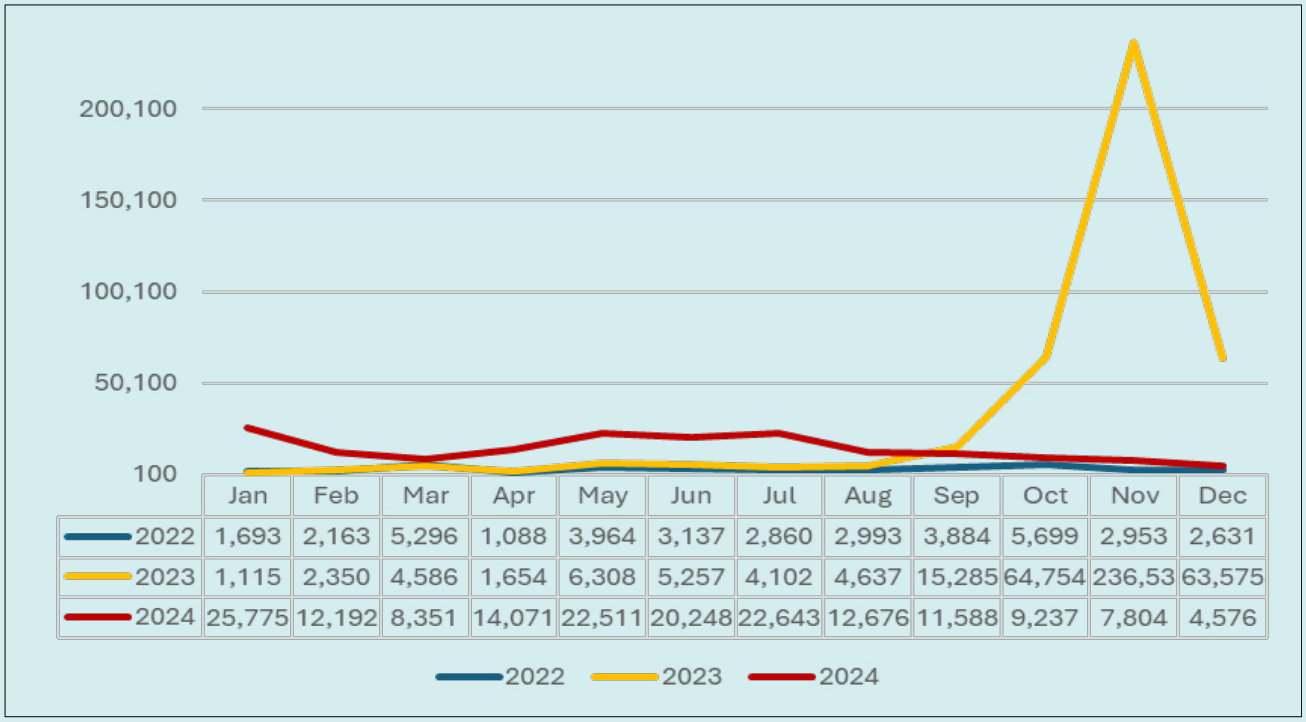
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	110,942	98,712	110,456	88,044	152,225	128,874	139,701	142,141	127,778	127,762	79,285	85,846
2024	80,989	70,059	51,655	62,223	71,414	62,637	77,743	84,238	99,304	100,383	90,239	64,673

6.3. Vaccination of returnees at UNHCR/IOM sites

Pakistan and Iran continue to host large numbers of Afghan refugees. In September 2023, the Government of Pakistan began repatriating undocumented Afghans, creating tremendous pressure on health and social services in Afghanistan. This continued through 2024 and a total of 171,672 children received the polio vaccine at these sites that year, compared to 410,154 in 2023. Close coordination maintained with UNHCR and IOM for vaccination at their centers with real- time data sharing. FLWs were trained to include returnees in host communities in micro plan and districts with significant influx of returnees identified (UNHCR/IOM data) and included in SNIDs. Information shared with BPHS NGOs to cover identified returnees with RI services. Surveillance system was sensitized towards identifying AFP cases amongst returnee population.

Vaccination teams remained active at key border points, ensuring that all eligible returnee children were reached and protected before reentering host communities.

Figure 12: Vaccination of returnee children by month, 2023 – 2024

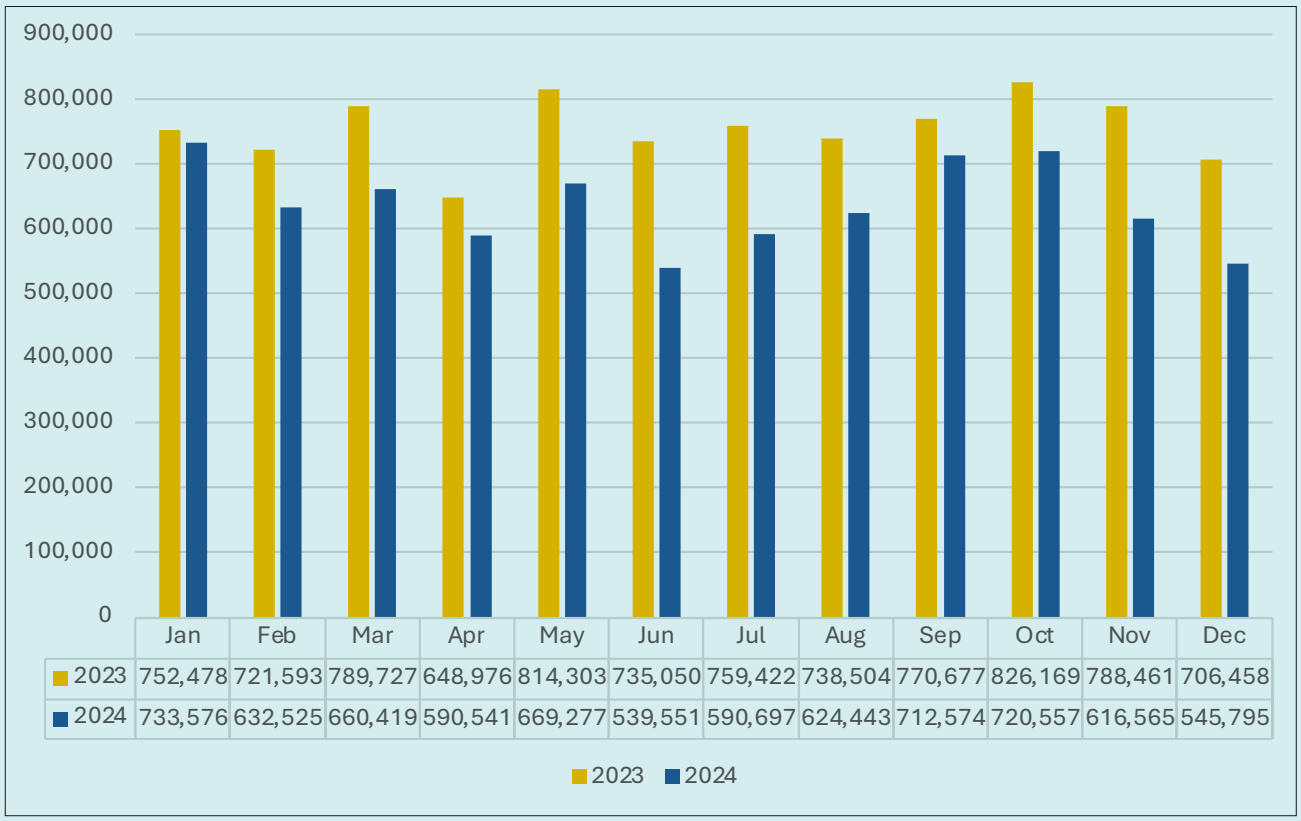


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	1,693	2,163	5,296	1,088	3,964	3,137	2,860	2,993	3,884	5,699	2,953	2,631
2023	1,115	2,350	4,586	1,654	6,308	5,257	4,102	4,637	15,285	64,754	236,53	63,575
2024	25,775	12,192	8,351	14,071	22,511	20,248	22,643	12,676	11,588	9,237	7,804	4,576

6.4. Permanent transit teams (PTTs)

In 2024, PTTs vaccinated 7,636,520 children. The number of PTTs in 2024 varied across months depending on the seasonal nomad movement pattern and ranged from 307 to 206, with an average of 257

Figure 13: PTT coverage by month, 2023 – 2024



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	752,478	721,593	789,727	648,976	814,303	735,050	759,422	738,504	770,677	826,169	788,461	706,458
2024	733,576	632,525	660,419	590,541	669,277	539,551	590,697	624,443	712,574	720,557	616,565	545,795

7. Limitations in Conducting House-to-House SIAs

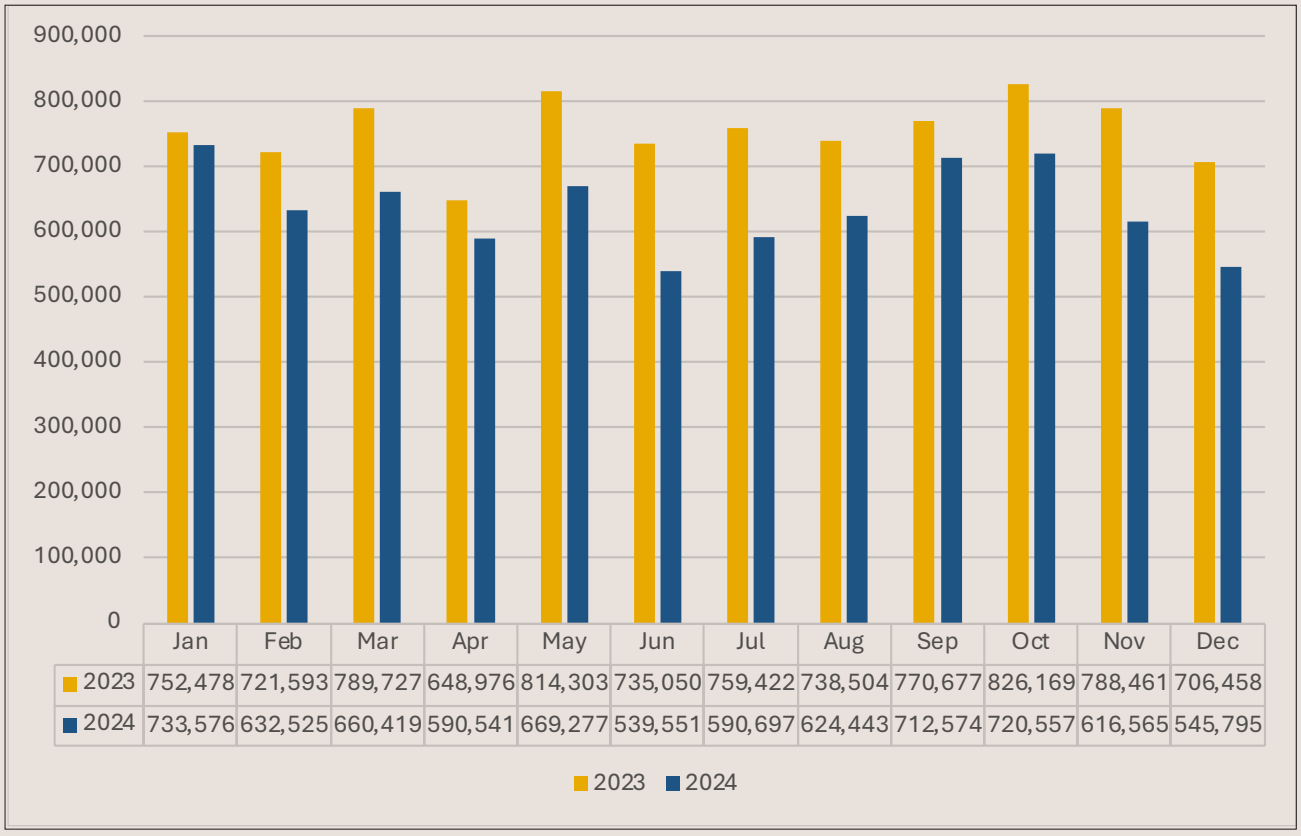
LIMITATIONS IN CONDUCTING HOUSE-TO-HOUSE SIAS

H2H was not allowed in the South, except in Nimroz province, till April 2024. After significant advocacy, all provinces in the South, except Kandahar, reverted to the H2H campaign in June and then in July, all districts of Kandahar were allowed to follow the H2H modality except Kandahar city. However, a country-wide restriction on H2H campaign was imposed in September and instruction was issued to adopt the M2M modality, resulting in the postponement of the September NIDs. After extensive advocacy and local-level negotiations, the campaign was implemented in October, using the S2S modality in most areas, while the M2M modality was followed in the remaining areas. The presence of many unreached children due to restrictions on implementing H2H campaigns remains a significant challenge, leading to widespread immunity gaps and, with them, children vulnerable to polio. Interference in the selection of frontline workers further undermines campaign quality, with missed children being geographically concentrated and mostly below two years of age. The political transition in 2021 enabled the programme to access as many as three million children across the South for the first time since May 2018.

Despite these gains, it is estimated that tens of thousands of children in the South remain unvaccinated due to campaigns being implemented through S2S and M2M in most districts of the region.

According to Post Campaign Monitoring data from the campaign in December 2024, over 15% of children were not reached due to a change of modality from H2H to S2S and M2M. Reported data show that 548,509 children against the target of 4,835,580 were not reached in the December campaign due to the change in modality.

Figure 14: Number of unreached children due to campaign modality, 2024



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
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8. Communication, Community Engagement, and Mobilization

COMMUNICATION, COMMUNITY ENGAGEMENT, AND MOBILIZATION

8.1. Community engagement to increase vaccine acceptance and reduce refusal.

While acceptance of polio vaccination remains high across the country, refusal rates are increasing. Household awareness surveys covering 12,658 caregivers in the December SNIDs indicated that the major reason for refusals is the misperception that the vaccine makes children sick (27%), followed by the vaccine is not Islamic (23%).

The programme aims to address refusals and sustain the gains of high vaccine acceptance and trust in general through community engagement, social mobilization, partnership, communications and advocacy interventions. Achievements in community engagement and social mobilization interventions in 2024 included:

- 638 female mobilizer/vaccinators were trained and deployed to conduct health education sessions at 392 health facilities in polio high-risk provinces in the South, South-east, East, North and West.
- A Knowledge, Attitude, and Practice study was conducted across Afghanistan in 2024 to track the knowledge of caregivers of children under five years of age. Based on the study findings, 63.9% of all respondents said they had actual knowledge of polio, including the poliovirus itself, its symptoms, transmission and vaccine, indicating 36% of the respondents did not have knowledge of polio. 70.1% of respondents expressed their intention to vaccinate their children during the campaign, which is in line with the reported percentage of vaccination. To address this in the South, for example, 4,750 caregivers were reached through community dialogue and public health promotion sessions conducted by female Community Engagement Officers.
- As part of the cross-border initiative, 152 community influencers were mapped in eight districts of the South and 482 influencers in the Southeast. These influencers continue to engage communities on the importance of polio vaccination.

8.2. Increased community trust and confidence by strengthening community networks and engagement to reduce missed children and refusals

In 2024, the Afghanistan Polio Programme focused on intensifying community engagement and communication between campaigns to counter a concerning rise in vaccine refusals, despite overall high levels of campaign awareness. The nationwide household surveys conducted in June 2024 revealed that 80% of respondents were aware of the vaccination campaign; however, persistent misconceptions, such as the belief that the vaccine is haram (24%) or causes illness (23%), continued to undermine acceptance and contributed to missed children in key high-risk provinces (UNICEF, 2024).

Recognizing that sustaining demand requires more than just campaign awareness, the programme invested in building community trust and reshaping and expanding narratives to reach underserved populations, particularly women and caregivers. A multipronged approach, combining community engagement, social mobilization, faith-based engagement, creation of local partnerships, and capacity building at subnational levels, was implemented to address socio-religious concerns, combat misinformation, and close immunity gaps.

Key Milestones and achievements:

- **Generating Qualitative Evidence for Adaptive Programming:** A refusal assessment was conducted in 2024 revealed that **69.2% of hard refusers** did not believe that poliovirus is real. Of these, **75.4% had no formal education**, and only **13.5% vaccinated their children with routine immunization.** Additionally, **90.1% lacked understanding of how the virus spreads**, and no households in target areas believed that the oral polio vaccine could prevent infection, indicating deep-rooted misinformation and mistrust. Another qualitative study on influencers identified knowledge gaps and recommended stronger **religious engagement and endorsements** to reinforce community demand for vaccination.
- **Female Participation and Empowerment as Catalysts for Change:** While women participation remained a challenge in the country and polio programme; **633 Female Mobilizer Vaccinators (FMVs)** were deployed across the country in health facilities. These FMVs conducted over 126,000 health education sessions with women and families and reached nearly **1.3 million caregivers.** Their presence played a critical role in reinforcing trust between caregivers and health service providers, while addressing common concerns and misconceptions about vaccine safety and religious permissibility.
- In a **notable milestone for the East region,** UNICEF and partners overcame a long-standing gender gap by successfully recruiting **female Social Mobilizers** - a cadre traditionally filled by men. By December 2024, **99.8% of social mobilizers in the East were female.** These mobilizers engaged directly with caregivers in their households and communities, leveraging shared cultural and familial bonds to deliver key health and polio vaccination messages. The result was a **marked decline in the proportion of missed children** and improved vaccine coverage, demonstrating the catalytic power of women-led engagement with families.
- **Expanding Campaign Reach through Community Dialogues:** A total of **8,808 campaign-based social mobilizers (40% female)** were engaged across multiple campaigns, reaching **1.35 million caregivers** with vaccination and polio messages. Their proximity to caregivers and communities and the ability to tailor adapt their communication to address local concerns were instrumental in reducing vaccine hesitancy and increasing caregiver confidence in oral polio vaccination.
- **Leveraging the Local Influencers to Enhance Community Trust:** Over **13,000 community influencers** - including religious leaders, community elders, health professionals, youth, and grandmothers - were mobilized to engage with caregivers and address vaccine-related concerns through culturally appropriate messages. These influencers collectively reached more than **104,000 caregivers,** enhancing community-led advocacy that was critical in regions with entrenched by anti-vaccine sentiments.
- **Improving Campaign Quality through Decentralized Programme Management Structure of Frontline Workers- Communication Cadres:** To institutionalize community engagement at subnational levels, the programme deployed **31 Provincial Communication Officers (PCOs) and 195 District Communication Officers (DCOs).** These officers played a pivotal role in operationalizing the SBC interventions by providing technical guidance and capacity building through supportive supervision, while leading the implementation of context-specific strategies tailored to the unique challenges in different geographical locations.

These DCOs facilitated **community consultations,** tracked **missed and zero-dose children,** and coordinated community-level dialogues and social mobilization. PCOs provided technical oversight, strengthened local partnerships by working with various partners, and ensured alignment between national and sub-national SBC plans. These cadres enhanced campaign responsiveness, ensured better inclusion of high-risk populations in targets, and contributed significantly to implementing **evidence-based** approaches.

The achievements above reflected a shift towards more human-centered approaches that prioritize trust, dialogue, and local ownership. As the programme deepened its community led

interventions, it also recognized the critical role of media partnership and advocacy in shaping public perception, influencing local norms, and reinforcing the credibility of health interventions. Building on this foundation, the next priority was to ensure that key messages were not only heard but also believed—but amplified through two-way communication through community-based structures.

8.3. Communications and advocacy interventions: Strengthening positive environment and public perception towards vaccination through positive messaging and dialogues

In 2024, media and communication efforts aimed at addressing rumors, misinformation, building community trust, and reinforcing public confidence. A mix of media interventions, social media outreach, content production, and capacity building enabled the programme to respond to emerging concerns in real time and sustain momentum in high-risk regions.

Traditional Media

To amplify key messages and counter misinformation, the programme collaborated with traditional media outlets. Regular engagement with media owners helped address misinformation while ensuring coordinated messaging across campaigns. In a rapidly evolving media landscape, shaped by the political transition in 2021, the programme maintained steady coverage and ensured that vaccination messages reached target audiences across the country.

During each campaign, Public Service Announcements (PSAs) were aired to maximize reach. In 2024, radio and television were used extensively during both SNIDs and NIDs.

For each SNID round, **120 radio stations and 35 TV channels** broadcast polio-related PSAs, reaching over **6 million people** per round. For NID campaigns, the reach expanded further, with **170 radio stations** and **45 TV channels** airing messages, reaching approximately **8.08 million people** per round.

In addition, **297 radio roundtable discussions** were conducted throughout the year, creating space for community dialogue and expert perspectives on polio vaccination. Prior to each campaign, more than **340 journalists** in high-risk regions participated in orientation sessions designed to equip them with accurate, timely information, enabling responsible, and informed reporting.

Social Media

Social media platforms - particularly **Polio Free Afghanistan** channels- played a vital role in engaging with parents and caregivers through interactive content, responsive messaging, and direct engagement. The programme created a space where questions and concerns about vaccines could be addressed quickly and respectfully.
An average of 58 million people were reached monthly with polio-related content. By the end of 2024, **the Polio Free Afghanistan Facebook page surpassed 2.6 million followers**, reflecting growing public engagement and trust in digital platforms as a source of reliable information.

Capacity Building

A total of **782 journalists** across the country were trained in 2024 on core principles of journalism, polio-specific content, and best practices in reporting health-related stories. The training emphasized verification of information, ethical reporting, and effective storytelling to counter vaccine misinformation and build public confidence.

Campaign Launches

To ensure continued community ownership and visibility, **campaign inaugurations were held at both regional and provincial levels,** with active participation from local authorities and media. These events served as high-visibility entry points for campaign messaging and reinforced the commitment of local leadership to the eradication effort.

Content Production

Strategic content production remained a cornerstone of communication efforts. Throughout the year, the programme developed a wide range of media products, including **advocacy videos, radio spots, photographs, infographics,** and **information materials,** to educate the public, address reasons behind refusals, and highlight the risk of polio among unvaccinated children.

Dissemination occurred through both traditional and social media channels.

- A total of **648 radio** and **42 television roundtable discussions** were conducted.
- A **radio drama,** produced in **Dari and Pashto,** aired **bi-weekly on 65 radio stations,** serving as an innovative and culturally resonant medium to communicate polio-related messages in an accessible format.

Despite significant investments in communication and advocacy, the programme faced a rise in the number of missed children toward the end of 2024. This was largely attributed to the shift in vaccination delivery from H2H to S2S modalities, which created new access and demand-generation challenges. Nevertheless, communication efforts played a vital role in maintaining public awareness, reinforcing vaccine confidence, and supporting frontline teams in navigating this transition. Trusted media Partnerships, timely messaging, and strong local engagement helped limit the scale of refusals and misinformation, particularly in high-risk areas. These efforts have laid important groundwork for future adaptations of the strategy, ensuring communities remain informed, engaged, and resilient in the face of evolving campaign approaches.

9. Polio Plus Activities

POLIO PLUS ACTIVITIES

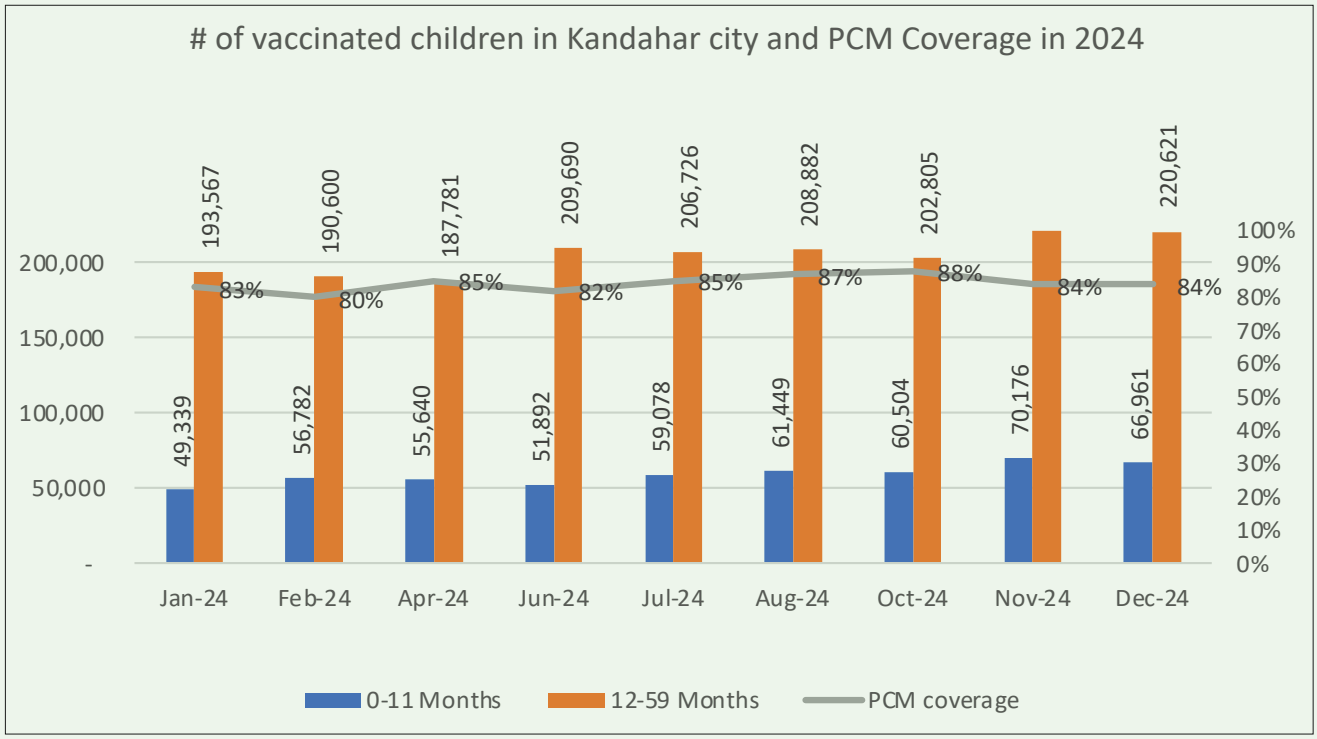
In 2024, the Polio Plus initiative continued to serve as a vital tool for reaching children in the Kandahar, where vaccination campaigns remained restricted to M2M or S2S modalities. These limitations, coupled with persistent immunity gaps, made it increasingly important to find new ways to sustain demand and improve coverage.

Throughout the year, Polio Plus efforts in Kandahar City yielded promising results. The number of children under five vaccinated increased from 242,906 in January to 287,582 by December, an 18 percent increase. More significantly, the number of infants under 12 months who received oral polio vaccine rose sharply from 49,339 to 70,176, representing a 42 percent gain over the same period. These figures reflect the impact of sustained community engagement and the appeal of practical and well-targeted incentives.

To address specific concerns related to low coverage among infants and in chronically missed areas, the programme introduced a revised incentive package in December 2023. Baby diapers were provided to caregivers who brought children under 12 months for vaccination, a move that helped encourage infant turnout. Scarves and caps were given to older siblings who accompanied younger children to sites, while a bar of soap was distributed to each vaccinated child between the ages of two and five. These additions not only acknowledged the effort of caregivers and siblings but also reinforced positive behaviors around hygiene and caregiving.

The refreshed incentive mix proved effective in motivating families to participate in campaigns, especially in areas where traditional outreach strategies were no longer feasible. The chart below shows the trends for the number of vaccinated children in Kandahar city from January to December 2024, as well as PCM coverage over the same period.

Figure 15: No. of children vaccinated in Kandahar City, Jan–Dec 2024



10. Islamic Advisory Group for Polio Eradication

ISLAMIC ADVISORY GROUP FOR POLIO ERADICATION

In 2024, the Polio Programme deepened its partnership with the National Islamic Advisory Group (NIAG) to address persistent vaccine refusals and misinformation in high-risk areas of Afghanistan. NIAG is composed of respected religious scholars and experts who advocate for polio vaccination through faith-based messaging rooted in Islamic principles. Their involvement has been critical in contexts where cultural sensitivities and security constraints limit the direct engagement of the programme. Through religious guidance, NIAG members affirmed the safety and religious permissibility of the polio vaccine, thereby countering deeply entrenched rumors and increasing trust among caregivers.

NIAG members conducted targeted community engagement activities across several high-risk provinces, particularly Kandahar and Hilmand, where vaccine refusals remain concentrated. They organized meetings with tribal elders, mosque imams, madrasa teachers, and local influencers to address concerns and build support for vaccination. Over the years, they facilitated the training of more than 300 frontline workers on Islamic perspectives related to health and vaccination, social mobilization, and interpersonal communication. These sessions not only equipped campaign staff with tools to respond to community doubts but also strengthened local capacity to sustain advocacy through culturally resonant messaging.

To advocate the importance of polio and routine vaccination, safe motherhood, hygiene, and disease prevention from an Islamic perspective, the NIAG focal points and members conducted 292 advocacy sessions with the participation of 10,055 religious scholars, students of madrasas, school students, and community elders. Through social media platforms, including Polio Free Afghanistan, the NIAG developed and published 36 Islamic health messages, four articles on polio, and 4,000 copies of a brochure on maternal and newborn health from an Islamic perspective, which were printed and distributed in Bamyan province. NIAG members and focal points also participated in 36 radio and television sessions at the national and provincial levels.

The impact of these efforts was visible through several high-profile refusal reversals, including previously resistant religious leaders who pledged their support for future campaigns. NIAG also helped reinforce coordination between the programme and provincial Ulema Councils, improving alignment between religious advocacy and operational planning. In areas where NIAG engagement was strong, their sessions have now become an essential component of campaign preparedness, contributing to improved vaccine acceptance and supporting broader goals under the child health agenda. Through this trusted network, the programme has made meaningful progress in restoring community confidence and expanding demand for immunization among the most vulnerable populations.

11. Vaccine and Cold Chain Management

VACCINE AND COLD CHAIN MANAGEMENT

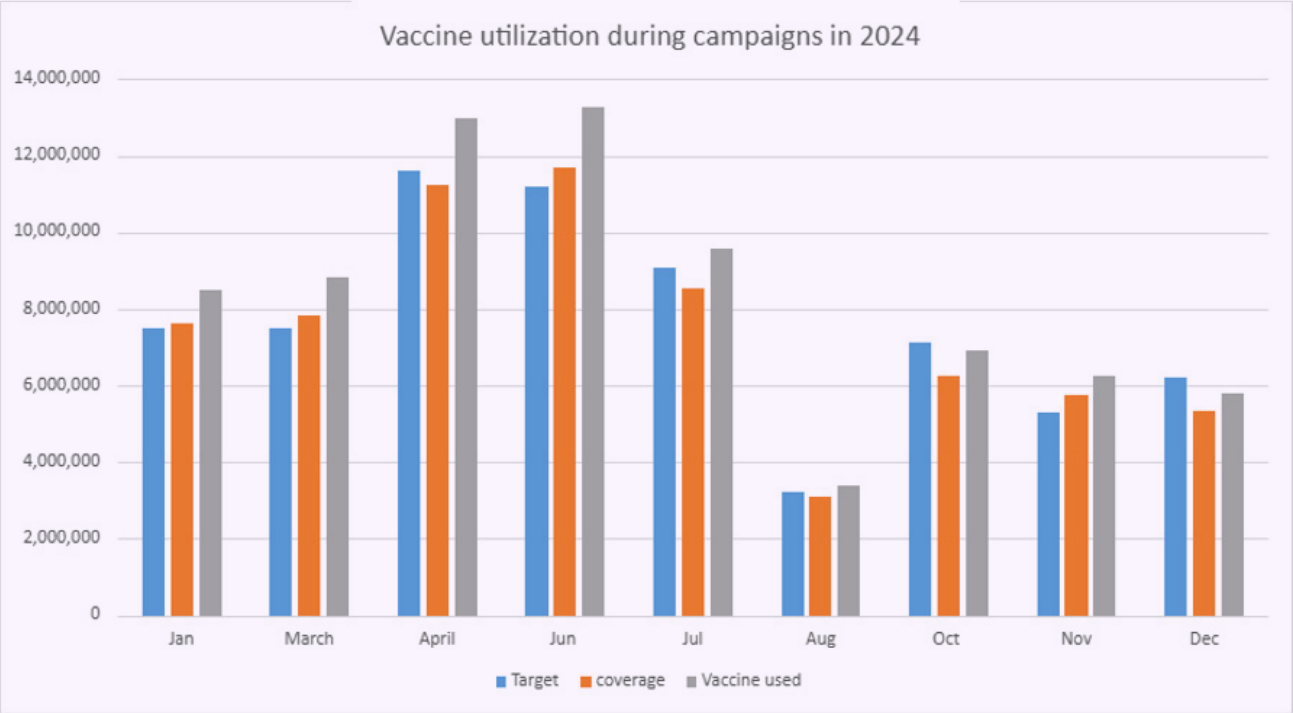
11.1. Vaccine procurement and management

In 2024, the programme continued to facilitate vaccine and cold chain equipment forecasting and procurement for all polio eradication activities including the polio campaigns, complementary vaccination activities and big catch-up. UNICEF procured and delivered over 93 million doses of polio vaccine (bOPV) in 2024 and provided vaccine and cold chain maintenance services to regional and provincial cold chain facilities during and between campaigns. There were no stock outs of OPV during the year, and all vaccine arrival reports were completed within three days of arrival.

The cumulative coverage for all nine polio campaigns was 67,338,735. A total of 9,644,411 or (14%) vaccinated through Complementary Vaccination Activities. Vaccine utilization reports from the provinces indicated average wastage rates of 11%, less than the 15% recommended. Empty and unusable vaccine vials returned from the field were safely disposed.

The distribution of vaccine and non-vaccine supplies to respective zones and provinces, districts, clusters, and service delivery points were completed as per the national schedule, maintaining optimum temperature. A strategy to decrease vaccine wastage was followed which involved OPV distribution and return of remaining OPV vials after each campaign to the Regional EPI Management Team or Provincial EPI Management Team vaccine storage facilities.

Figure 16: Vaccine Utilization in 2024



11.2. Cold chain management

The programme strengthened the cold chain system at all levels and the provision of cold chain equipment based on quarterly inventory of cold chain equipment. For maintaining optimal storage capacity, a total of 100,000 icepacks, 20,000 vaccine carriers, 2,000 cold boxes and 70 deep freezers were procured in 2023 for 2024 and distributed to sites based on quarterly inventories.

For strengthening vaccine and cold chain management, 260 key PEI/EPI staff involved in vaccine and cold chain management were trained on correct vaccine and cold chain management during polio campaigns. six cold chain technical extenders at regional levels provided technical support to the cold chain team at regional and provincial levels.

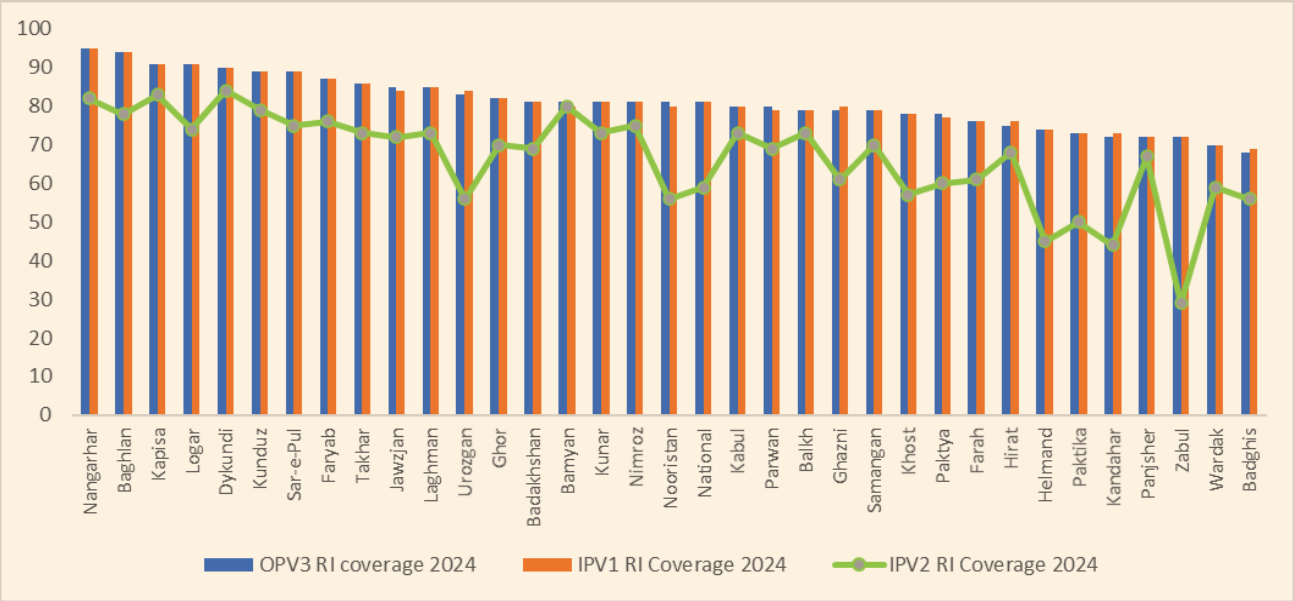
12. Routine EPI Strengthening

12.1. EPI activities and immunization coverage

Afghanistan's routine immunization strategy continues to rely on fixed-site vaccinations, outreach sessions, and mobile vaccination teams. In 2024, these services were provided through 2,741 fixed sites across public and private health facilities.

The immunization programme targeted 1.7 million children under the age of one. Reported coverage for the third dose of oral polio vaccine (OPV3) and the first dose of Inactivated Polio Vaccine (IPV1) reached 81%, while the second dose of IPV (IPV2) coverage stood at 66%. Whereas according to WUENIC estimates, the OPV3 and IPV1 coverage reached at 59%, although IPV2 coverage remains very low at 49%.

Figure 17: OPV3, IPV1, IPV2 Routine immunization – reported coverage 2024, by province



Moreover, the provincial-level data reveals that 20 provinces reported OPV3 coverage rates more than 80%, while 14 provinces reported less than 80% routine immunization coverage. As the last census was conducted in 1979 and routine vaccination procurement mostly rely on the UN population, which was around 43.3 million in 2024, and current population estimates are based on projected growth rates at 2.4%. Figure 17 illustrates the reported OPV3, IPV1 and IPV2 coverage for 2024.

The programme regularly analyses data on the routine OPV vaccination status of non-polio AFP cases and shares the findings with the polio field teams as well as with the EPI for taking necessary measures to investigate why the children were missed and actions to be taken to ensure their coverage. The data for 2024 show that 27% of 978 AFP cases aged between 12-23 months received less than three doses of OPV through the routine immunization programme, while the proportion of children with 'zero dose" among this age group is 13%.

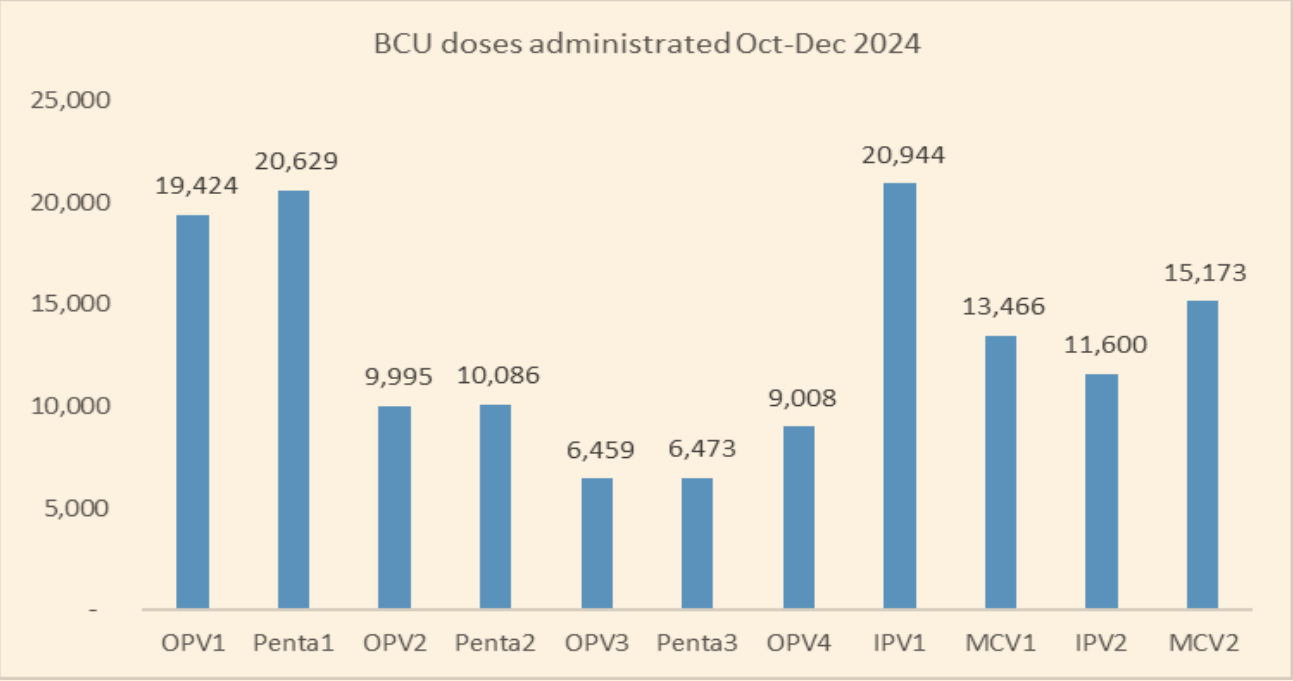
As part of support to the EPI, polio field staff monitor support to routine immunization activities at fixed sites, and among outreach and mobile teams. In 2024, WHO Provincial and District Polio Officers conducted 3,560 monitoring visits to routine immunization activities, an increase from 1,833 in 2022.

The National EPI in 2024 conducted the following activities to strengthen routine immunization and VPD surveillance in Afghanistan:

- Capacity building of 5,500 vaccinators on integration of Big Catch-up vaccination in routine immunization in primary health care for under-five children, who have missed their scheduled vaccination during the COVID-19 pandemic and before the government transition due to active fighting in the country.
- A 21-day pre-service training programme was conducted for 385 newly recruited vaccinators for sub-health centers across the country.
- An 8-day training programme was conducted for 229 family health house midwives to deliver routine immunization services in remote and hard-to-reach areas.
- Training for 31 regional master trainers was conducted, enabling them to disseminate knowledge to the regional level.
- Training on VPD laboratory surveillance was conducted, resulting in expanded Measles IgM testing capacity at the Central Public Health Laboratory.
- The Central Public Health Laboratory achieved accreditation for Measles and Rubella serology testing.
- VPD surveillance reporting tools are outdated and distributed.
- Samples of measles and rotavirus have been sent to NIH for quality control and genotyping.
- Refresher training on AFR (Acute Fever Rash) surveillance was conducted for regional surveillance focal points.

The Big Catch-up (BCU) activities began in October 2024, and the BCU was officially inaugurated in November 2024 by the Minister of Public Health in the new National EPI building. In the last quarter of 2024, BCU doses were administered through routine immunization strategies, including fixed, outreach, and mobile approaches. The figure below shows the number of BCU doses for different antigens.

Figure 18: BCU doses administered



Similarly, in 2024 Multi Antigen Acceleration Campaign (MAAC) was conducted in 78 polio and measles high-risk districts in 25 provinces. The MAAC was implemented in two phases first phase in 53 districts and the second in 25 districts. Moreover, each phase was implemented further in three rounds. Subsequently, 187,901 doses of OPV3 were implemented in the first phase and 8,358 doses of OPV3 were implemented in the second phase of the MAAC campaign. Furthermore, 48,780 children received IPV1, and 22,728 doses of IPV2 were administered in the first phase of the MAAC, while 21,379 IPV1 and 18,574 IPV2 doses were administered in the second phase of the MAAC campaign.

13. Technical Advisory Group for Polio Eradication

TECHNICAL ADVISORY GROUP FOR POLIO ERADICATION

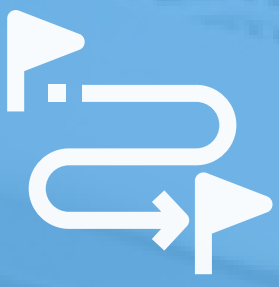
The Technical Advisory Group (TAG) for polio eradication for Afghanistan is an independent group of international experts in public health and polio eradication. The TAG meets once or more each year, depending on the context and need, to review the progress of polio eradication and recommend improvements to the country programme to ensure the goal of eradication is achieved.

The TAG met in Doha, Qatar, from 22 to 25 May 2024 to jointly review the eradication programmes of Afghanistan and Pakistan, the two-remaining endemic, with the aim of further synchronizing eradication activities across the epidemiological block.

The TAG concluded that interrupting WPV1 by the end of 2024 is unrealistic under current circumstances; however, WPV1 interruption may be achievable in the next low season if both country programmes urgently and comprehensively implement TAG recommendations.

The TAG also concluded that in the current epidemiological context, the window of opportunity will soon close if both the countries do not make strategic shifts and take collective action to fully identify, map and reach children missing vaccination. The TAG also recognized that both country programmes clearly understand their challenges, fully acknowledge implementation gaps, and have the resilience and capabilities to address these critical gaps.

TAG appreciated the efforts and resilience of the team in the East region and noted improvements in quality of the programme activities. it was reassured by the external audit's findings related to validity and reliability of both SIAs and surveillance data reported by the programme.



14. Challenges and Way Forward

CHALLENGES AND WAY FORWARD

14.1. Challenges in 2024

14.1.1. The main challenge in 2024 was the restriction on H2H vaccination in the South, particularly in Kandahar province till June, with the quality of campaigns remaining sub-optimal.

14.1.2. Progress was made when H2H campaign was allowed in rest of South, except Kandahar province, in June, and across the entire South region, except Kandahar City, during the July and August 2025 SIAs. However, a nationwide restriction on the H2H modality imposed by the authorities in September 2025 posed a significant risk to progress, particularly in the South region, undermining efforts to halt ongoing WPV1 transmission in that region.

14.1.3. The change in modality of campaign to M2M and S2S risked the gains made in the East and complicated the response to the South outbreak, where a persistent critical immunity gap resulted from previous campaign modalities and bans.

14.1.4. The programme's inability to record missed or absent children during campaigns, due to restrictions on the H2H campaign that prevented daily revisits and Day-4 revisits without a list of missed or absent children, posed significant challenges. Post-campaign monitoring for the December 2024 SIA revealed that 19.5% of children were missed, with 13% in the Northeast Region and 10.5% in the Central Region.

14.1.5. Detailed analysis of data at the cluster level showed that the quality and coverage during campaigns cannot be maintained uniformly at the desired level without the H2H modality.

14.1.6. Presence of high-risk mobile populations within Afghanistan and a significant increase in the number of returnees from Pakistan in the last quarter of 2023, continuing into the first quarter of 2024, posed challenge for the programme. With the virus circulating on both sides of the border, this influx significantly increased the risk of poliovirus spread across the shared border as well as within Afghanistan.

14.1.7. The number of vaccine refusals increased in the South, Southeast, and East regions from January to July 2024. In the East region, where the H2H campaign and recording of missed or absent children were permitted until July, refusals rose from 3,546 to 7,364. In the Southeast region, refusals increased from 27,704 to 33,488 during the same period. In the South region, where the H2H campaign with recording of missed or absent children was allowed in July, refusals reached 41,667.

14.1.8. Low EPI coverage, particularly in polio- risk areas (South, Southeast and Northeast regions).

14.1.9. The lack of updated census data in the country hampered accurate demographic assessments and impacted the effectiveness of health interventions, including vaccinations in RI.

14.1.10. In 2024, interference by local authorities in the selection of frontline workers persisted in some regions, alongside pressure on partners regarding the recruitment of District Polio Officers and District Communication Officers.

14.1.11. Restriction on female participation in campaigns in Kandahar province and elsewhere in the country, particularly in vaccinating children, newborns, infants and sick children.

14.1.12. Similar restrictions on female participation and limitations on community-level interactions severely affected SBC interventions, hindering evidence generation and the effectiveness of SBC strategies.

14.1.13. The programme operates under unpredictable and uncertain conditions with frequent last-minute directives, complicating implementation of campaign activities leading to campaign efficacy.

14.2. Way Forward

The Afghanistan polio programme aims to protect all children across the country by eradicating the virus and securing a polio-free future for all. To reach this goal, the current outbreak must be brought under control as quickly as possible. The polio programme will remain focused on optimizing the modality allowed (S2S) to protect as many children as possible in Afghanistan and reversing the course of the current poliovirus outbreak. This pivot will require tailored approaches in different geographies.

The programme aims to protect gains in the East region and slow the outbreak in the South region by targeting the following milestones by mid-2025, as recommended by the TAG:

East Region:

- No new WPV1 cases
- No persistent lineage detected in positive environmental samples

South Region

- No new polio cases
- Declining trends in the number of WPV1 detections in environmental samples

Everywhere else in country: no local transmission established

- No new local transmission established elsewhere in the country

The polio eradication strategy in 2025 will also need to consider broader contexts, including evolving geopolitical dynamics in the region and globally, an expected influx of repatriated refugees from across the border in Pakistan, and increasing financial constraints on GPEI that will only be exacerbated by donor fatigue if Afghanistan does not demonstrate tangible epidemiological progress in 2025.

To drive progress toward the mid-2025 milestones as outline above amidst an evolving environment of operational constraints and reduced financial resources, the polio programme will focus on optimizing the allowed campaign modality (S2S), ensuring strong government ownership, and leveraging additional partnerships and tools to maximize reach where children are at highest risk of poliovirus.

This translates into four main strategic objectives as follows:

1. **“PUSH”** – To place vaccination service as close to beneficiaries as possible, build capacity and enabling programme to quantify and track missed children.

2. **“PULL”** – To activate community engagement and mobilization to ‘pull’ beneficiaries to vaccination sites (S2S modality) during campaigns as well as to leverage broader communications to create an enabling environment for the programme beyond campaigns.

3. **ADVOCACY** – To improve ownership of the programme at all levels through targeted interactions and messaging through engagement of key decision-makers.

4. **EPI** – To provide operational support to Expanded Programme on Immunization (EPI) in strategic geographies to maximize population immunity in areas of highest risk for poliovirus.

Maximizing PUSH

S2S campaigns, in which families must bring eligible children to fixed vaccination sites during campaigns (unlike the H2H modality, considered the gold standard) require an entirely different operational approach. The programme is focused on placing fixed vaccination sites as close as possible to families who can benefit most from this service:

- Maintain H2H level of vaccination teams to maximize penetration.
- Record missed children in culturally appropriate ways.
- List and track newborns for polio SIAs and for the Expanded Programme on Immunization (EPI).
- Finetune timings of team visits, as well as team composition, to optimize reach of caregivers.
- Conduct Inactivated Polio Vaccine (IPV) SIAs, using jet injectors in the East and South regions.
- Conduct community response vaccinations for specific groups of polio AFP cases
- Systematically map and vaccinate different HRMPs settlement sites.
- Conduct pre-campaign planning meetings with all district governors and departments like PVPV, PHD, etc., local and religious influencers.
- Leverage support of GPEI humanitarian partners.

Maximizing PULL

Optimizing S2S campaigns will also require a clear "pull" strategy that complements the "push" factor by enhancing community trust in the programme and vaccine (as well as awareness of S2S modality), effectively drawing families with eligible children to vaccination sites:

- Build and maintain an enabling environment through traditional and social media partnerships.
- Proactive media messaging in advance of, and during, campaigns.
- Ensuring accurate information access through social media and other platforms.
- Intensify between-campaign activities to engage communities through local influencers/ groups and ensure social mobilization workforce is best-equipped to address evolving challenges.
- Strengthening social mobilizer teams, including increasing number of female mobilizers.
- Strengthen advocacy for local ownership and oversight of SIAs by authorities.
- Identify enablers with influence over local decision-makers at district level.
- Directly engage local authorities ahead of each campaign to ensure support and ownership.
- Strengthen campaign-based mobilization activities to optimize 'pull' to vaccination sites.

Improving EPI in key areas and other integrated measures

While the polio programme will implement clear "push" and "pull" interventions to optimize S2S campaigns, data shows that inherent limitations in the S2S modality will leave pockets of children unreached in the most vulnerable areas, where continued poliovirus transmission meets low routine immunization levels through EPI. To address these gaps, the polio programme will deploy

supplementary efforts to boost children's immunity in the highest-risk provinces, prioritizing the major population centers of Kandahar and Helmand in the South region due to their low immunity levels and historical role as traditional reservoirs and amplifiers of the poliovirus to other regions. With targeted resources, the polio programme will support EPI in the development and implementation of actionable roadmaps in the three highest priority urban/peri-urban areas: Kandahar City, Lashkargah and Nahr-e Seraj. These roadmaps will aim to address key barriers and increase immunization by 30% by the end of 2025 and will include intensified interventions such as Periodic Intensification of Routine Immunization (PIRIs), health camps and Multi-age Cohort Vaccinations (MACs) as appropriate.

- Humanitarian engagement for assistance in positive messaging and community outreach with OPV.
- Community response vaccination for under-immunized AFP cases, or less than 90% area survey, in the South region, followed by review of basic SIA operations.
- Engage female Community Health Supervisors and Workers, or other appropriate mechanisms, through a pay-for-performance scheme to track newborns, mobilize missed children for vaccination campaigns, and provide other health services, particularly in the South region.
- Redirecting WASH interventions to polio risk areas.

Integrated Service Delivery (ISD) approach

A strengthened ISD approach that integrates immunization efforts with broader health services will be implemented to reduce the number of zero-dose children, enhance immunization coverage, and improve child survival and development outcomes. ISD activities will be expanded in polio reservoir areas to combat persistent poliovirus transmission while addressing broader public health challenges by building trust within communities through improved access to essential health, nutrition, and WASH services and encouraging greater acceptance of polio vaccinations. This work will be focused in the four endemic provinces (Nangarhar, Kunar, Kandahar, and Helmand) along with key districts including Jalalabad, Behsud, Batikot, Asadabad, Dangam, Kandahar, Spin Boldak, Shahwalikot, Maiwand, Arghestan, Lashkargah, and Nehr Siraj – as identified based on high polio transmission rates, poor health and nutrition indicators, and low vaccination coverage.

Improving AFP surveillance

In 2025, the programme will continue to expand and enhance desk and field surveillance reviews at the most local administrative levels. The programme will prioritize capacity building, integration, monitoring, and evaluation to continue enhancing surveillance sensitivity and address existing gaps effectively.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