

NATIONAL  
EMERGENCY ACTION  
PLAN FOR POLIO  
ERADICATION

Islamic Republic of Afghanistan

*2018*

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## Acronyms

AFP	Acute flaccid paralysis
BPHS	Basic package of health services
CBT	Cross-border Team
cVDPV	Circulating vaccine-derived poliovirus
DDM	Direct Disbursement Mechanism
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunization
FLW	Front-line worker
HRD	High risk district
ICM	Intra-campaign monitor/monitoring
ICN	Immunization Communication Network
IPV	Inactivated polio vaccine
IVR	Interactive Voice Response
LQAS	Lot Quality Assurance Sampling
M&A	Monitoring and Accountability
MoPH	Ministry of Public Health
mOPV2	Monovalent oral polio vaccine type 2
NCC	National Certification Committee
NEAP	National Emergency Action Plan
NID	National Immunization Day
OPV	Oral polio vaccine
PCM	Post-campaign monitoring
PEI	Polio Eradication Initiative
PEMT	Provincial EPI Management Team
PPT	Permanent Polio Team
PTT	Permanent Transit Team
RCC	Regional Certification Commission
SIA	Supplementary immunization activity
SNID	Subnational Immunization Day
TAG	Technical Advisory Group
UNICEF	United Nations Children's Fund
VHR	Very high risk
WHO	World Health Organization
WPV	Wild poliovirus
WPV1	Wild polio virus type 1

## Message from the HE Health Minister

Polio eradication continues to be the highest priority of the Ministry of Public Health. His Excellency the President of the Islamic Republic of Afghanistan continues to oversee polio eradication efforts and under his direction and leadership the Afghanistan high council for polio eradication ensures full inter-sectoral coordination and a truly national programme.

2017 was a difficult year for polio eradication efforts in Afghanistan, with the country reporting a higher number of cases than the previous year. However, in reflection, while the absolute figures of the polio virus isolation in AFP cases and environmental samples at face value paint a negative picture of polio eradication efforts, we can't afford to lose heart or focus. Despite the daily challenges the programme faces, including insecurity, there has been tremendous progress in improving vaccination reach, campaign quality and vaccine acceptability, all leading to a reduction in immunity gaps.

Poliovirus is now fighting for survival on fewer and fewer focused fronts. We are no longer seeing those maps with dots of polioviruses scattered everywhere, which gives us hope that we are nearing the end despite what the numbers say. 98% of the country is in fact polio-free, which is a tremendous achievement for a country facing enormous and complex challenges.

I am pleased to share with you Afghanistan's National Polio Eradication Emergency Action Plan (NEAP) for 2018, providing a solid roadmap of what it will take to stop polio transmission in the country. Emergency Operations Centers continue to drive the implementation of the NEAP in a coordinated way. Through the efforts of the EOCs, we have seen unprecedented coordination and oversight of polio efforts and importantly, improved accountability.

In 2018, the EOC's will continue to lead and manage Afghanistan's effort to stop poliovirus transmission. Based on the lessons learnt over the past year, Government and partners have clearly articulated the priorities for 2018 which include: stopping transmission in Kandahar and Nangarhar through the full implementation of the Southern and Northern Corridor Action Plans working closely with Pakistan; gaining and maintaining access in the Southern region as well as interventions to improve quality; improving campaign quality in the accessible areas; addressing high risk mobile populations; and improving vaccine acceptance to reduce refusals. Focused attention, resources and activities will be targeted to the remaining reservoirs of the country. This document clearly articulates how we intend to build on recent successes, reverse setbacks, measure results, create an enabling environment, maintain neutrality, foster coordination and implement accountability.

There are a number of challenges that stand in the way of stopping polio in Afghanistan, most notably insecurity and enormous population mobility. I continue to be encouraged by the drive and stamina the EOC teams have, in finding new solutions to address the challenges faced by the programme. We are now starting to see results and these efforts must be further strengthened in 2018 to further close off any immunity gaps, including renewed focus on strengthening routine immunization.

I continue to be inspired by the heroic efforts of the hundreds of thousands of people who are at the frontline of Afghanistan's fight to stop polio despite the challenges they face on a daily basis. We must pay special tribute to those that have lost their lives in the past year – they are the real heroes of the programme and we will strive to ensure an end of polio in their honor.

The Government of Afghanistan is grateful for the continued support of the international community in this collective effort. The opportunity to stop polio transmission is the best it has ever been, due to massive gains in childhood immunity, stronger surveillance, and improved operations. Continued support through 2018 and beyond will be critical to protect past investments and gains made, and most importantly, ensure that children worldwide are protected from polio forever. The Ministry of Public Health appreciates the technical and financial support of all partners and donors. Working together with our partners, I am optimistic that Afghanistan will soon be polio-free.

Sincerely,

**Dr. Ferozuddin Feroz**

**The Minister of Public Health**

## Background and context

Afghanistan remains one of the three polio endemic countries, together with Pakistan and Nigeria. Of these, Afghanistan and Pakistan form one common epidemiological block with shared transmission across the borders.

Since 2016, the programme has scaled up its efforts to stop circulation of WPV. Although Afghanistan, along with Pakistan, has reported transmission in as late as the last quarter of 2017, there has been tremendous progress in polio eradication efforts. Key programme performance indicators including campaign quality (coverage), population immunity, vaccine acceptance and access situation shows that programme is reaching more children than ever before.

Afghanistan's National Emergency Action Plan (NEAP) 2016-2017 has served as the guiding document for all polio eradication activities across the country. The NEAP was fully implemented by all members of the polio team from Government and partners with direct oversight and coordination from National and regional EOCs. The NEAP was regularly reviewed and updated to ensure alignment with the evolving priorities and identified challenges.

It is important to highlight that most areas of Afghanistan remain polio free. Afghanistan was able to stop all ongoing transmission of 2014-2016 in 12 provinces of 5 regions. The new outbreaks of 2016 in Kunar and Paktika were also successfully stopped with a swift and robust response.

In 2017, transmission across the Southern Corridor and within the Northern Corridor has further reiterated the importance of identifying and reaching high risk mobile populations working in collaboration and synchronization with Pakistan. Access continues to pose a significant challenge to polio eradication efforts in Afghanistan. A total of 10 of the 14 cases of polio identified in 2017 are from the Southern Region. The epicenter of this outbreak was in Shahwalikot district of Kandahar which was inaccessible for polio vaccination campaigns for more than six months in 2017. Unlike in past, the new outbreak in Southern region is limited to a relatively small geographical area and has lower peak.

Nangarhar province of the Eastern Region, which forms part of the Northern Corridor, reported three polio cases in the 2<sup>nd</sup> half of 2017. Circulation in east was from the R4C5B5C chain of viruses which has been circulating across the Northern corridor between Afghanistan and Pakistan. Identifying the potential missed pockets and/or groups of populations is one of the major tasks for both Afghanistan and Pakistan during first half of 2018.

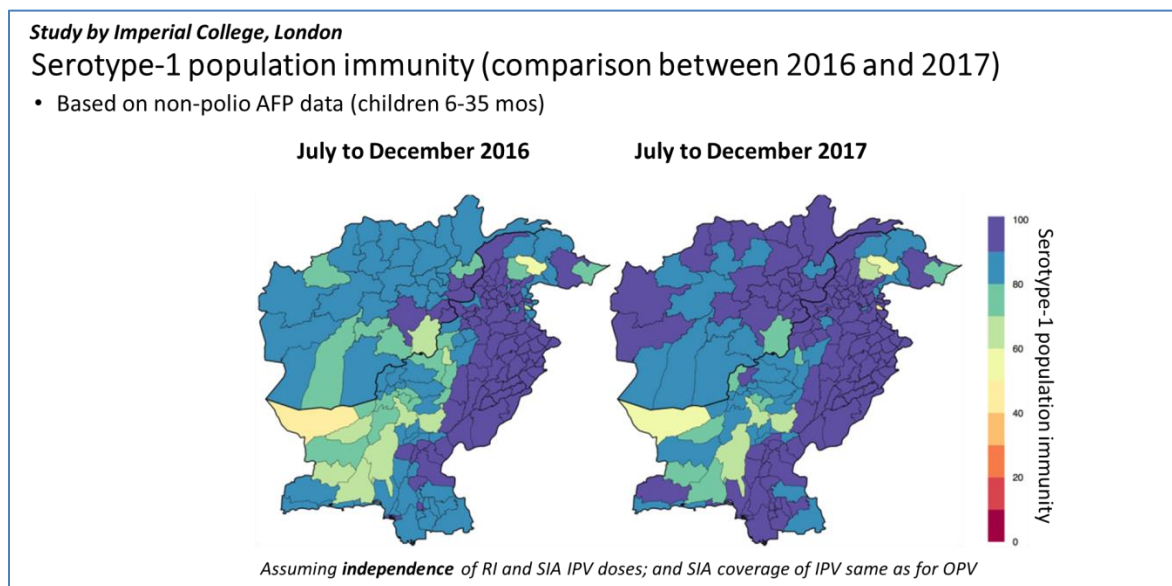
In early 2017, transmission was detected in Kunduz which had more than 150,000 children inaccessible for vaccination since August 2015. This vulnerable population posed a strong risk and a potential for a major outbreak. The outbreak was quickly curtailed through an aggressive response which yielded positive results and no secondary cases.

Afghanistan has continued to expand its environmental surveillance system, which now comprises 20 sampling sites covering all regions of the country. In 2017, a total of 42 WPV isolates were reported from 316 environmental samples, mostly from Kandahar, Helmand and Nangarhar provinces.

An extensive risk categorization process was undertaken in 2015, based on poliovirus epidemiology and other factors, which was further refined during 2017. A total of 15 districts have been classified as ‘Focus Districts’ all of which are in Kandahar and Helmand province. An additional 35 districts are classified as “Very High Risk Districts’ and 53 as ‘High Risk Districts’.

Afghanistan continued to implement an intensive SIA schedule in 2016/2017 which included 4 NIDs and 6 SNIDs on an annual basis. Under the leadership of the National EOC, a number of new initiatives were implemented in the prioritized districts as part of the NEAP to further improve SIA quality. These initiatives are starting to translate into improvements in the quality of SIAs.

Over time, the immunity profile (the history of oral polio vaccine (OPV) doses received) of non-polio acute flaccid paralysis (AFP) cases has continued to show improvement, as seen in analysis done by Imperial college, London.



Afghanistan shares a long border with Pakistan, forming one common reservoir of poliovirus circulation. There are two epidemiological corridors: a northern corridor that extends from the greater Peshawar-Khyber area of Khyber Pakhtunkhwa Province and the Federally Administered Tribal Area in Pakistan into Nangarhar and Kunar provinces of Eastern Region, Afghanistan. The Southern Corridor extends from the Quetta block of Baluchistan province, Pakistan, into Kandahar and Helmand provinces of Southern Afghanistan.

The polio epidemiology in Afghanistan in 2016-17 and experiences from other endemic countries highlight the crucial role of mobile populations in sustaining and spreading polio transmission. These populations are particularly important in the current epidemiological context of Afghanistan as well as Pakistan as they are instrumental in carrying the transmission across borders and making the two countries a single epidemiological block. Both country programmes have jointly developed a HRMP strategy to address these important groups. The programme has identified four main categories of HRMPs that are of importance for polio eradication, including: 1) long distance travelers within the

reservoir areas; 2) straddling populations along the bordering areas; 3) nomadic populations; and 4) returnee refugees. Special plans have been developed on both sides of the border to reach these population groups in coordination with Pakistan.

Since the establishment of the EOCs, coordination with the Pakistan national polio EOC has been strengthened, including regular cross-border coordination meetings at all levels; harmonization of the target age group for cross-border vaccination; improved cross-notification of AFP cases; microplanning and sharing of data from districts on both sides of the border; production of common communication materials and messages used in both countries; and synchronization of campaign dates.

Access to children for vaccination remains a challenge in stopping the transmission of WPV. A large number of children are missed from vaccination during SIAs due to insecurity, mostly because of the inability of vaccination teams to reach children in security-compromised areas. In certain areas, it is possible to implement the campaign, but with limitations in programme oversight and management.

Four categories designate the access status of districts, as follows:

**Category 1 – Fully accessible:** These districts are fully accessible for all components of Polio Eradication programme implementation.

**Category 2 – Partially accessible:** While vaccination campaigns are conducted in some parts of these districts, other areas are not accessible to campaigns.

**Category 3 – Accessible with limitations:** The implementation of vaccination campaigns is possible in these districts. However, the movement of non-resident supervisors and monitors is not without risk; there are limitations and restrictions on effective implementation and monitoring of the performance of all phases of SIA implementation - including FLW selection, training, supervision, and monitoring of campaign activities.

**Category 4 – Inaccessible:** These districts are totally inaccessible for vaccination campaign implementation.

The cause of inaccessibility in Categories 2 and 4 is usually active fighting nearby or “bans” on immunization campaigns. The number of inaccessible children, and the area of inaccessibility, varies from campaign to campaign, owing to the dynamic security situation on the ground. In Category 3 districts, obtaining accurate and objective information on the quality of campaigns remains one of the most critical challenges.

In identifying those priorities for stopping transmission in 2018, the National EOC reviewed the progress made in the implementation of the NEAP, the remaining challenges faced by the programme. The ‘Way forward 2018’ was presented to the Technical Advisory Group (TAG) during their meeting in November 2017 for review and further inputs. Through active consultation with technical partners, field colleagues and other stakeholders, the NEAP 2018 has been adapted to ensure the programme is effectively designed and structured to achieve the target of stopping transmission.



## Progress during the implementation of NEAP 2016-2017

The national polio eradication programme made significant progress in 2016/2017, through the consistent implementation of the NEAP, guided by strong government leadership and strengthened coordination between partners, following the establishment of the EOCs.

During the November 2017 meeting of the TAG, experts acknowledged that there is strong political commitment for polio eradication at the highest level of the government led by HE President, HE CEO and HE Health Minister along with strong support and commitment of WHO, UNICEF and the entire UN system. It also recognized that the national and regional EOCs are functioning in a well-coordinated manner.

The TAG noted that the NEAP 2016-2017 was fully implemented and appreciated that the programme implemented many new initiatives beyond NEAP to address emerging and challenges, including: a revised tally sheet to focus on guest and absent children; household-based microplanning; expansion of environment sampling; HRMP strategy; formation of selection committee to improve selection of FLWs; 15 focus district plan; and cluster approach to address refusals.

The overall objectives of NEAP 2016-2017 related to the interruption of transmission in South and East (Objective 1 & 2), aggressive response to outbreak (Obj. 4) and sustaining high quality of surveillance (Obj. 5) were fully achieved. Although, overall population immunity in the high-risk districts increased, gaps remain particularly in Kandahar province (Obj. 3).

**Strong government ownership and commitment;** Polio eradication efforts in Afghanistan continue to be the highest priority within the Ministry of Health. The TAG and IMB expressed appreciation for the commitment and leadership at the highest level of government, with His Excellency the President personally chairing meetings of the national steering committee leading to strong participation of the Chief Executive Officer, cabinet members, Governors and partners. Under the leadership of the President's office, there is also strong inter-sectoral support across key Ministries to address the challenges faced in the field, through the Afghanistan high council for polio eradication.

**All partners working as one team under the EOC umbrella;** The EOCs have continued to effectively function as the core platform for delivery of the NEAP. Together with the Ministry of Public Health, UNICEF, WHO and other collaborating partners are active members of the Emergency Operations Centre (EOC) to ensure streamlined coordination among partners and granular data analysis to guide quick decision making across the programme. The NEAP continued to serve as the principle document guiding polio eradication activities in Afghanistan and clarifying roles and responsibilities of all partners in the country. Partners plan, coordinate and ensure that the targets of the NEAP were monitored closely and fully achieved. The NEAP clearly brings together all components of the programme and delineates the organization accountable for delivering the activities required to stop polio transmission in Afghanistan.

**New importations in East, Southeast and Northeast successfully contained;** in 2016, the Afghanistan programme faced multiple outbreaks in the Eastern, Southeastern and Northeastern regions of the

country, predominantly in inaccessible areas. As a result of aggressive dialogue, effective implementation of complementary vaccination approaches, deployment of locally appropriate human resources for monitoring, and swift implementation of aggressive polio campaigns, including with IPV, the country has successfully stopped transmission in these areas.

**Overall improvement in quality of campaigns, particularly in VHRDs;** a number of key initiatives were implemented to focus on improving campaign quality in the VHRDs. These included: revised household based microplanning; new tally sheet to include guest children; efforts to improve FLW selection and training; deployment of national monitors; special emphasis on HRMP and increased household and community engagement. As a result of these targeted efforts and additional resources the numbers of failed lots in the VHRDs have reduced from 30 in 2015 to less than 10 percent in December 2017.

**Overall improvement in vaccine acceptability as shown in Harvard Poll data;** the programme continues to assess community attitudes and perceptions through multiple channels. Results of a poll conducted together with Harvard University show improvements in overall acceptability across a number of areas. For example, the percentage of caregivers saying they intend to give OPV every time increased from 83% in 2015 to 98% in 2017 (same districts); the percentage of caregivers who say polio is curable decreased from 43% in 2015 down to 8% in 2017, indicating that community members are understanding the messages being disseminated through multiple approaches by the programme. As a result of efforts to improve trust in the FLW through selection and training, trust in this important cadre of human resources increased from 73% in 2015 to 82% in 2017. Although the country still faces pockets of vaccine acceptability in key parts of the country, overall acceptance remains high.

**Improved access for SIAs in Helmand, Kunduz and Southeast;** although access continues to be a fluid challenge within the Afghanistan context, through intensive dialogue at multiple levels and in particular at the community level, the programme managed to gain and maintain access for campaigns in Helmand, Kunduz and the Southeast. Although there are sporadic pockets of inaccessible children, the programme has managed to gain quality access in Helmand and the Southeast which means better oversight of campaign activities. National and regional monitors can now actively monitor activities in these areas. Of note in 2017, following the notification of a polio case in Kunduz in February, the programme successfully negotiated for full access to implement response activities. Within 2 months, the programme had implemented 3 rounds of SIAs including with IPV to curtail the outbreak. There have been no subsequent cases reported as the result of the rapid response with quality.

**Sustained high quality of surveillance including in inaccessible areas;** the Afghanistan programme continues to focus on ensuring the highest possible quality of surveillance activities to be able to detect and respond to potential cases. Special focus is placed on assessing the performance in the inaccessible areas. During the life span of the NEAP, the number of reporting volunteers was expanded from 17,000 to 28,000 to enhance the reporting system. As well the environmental surveillance system was expanded to include 6 new sites. The surveillance network even in the access compromised areas is reaching well above the global standards. In areas where population density is low leading to zero reporting of AFP cases, the programme has also introduced healthy child sampling to further

supplement the system. It is important to highlight that the surveillance system was able to detect and respond to cases in areas where access is a challenge, including Kunduz.

**Remote and third party monitoring expanded in security compromised areas;** the programme continues to strengthen its focus on remote monitoring to obtain information from other sources, including from independent third-party monitors, feedback from communities and populations through telephonic surveys operated under a call centre which was established at the EOC. Particular focus has been placed on collecting this information from the security compromised areas. During 2017, on an average 10,000 mobile users were surveyed remotely in each campaign to get feedback on the reach. Triangulation of data from different sources helps to validate the monitoring findings and strengthen the quality of monitoring information used for identification of gaps and necessary corrective actions.

**ICN in place in most of VHRDs, flexible approach for remaining areas;** the country has expanded the ICN to most of the VHRDs. However, in areas where it is not possible to implement the approach, flexible approaches are being implemented to support social mobilization activities, including deployment of campaign based social mobilizers, working more substantively through Community Influencers, and having longer term social mobilization personnel at the cluster level.

**Strategy for high risk mobile population being implemented and further strengthened;** in 2017, together with Pakistan, the programme took a more systematic approach to focus on HRMPs. The two countries agreed on four categories of population groups. Specific strategies were developed for all four categories of HRMP and implementation of these strategies continues to be done in close coordination with the Pakistan team. The coordination with Pakistan on HRMP is being further strengthened and joint identification, mapping is being developed.

**Strong cross border coordination with Pakistan at national and subnational levels;** Special emphasis continued to be placed on strengthening coordination with the Pakistan EOCs at all levels, given continued transmission across the common reservoir. In 2017, the country teams met more than 4 times to coordinate campaigns, agree on common strategies for reaching HRMPs and outbreak response activities. There is now a well-defined Southern Corridor Action Plan which was developed collectively to address the unique challenges across 18 priority districts of Afghanistan and Pakistan.

**More transparent data and strong accountability framework;** In 2017, emphasis was placed on strengthening the data and reporting system to encourage an environment of open and transparent sharing of information. The national EOC held regular meetings with the field colleagues to listen to their feedback and encourage people to provide accurate information about the real challenges and issues. A database was established to enlist all FLWs to track performance as well as payment. These efforts have been linked to the accountability framework, where reporting of any false information lead to immediate dismissal.

**Environmental sites revalidated; frequency of collection in south region doubled and six new sites started;** Afghanistan continued to focus efforts on strengthening its surveillance system by revalidating the effectiveness of all environmental surveillance sites. Given the importance of the Southern region,

the programme doubled the frequency of sample collection. As well six new sites were added to further strengthen the system in Kunduz, Balkh, Herat, Khost, Jalalabad and Kandahar.

**External and internal surveillance reviews conducted;** In an effort to identify possible gaps in the surveillance system, in the past 1.5 years, the programme has conducted both internal and external reviews of the surveillance system. There was also an independent desk review conducted by CDC in 2017. The overall findings of the reviews indicated that circulation of WPV/cVDPV is unlikely to be missed.

## Lessons learned in the 2016-2017 period

The key lessons learned during the implementation of NEAP 2016-2017 are helping to guide the development of NEAP 2018. These lessons include:

- Strong coordination at all levels, with clear accountability, is critical to achieve results. Results can be attained most effectively by working as *one team* to deliver *one plan*.
- For access compromised areas:
  - Maintaining neutrality while addressing the issues related to quality in accessible areas with limitations (cat. 3)
  - Continue adaptation to local security context including preparedness for campaign in any window of opportunity
  - Innovative solutions to monitor and intervene for quality
- Strong emphasis on high risk districts (VHRDs, FDs and HRDs) is critical in maintaining focus
- Interventions to strengthen programme basics critical to improving quality (Microplanning, selection, training, revised tally sheets, timely payment and accountability)
- Too many initiatives at one time could be counterproductive
- Deploying appropriate National level staff in high risk areas during pre and intra campaign phase can make the difference in quality
- Focus on high risk mobile populations is critical for success
- Data validation, triangulation and use for action improved programmatic decision making

## Risks and Challenges for implementing the NEAP 2018

The national polio eradication programme continues to face a number of challenges and risks, including:

- continued transmission in the Southern region and further spread to other polio-free areas;
- presence of orphan viruses in the Eastern region signifying ongoing undetected transmission in the Northern corridor and possibility to importations in polio free areas
- areas with chronic inaccessibility i.e. 23,000 under 5 children inaccessible for more than 6 months in Kunar and Nangarhar

- areas having access with limitations resulting in sub-optimal quality campaigns, particularly in Kandahar, Helmand, Farah and Paktika (i.e. have security challenges/ access only with permission resulting in suboptimal campaign quality; have on and off bans)
- suboptimal campaign quality in some of accessible VHRDs, primarily due to challenges related to FLW selection, accountability, training quality and ICM
- Pockets of refusals particularly in Kandahar and Paktika.
- All the above challenges are compounded by presence of high risk mobile populations which are crucial in sustaining and spreading transmission across the epidemiological block. These include long distance travelers, nomads, straddling populations and returnees.

## Goal

To stop wild poliovirus transmission in Afghanistan by the end of the low transmission season (July 2018), with no WPV1 thereafter

## Priorities for 2018

1. Stopping transmission in Kandahar and Nangarhar
2. Gaining and maintaining access specially in the Southern region with focused interventions to improve quality
3. Improving quality of campaigns in accessible areas
4. Addressing high risk mobile populations
5. Addressing refusals

## Objectives

1. To interrupt transmission in the focus districts of the Southern region and the VHRDs of the Eastern region by the end of the ongoing high transmission season.
2. To achieve and maintain high population immunity in the rest of the VHRDs and HRDs, ensuring no secondary cases following possible importation.
3. To achieve and maintain high population immunity among HRMPs
4. To rapidly and effectively respond to any importation of WPV1 and/or emergence of VDPV2 into polio free areas of Afghanistan
5. To maintain high levels of surveillance quality across the country with surveillance quality indicators meeting the global standards in all provinces

## Targets and milestones

1. Interrupt transmission of poliovirus in the Southern region by end January 2018
2. 'Zero dose OPV' among NPAFP cases reduced to 'Zero' by end of Q1 2018
3. Conduct 3 NIDs and 6 SNIDs in 2018 with 2 NIDs and 3 SNIDs during the low transmission season

- a. Reaching over 90% of children during each SIA in all FDs, VHRDs and HRDs as per PCM data
  - b. > 90% lots accepted at 80% in FDs/VHRDs/HRDs
- 4. Cluster level issue based review and intervention in all FDs by end of Q1 to ensure coverage of >80% as per remote monitoring (PCM/TPM)
- 5. Reduce remaining chronic refusals to 50% of current level in focus districts by end of Q2 2018
- 6. Maintain a NPAFP rate of >2/100,000 and stool adequacy of >80% in every district across the country

## Guiding principals

1. Maintain programme neutrality and gain access to **all children with OPV, irrespective of the area where they reside;**
2. **Gain and maintain access** and use flexible approaches;
3. Focus on identified **high-risk provinces, districts, population groups and chronically missed children;**
4. Strengthen programme operations by **continuously improving 'the basics';**
5. Underpin all strategies by sustaining strong **household and community engagement;**
6. Use of polio assets for supporting **improvement in EPI coverage in high risk areas; and**
7. Enhance **monitoring and accountability** of all stakeholders, at all levels.

## Governance and coordination

As highlighted in NEAP 2016-17, during the 2nd half of 2015, an overall governance and management framework for the national Polio Eradication Initiative (PEI) in Afghanistan was restructured to encourage evidence-based decision-making, improved situational awareness, early problem detection and a joint coordinated response. The core role of programme management was assigned to the National Emergency Operation Centers when they were established in late 2015. The following section outlines the governance and coordination structure of Polio Eradication Initiative in Afghanistan.

## Leadership and Oversight

Afghanistan's national polio eradication programme enjoys strong support from the country's highest political leadership. H.E. the President of the Islamic Republic of Afghanistan maintains direct oversight of polio eradication efforts. The President monitors and oversees the implementation of the NEAP through the national Polio Eradication Steering Committee and the Presidential Focal Point for the Polio Eradication Programme. His Excellency encourages the neutrality and impartiality of polio vaccination and other health service delivery. At the national level, a number of bodies continue to govern and oversee the implementation of the NEAP. These include:

- **The Polio Steering Committee:** The Steering Committee is the highest forum used by the national leadership to support the polio Programme. The Committee is chaired by the President of the Islamic Republic of Afghanistan, and its members are the Chief Executive of the Islamic Republic of Afghanistan, cabinet members and governors of all 34 provinces. Meetings of the National Steering Committee take place on a biannual basis to ensure that the eradication Programme is seen and treated as a national public health emergency, with full support from all line ministries, and provincial governors.
- **The Presidential Focal Point for Polio Eradication:** The President of the Islamic Republic of Afghanistan assigned a Focal Point for Polio Eradication to represent the presidential office, provide required day-to-day support through line ministries and governors, and regularly update the President on the programme's progress. The Presidential Focal Point has regular meetings with line ministries and departments and the governors of the high-risk provinces to ensure multi-sectoral support for the polio eradication programme at the national and provincial levels. Recently the office of the Presidential Focal Point enhanced the accountability of governors and line ministries.
- **The Afghanistan high council for polio eradication:** The Afghanistan high council for polio eradication meets during the first week of every quarter. It is chaired by the Presidential Focal Point for Polio Eradication, with the participation of the Minister of Public Health, line ministries and departments, the polio team and representatives of donor and partner agencies. The Afghanistan high council for polio eradication is the second highest political forum which brings together key line ministries and line departments of the government to ensure optimal support to the polio program wherever and whenever needed.
- **Polio Executive Committee:** The Polio Executive Committee is a newly established forum which will have its first meeting in first week of March 2018. The committee is a closed group

comprising the leadership of the MoPH (The Minister of Public Health and National Polio Focal Point), Presidential focal point for polio eradication, country representatives of UNICEF and WHO, director national EOC (incident manager) and polio team leads of WHO and UNICEF. This meeting is meant to ensure the senior leadership of key stakeholders involved directly in programme implementation are apprised of the progress, challenges and way forward which will be provided to the leadership by the National Focal Point.

- **Polio Policy Dialogue:** The Polio Policy Dialogue will meet on a quarterly basis, under the leadership of the Minister of Public Health. The meeting will bring together all in-country donors and partners to ensure all key stakeholders have an accurate picture of the programme performance. Donors and partners will be briefed on the programme progress, challenges and priorities to ensure a collective understanding of the situation.
- During 2018, EOCs will continue to strengthen coordination with line ministries and expand their support wherever needed. Some of the examples of coordination with other units of the Ministry of Public Health and other line ministries and departments are as follows:
  - **GCMU, BPHS Implementing NGOs:** Through the support of Grant and Contract Management Unit PEI/EPI team signed MoU with BPHS NGOs of 5 priority provinces to ensure their engagement within the programme as part of PEI/EPI integration. As per the signed MoU, the programme will continue to provide monitoring and supervision support for fixed, outreach and mobile sessions of routine EPI. During 2018, the support to routine EPI will be further expanded and made more systematic, through monthly coordination meetings. Coordination with BPHS NGOs and GCMU at National/provincial level will be further strengthened with the deployment of a coordinator to be based at the national EOC.
  - **Ministry of Education:** The Ministry of Education is supporting polio programme by engaging all schools in Focused Districts and Very High-Risk Districts of the country in polio SIAs. As part of this programme, school students are engaged as community advocates who report on children missed in the first three days of every campaign. The list of children reported as missed by school students is shared by the school administration for follow up on the revisit day. In 2017, a total of 520 schools in 18 VHRDs and Focused Districts were included in the school engagement programme. In the first quarter of 2018, the programme will be expanded to all focused and very high-risk districts of Kandahar, Helmand, Nangarhar and Kunar. Moreover, in the second quarter of 2018, an impact analysis of the programme will be conducted to assess its role in identifying and reducing missed children.
  - **Ministry of Haj and Awqaf:** The Ministry of Haj and Awqaf continues to support the polio programme in organizing Ulema conferences in priority areas. In Quarter 3 of 2017, the Ministry of Haj and Awqaf agreed to send polio messages along with Juma Khutba, which goes to every registered mosque in the country, before every round of SIAs. During 2018, the polio programme will distribute Fatwa books to all registered mosques through the Ministry of Haj and Awqaf. Before every round of SIAs, a message



from the National Islamic Advisory Group will be incorporated within the Khutba of Juma Prayer and distributed to all mosques.

- **Ministry of Communication and Technology:** The Ministry of Communication and Technology continues to play a crucial role in supporting the monitoring of vaccination reach to all parts of the country. The Afghanistan Telecommunication Regulation Authority (ATRA) provides mobile phone numbers of telephonic subscribers of all companies in Focused, VHRDs, HRDs and other districts with monitoring limitation, that are used by the EOC call center to identify missed households for follow up during the revisit. In 2018, the programme will further strengthen its coordination with the Ministry of Telecommunication and Technology to establish a hotline number to facilitate feedback between the frontline workers, community and the programme.
- **Security Departments:** Maintaining the neutrality of the programme is one of the hallmarks of the Afghanistan polio programme. Despite the complex security dynamics, the programme was able to maintain its neutrality throughout 2017. The role of the security departments in maintaining neutrality is indispensable. The programme will continue to coordinate with the Ministries of Defence and Internal Affairs to ensure that programme neutrality is not jeopardized under any circumstances.

#### At the regional, provincial and district levels

- The provincial governors' engagement in the polio programme has increased, particularly in the high-risk provinces of Southern, Eastern and Western Regions. Multisectoral Task force meetings chaired by the provincial governors are being conducted before most campaigns.
- During 2018, the polio team will ensure that provincial and district polio task forces (Multisectoral meetings) are fully functional and are meeting before every campaign. The key outcome of the meeting will be shared and tracked from the national level.

## Management and Coordination of Polio Eradication Initiatives

### Emergency Operations Centers

The daily operation of Afghanistan's polio eradication Programme is managed by Emergency Operations Centres (EOCs). In line with the recommendations of the global Independent Monitoring Board and TAG, and to ensure quick evidence-based decision-making and timely communication, EOCs were established at the national level and in the country's priority regions during the last quarter of 2015. Four regional EOCs are functional in Eastern, Southern, Southeastern and Western Regions (Figure 6). An EOC is a coordination body that brings all implementing partners of the PEI under a single roof to plan, organize and implement polio eradication activities. It maximizes the use of existing PEI assets rather than creating a parallel structure. EOCs bring together all polio partners to work in the same physical setting for better coordination, information sharing, quick decision-making and joint management of the national polio eradication Programme. To ensure timely communication between districts, provinces and regions, and the national level, EOCs cut through all bureaucratic red tape. After their establishment, polio eradication became a nationally-driven effort. The national EOC has a direct

reporting and commanding relationship with all regional EOCs, Regional Expanded Programme on Immunization (EPI) Management Teams and Provincial EPI Management Teams (PEMTs).

The national EOC has overall responsibility for the stewardship of the national polio eradication Programme. It defines the strategies, identifies the high-risk areas, develops the tools needed, evaluates the Programme, provide programmatic and management support to regional EOCs and tracks the performance of districts. It will continue to ensure that all the strategies developed at the national level, are shared with the provinces and undergo consultation before finalization. While the regional EOCs have some autonomous decision-making power, their main role is to coordinate and execute the strategies defined at the national level. During 2018, EOC operations will be further strengthened by:

- consolidating working group and task team modalities at the national level to ensure effective and coordinated use of resources
- monthly tracking of NEAP implementation
- improving communication and engagement with regional EOC and providing support in the preparation, implementation and assessment of campaign
- further empowering REOCs to take operational decisions
- close guidance from national to regional level in improving the effectiveness and efficiency of the EOCs
- reprioritization of roles and focus so the regional EOCs can spend more time on improving quality of campaigns and addressing challenges in the field
- quarterly reviews of the NEAP implementation with regional teams

In addition to EOCs, provincial coordination units were established during the first quarter of 2016 in the five priority provinces (Kandahar, Helmand, Nangarhar, Kunar and Farah) to support data management.

## **Cross-border coordination**

Afghanistan and Pakistan form one common reservoir of poliovirus circulation. The national polio eradication programme will continue to strengthen cross-border coordination with the Pakistan team at all levels.

As agreed by the national teams of both countries, the following activities will be carried out:

- National level:
  - Fortnightly communication between leads of SIA, HRMP, Communication, Surveillance and M&E task teams/working groups
  - Biannual face to face meetings and regular VCs
  - Event based communication and coordination
- Regional/provincial level:
  - Fortnightly VC, guided by National EOC
  - Biannual face to face meetings

Key areas of coordination will include synchronization of SIAs dates, HRMP strategy, Southern corridor action plan, Northern corridor action plan, surveillance, joint response to outbreaks at the border, Uniform communication materials/messages at cross border transit points and possible coordinated response to refusals where needed

## **Strategic approaches**

The key approaches for achieving the goal of interrupting transmission in 2018 include:

- Intense SIA schedule synchronized with Pakistan and strategic use of IPV in SIAs.
- Sustaining focus on high risk areas
- Southern corridor action plan
- Northern corridor action plan
- High risk mobile population strategy
- Focus on improving campaign quality by improving programme basics
- Data triangulation to improve performance
- Addressing access challenge areas
- Complementary vaccination activities
- Building demand for immunization

## **Supplementary immunization activities**

In 2018, the national polio eradication programme will continue to follow an intense OPV SIA schedule:

- Three NIDs and six Sub-national Immunization Days (SNIDs) as per globally approved calendar.
- The SIA dates are fully synchronized with Pakistan.

For every new polio event, the programme will conduct three response campaigns.

## **Inactivated polio vaccine**

IPV-OPV SIAs will be conducted in chronically inaccessible areas (inaccessible for more than 3 campaigns) as and when access is gained.

## **Focus on high-risk areas**

The national polio eradication programme continues to focus attention and resources on high-risk areas to achieve the goal of stopping the transmission of WPV. Certain geographical areas and groups are more vulnerable to polio transmission and they have played a vital role in sustaining transmission over time.

An analysis of the past cases in Afghanistan has shown that more than 80% of cases have come from six provinces: Kandahar, Helmand, Nangarhar, Kunar, Paktika and Farah. These are considered the high-risk provinces.

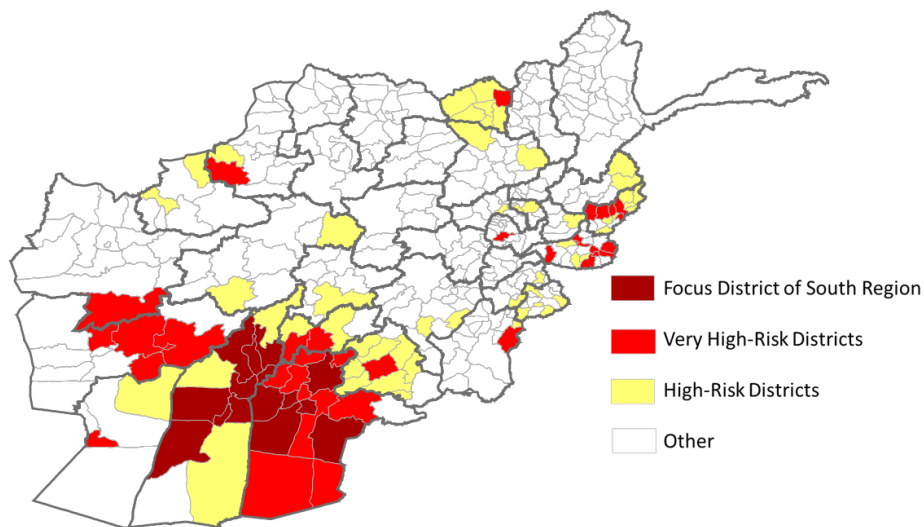
Based on poliovirus epidemiology and other factors, including access to implement SIAs, population immunity and the presence of refugees and internally displaced persons, Afghanistan has identified 103 districts which are at relatively higher risk for polio transmission.

Further disaggregated district level analysis shows that 15 districts of Kandahar and Helmand have been responsible for 90% of cases in the southern region over the past decade and are responsible for all chains in Afghanistan which have lasted for more than 6 months. These 15 districts are classified as 'Focus districts'. Apart from these, 35 districts have been classified as 'Very high risk districts' and 53 as 'high risk districts'.

A review of the epidemiology of the poliovirus in 2016 and 2017 clearly shows the accuracy of the risk categorization of FDs and VHRDs. The programme will continue to focus efforts and resources in these districts, while maintaining good quality activity in the HRDs and Non HRDs.

A special '15 district plan' was developed in late 2017, as part of the broader Southern Corridor Action to focus attention on these priority areas.

#### **Risk level in districts of polio transmission, 2018**



### **Southern corridor action plan**

Quetta block along with Kandahar and Helmand form the southern corridor of transmission within the Afghanistan-Pakistan epidemiological block. The epidemiology of poliovirus further highlights the importance of population movement and shared features within this corridor. In order to address the

challenges of this corridor, Afghanistan and Pakistan have developed the Southern Corridor Action Plan focusing on 15 districts of Helmand and Kandahar and 3 districts of Baluchistan.

These 15 districts of the southern region include 9 districts of Helmand and 6 districts of Kandahar. Together these districts have 1.1 million under 5 children and have been responsible for 90% of all polio cases in the Southern region as well as for all chains of transmission that have lasted for more than 6 months.

These districts have unique socio-political and security related challenges which makes them vulnerable for transmission including high population movement. Districts in this region also have complex challenges to achieving consistently high vaccination coverage. As part of the Southern Corridor Action Plan, Afghanistan aims to focus on improving population immunity in 15 focus districts along with fully implementing the HRMP strategy in the region. In 2018, this plan will be fully implemented with strengthened coordination with Pakistan and tracking from the national level.

The key components aimed at addressing the challenges in 15 focused districts are:

### **Cluster level analysis and plan of action**

After each campaign, cluster level analysis will be conducted to assess various components of campaign implementation for corrective action ahead of the next campaign. The analysis is done using a standard tool for cluster level data collection, identifying challenges and planning corrective actions on the following components:

- Access status
- Vaccine acceptance
- Operational challenges such as missed areas, FLW selection, training and implementation etc.
- Dynamics of high risk mobile populations and plans to vaccinate them

### **Continuous senior national level officer support in the region**

Senior officers representing the National EOC will facilitate the cluster level analysis that includes extensive discussions with individual district teams. The cluster level analysis will inform the development of an action plan to address the identified issues. The senior officer will also help identify areas where support is needed from the regional and national level and coordinates these actions from respective levels. The implementation of the cluster wise plan is followed up after each campaign for compliance.

### **Gaining and maintaining access**

Inaccessibility and insecurity have direct impact on missed children and the quality of campaigns in the focus districts, as the majority of these districts are not under the direct control of the government. Hence gaining and maintaining access in these districts becomes very important while at the same time making efforts to improve campaign quality by ensuring programme basics are in place. Interventions in this aspect are:

- Maintaining programme neutrality
- Flexible approach for vaccination in these areas as per the prevailing security and access situation
- Dialogue at all levels with key authorities/stakeholders to ensure they are on board to minimize potential disruptions to access
- Deployment of national / regional level staff to improve campaign quality focussing on programme basics; remote monitoring of campaign's quality using mobile technology and third party monitoring; and sharing feedback on the gaps in quality and operations with concerned authorities

### **Deployment of national staff to ensure proper selection, training and monitoring**

National monitors are deployed to focused districts ahead of each campaign to overcome the operational challenges and to have a national level oversight on all phases of campaign implementation in these districts. The national monitors focus on proper selection of FLWs, ensure replacement of poor performers, monitor the quality of trainings and various preparatory meetings and monitor the implementation of the campaign. These monitors debrief the provincial and regional teams and assist them in planning corrective actions. All monitors are debriefed at the national level after each campaign.

### **Cluster approach to address refusals**

Some priority districts, particularly in Kandahar, have a relatively higher proportion of refusals which are clustered in some specific areas for example Kandahar, Panjaway, Spinboldak, Zherai and Shahwalikot.

For addressing refusals in these districts the following interventions will be implemented:

- The social mobilizers list each child in their team area in the ICN registers and track the vaccination status of each child in each campaign (where ICN are deployed).
- The refusals are identified and the reasons of refusals are recorded. Status of refusals is tracked over the rounds to identify chronic refusals. Based on the reasons of refusals, influencers are identified for each cluster. Along with the DC, DPO and DCO of the given cluster, these influencers form a refusal committee which visits the identified refusal families to ensure vaccine acceptance.
- Social mobilization activities such as media interactions, door-to-door dissemination of IEC material, mural wall art paintings, local circus with polio message, generating support from local doctors etc. are also undertaken to increase the awareness.

### **High risk mobile population strategy**

The Southern Region has significant numbers of all four types of high risk mobile populations namely a) long distance travellers within the reservoir areas; b) straddling population along the bordering areas; c) nomadic populations; and d) returnee refugees.

The strategies adopted to vaccinate these mobile populations are:

1. Long distance travellers within the reservoir areas: identification of areas with high number of travellers, assessment of seasonality and movement patterns through community surveys by ICN and focus on vaccinating non-residents during FLW trainings. These populations are also vaccinated at cross-border vaccination points.
2. Straddling populations living along the bordering areas: mapping of areas with straddling populations and populations related to these tribes, inclusion of these populations in microplan and focused monitoring of implementation, cross-border coordination to identify influential religious leaders to address refusals in these populations and vaccination at cross border vaccination points.
3. Nomadic populations: mapping nomadic groups, routes, seasonality and transit places, permanent transit teams along the routes of travel of nomads, additional seasonal transit teams during the season of movement of nomads, cross-border posts at the point of entry of nomadic groups.
4. Returnee refugees: OPV, IPV and measles vaccination at UNHCR and IOM centers while the returnees visit to collect assistance benefits, cross-border posts strengthened to cater to increased flow through borders at Friendship gate in Kandahar, coordination with MORR, UNHCR and IOM to get data on villages/districts of final settlement of returnee populations, flagging villages and districts with high number of returnees to ensure their inclusion in microplan, and focus on training and monitoring.

### **Periodic staggered campaigns**

To ensure greater focus on campaign preparatory activities and monitoring of implementation, the campaign in 15 focused districts will be staggered, once in a quarter, to mobilize national, regional and provincial PEI partner staff to support the campaigns. This greater focus is helpful for cluster level interventions and improving the quality of the campaigns in these districts.

### **Polio Plus including improving EPI coverage**

The Minister of Public Health has directed the acceleration of EPI activities in the 15 focused districts. In order to improve population immunity and increase the vaccine acceptance, PEI will coordinate closely with other departments and ministries to provide polio plus services.

- NEOC and REOC will closely collaborate with the BPHS implementers for improvement in EPI coverage in these districts.
- Wherever feasible and needed, mobile health teams will be deployed to provide health services. Close oversight should be maintained to avoid duplication of services in these areas and to ensure full programme implementation.

### **Additional monitoring methodologies**

Given the limitations of monitoring some parts of the region, alternate methodologies of monitoring are deployed which are triangulated with other data sources. Alternate monitoring methodologies adopted

are 1) Remote telephonic monitoring, 2) School engagement in polio programme 3) third party monitoring.

## **Northern corridor action plan (NCAP)**

The dynamics of virus transmission in recent years and molecular data establishing cross-linkages across borders shows that the Nangarhar and Kunar province of Afghanistan in the Eastern region along with the greater Peshawar area of Pakistan forms a common epidemiological zone. This is commonly referred to as the 'Northern corridor' for polio transmission. The epidemiology is further complicated by the identification of multiple orphan polioviruses since January 2016 indicating the presence of areas or populations that may be isolated from surveillance and/or vaccination activities. The complex epidemiology is created by the extensive intermixing of populations across the borders for various socio-economic reasons and a huge influx of returnee refugee populations since June 2016.

During its meeting in November 2017, the TAG recommended that a Northern Corridor Action Plan should be developed jointly with Pakistan by the end of Q1 2018 with the aim of identifying potential population groups which may be harbouring and spreading transmission in the northern corridor.

Key objectives:

- Joint efforts of Afghanistan and Pakistan PEI programmes to identify any geographical or social clusters beyond the reach of the programme.
- Further strengthening the ongoing vaccination and surveillance activities in the corridor.

The NCAP will be fully developed, implemented and monitored in coordination with Pakistan. This plan incorporates the following targeted activities to fulfil the planned objectives:

### **Focus on returnee refugees**

Since June 2016, a huge influx of returnee population has been witnessed moving back to Afghanistan from Pakistan. Torkham border is one of the two major border crossing points between Afghanistan and Pakistan and a significant proportion of returnees take this route of entry into Afghanistan. Key interventions for reaching returnees are:

- Vaccination of returnee children with bivalent oral polio vaccine, inactivated polio vaccine and measles vaccine at the point of entry and at repatriation centres.
- Gathering information on point of origin and destination from the MORR, UNHCR/IOM data, periodic household surveys by the ICN social mobilizers.
- Identification of villages with high returnee refugees and temporary settlements and inclusion in the polio microplans for a greater focus during SIAs.
- Gearing up surveillance system in area of settlement for reporting of any AFP cases

Apart from the vaccination of this population, as a part of the national HRMP strategy, specific interventions are undertaken to vaccinate nomads, guest children and straddling populations.



## Identification of social/geographical clusters of unreached populations across borders

The presence of multiple orphan polioviruses indicates the existence of unreached populations which may be socially and/or geographically clustered. The following interventions will be done to identify these populations:

- Mapping of geographical clustering of under reached populations (for SIAs and surveillance)
  - Inaccessible clusters of Afghanistan and corresponding areas in Pakistan; vacated areas/ security compromised areas of Pakistan and corresponding areas of Afghanistan
  - Accessible areas which are potentially being missed or have suboptimal/unknown campaign quality/ surveillance
  - Movement patterns of these populations, including formal and informal routes
- Social mapping and profiling of populations, including movement pattern, linked to human or environmental poliovirus isolate
  - reviewing the status of surveillance and immunization activities in a disaggregated manner in relation to the mapping and profiling conducted
- Using geo-spatial technology to triangulate various information available with the programme

## Addressing inaccessible areas

In Eastern region, there are small sub-district level pockets of chronically inaccessible children for vaccination. These populations are scattered in small clusters across the eastern region and are probably not large enough to sustain transmission over a long period of time. However the following interventions will be undertaken by the programme:

- Strengthening of AFP surveillance activities to identify AFP cases from inaccessible areas
  - Surveillance review in inaccessible areas including engagement of a locally appropriate third party to search for AFP cases in the community
  - Expanding the surveillance network in areas bordering inaccessible populations – this includes involving any possible health facility of any type in the surveillance network
  - Frequent surveillance visits to reporting sites and reporting volunteers which may possibly cater to inaccessible populations
- Deployment and continuous review of permanent transit teams at the entry/exit points of inaccessible areas
- Health camps in and around inaccessible areas to provide vaccination and to identify any AFP case

## Sustaining quality of campaigns with a focus on improvement in the weak areas

Cluster and team level analysis of SIA quality will be conducted to identify weak areas including gaps in coverage due to programme performance, insecurity or refusals. These gaps will be addressed in a systematic manner prioritizing VHRDs and HRDs for interventions.

## **Additional monitoring methodologies**

Given the limitations of monitoring in some parts of the region, alternate methodologies of monitoring are deployed which are triangulated with other data sources. Alternate monitoring methodologies adopted are 1) Remote telephonic monitoring, 2) school engagement in polio programme 3) third party monitoring.

Monitors from the national and regional levels will also be identified who have access in those areas.

## **Enhancing campaign quality**

The national polio eradication programme has identified a number of interventions to improve the quality of campaigns. These will be prioritized in the high-risk provinces and FD/VHRDs.

The focus of the programme is on identifying clusters of chronically missed children and refusals, and on ensuring that communication and operational plans are aligned to address the local issues at cluster level.

The key interventions for improving quality are outlined below.

## **Microplan revision**

In 2017, microplans have been revised with physical validation of each house and settlement. This was completed in 364 districts of the country. 35 districts are remaining due to security concerns.

In 2018, the programme will:

- Complete the microplanning exercise in 35 districts. If physical validation not possible due to security, satellite imagery will be used to guide the microplanning process.
- In Q3-Q4, the house based microplanning will be repeated across the entire country
- Apart from these, microplans of all the districts will be updated regularly to include new settlements and HRMPs.

## **Front-line worker selection, motivation and capacity building**

Front-line workers (FLWs) and their supervisors are the key polio field staff delivering polio immunization services to the population. In 2016-2017, the programme has taken many steps to improve the selection of FLWs, to improve the quality of training by revising the module and monitoring of training from national level, as well as ensuring timely and transparent payment and implementation of accountability framework.

In 2018, the programme will continue these interventions as outlined below:

## **Improving team selection**

- Selection committees at provincial level will be made fully functional and responsible for the oversight of FLW selection and performance. Selection committees in the high risk provinces will

have at least one female member, to promote the recruitment of female FLWs. These committees will be held accountable for appropriate selection as per the guideline.

- Special focus will be put on engaging more females as FLWs, particularly in urban areas. Illiteracy will not be a barrier in selection as vaccinator (at least one of the vaccinators should be literate).
- For focus districts, the selection of district and sub-district level FLWs will be overseen by national/regional level staff.
- Strong steps will be taken against interference in selection.
- FLWs registration and tracking from national level will be continued.

### ICN as one of the two team member

The Afghanistan TAG Meeting of April 2017 agreed in principle with the country proposition of piloting a two-member team approach to strengthen the linkages between operations and communication as well as to streamline resources. The two-team members would be composed of one vaccinator (campaign based) and one Social Mobilizer (full time based), and would replace the strategy with a team composed of two vaccinators and one mobilizer. The aim of the approach is to consolidate the vaccinator and ICN into becoming a single operation unit with single data stream and single accountability. The EOC developed SOPs and a modified training which was piloted in one district of the south and the east as recommended by the TAG. The programme continues to monitor and track the pilot by deploying additional monitors into these areas.

In 2018, the trial of the two-member team will be expanded to an additional four districts of the South and East (high risk districts with challenges), making full use of any lessons learnt in the original two district trial; after 3 campaigns the results should be reviewed to inform further decisions on expansion.

### Improving the quality of training

- Training modules for vaccinators, supervisors and coordinators have been revised in Q4 2017 to make it simpler and easier to impart. These revised training modules will be fully implemented in 2018.
- Monitoring of training sessions will be streamlined and strengthened with concurrent feedback to the NEOC. Feedback on the findings from monitoring of training sessions will be used both concurrently as well as during post campaign reviews for corrective action.
- In high risk, poor performing areas, programme staff will provide trainings to FLWs.

### Monitoring and performance management

- The performance of vaccinators and supervisors will be tracked over subsequent campaigns, particularly in the VHR districts.
- In line with the accountability framework, the well-performing FLWs will be recognized and the poor performers will be identified for further capacity building/sanctioning.

## Ensuring the timely payment of FLWs

Currently, the programme uses two financial transaction methods. One is the Direct Disbursement Mechanism (DDM), which makes payments available directly to target beneficiaries using the banking system or mobile phone technology (M-Paisa). The other is cash distribution following a cash transfer to the local polio partners' joint account. In 2016-2017, the scope of DDM has been expanded but it is still less than 50%.

In 2018, the national polio eradication programme will:

- Expand DDM to the entire country by the end of Q2 2018. The DDM system will be modified to ensure payment directly to FLWs.
- Aim to ensure the payment of vaccinators within 30 days of the end of every campaign;
- Track the payment of vaccinators from the national level and take corrective actions in case of delayed payment;
- Revise TOR of financial committee at the provincial level
- Apply a strict “zero-tolerance” policy related to any misappropriation of payments and PEI resources.

## Intensified supportive supervision

Supervision of all phases of a campaign will be intensified by systematically engaging national-, regional- and provincial-level programme staff, including EOC members, for supervision in the field – particularly in the five high-risk provinces and FD/VHRDs. To meet this demand, the following interventions will be implemented:

- identification of national- and regional-level monitors from different agencies, who will be trained in supportive supervision, the use of standardized tools and programme oversight;
- deployment of these monitors to high-risk provinces/districts to oversee and take corrective action during the pre-campaign phase and for the whole duration of the campaign; and
- concurrent feedback and corrective action at the local level along with daily feedback to regional and national EOCs. A final debrief at the national level will be held focusing on the follow-up actions discussed during the post-campaign review meeting.

The quality of supervision by front-line supervisors (cluster supervisors) will also be enhanced by:

- rationalizing the workload of cluster supervisors by ensuring each covers a maximum of five teams;
- providing them with intensive training on supportive supervision techniques;
- enhancing their supervision by District Coordinators and intra-campaign monitors (ICM);
- analysing all supervisory checklists at the provincial level; and
- tracking performances by cluster supervisor area, including all components (i.e. post-campaign monitoring (PCM), training attendance and missed children).

## **Implementation of revised tally sheet**

The programme has revised the house to house tally sheet to make it house based as well as to have more focus on guest, out of house and absent children.

In 2018, this revised tally sheet will be fully implemented and a tally sheet audit will be conducted in poor performing high risk areas on a rotating basis.

## **Intra-campaign transit strategy strengthening**

The monitoring findings and different surveys show that a significant proportion of missed children are due to absent from house at the time of visit. In order to maximize opportunity to vaccinate these children, programme conducts revisit strategy, catch-up vaccination and also deploys intra campaign teams to vaccinate children during the movement. House-to-house teams will also be encouraged to take advantage of immunizing every child they encounter outside the household.

In Q1 2018, the programme will review and expand the existing intra-campaign transit teams to cover all major transit points. Monitoring and supervision of transit teams will also be intensified.

## **Reaching children missed during the campaign**

Reducing missed children remains one of the biggest challenges of the Polio programme in Afghanistan. On average, 4.1% of children remained missed after campaign in 2017; with 2.4% missed due to absence, 0.7% due to newborn/sick/sleep and 0.24% due to refusal.

In early 2016-17, the national polio eradication programme modified and expanded the revisit strategy, whereby vaccination teams revisit households where one or more resident children were missed from vaccination during the first team visit.

In 2018, the programme will continue to strengthen revisits by intensified focus on this component during ICM, supervision, data analysis and review meetings.

### **Catch up by ICN for children missed during revisit**

Apart from revisits by the vaccination teams, in VHRDs, social mobilizers have been conducting an additional visit (called 'Catch Up') to households with missed children. In 2017, this has contributed to immunization of 70% of children missed due to absence and 30% of children missed due to refusal in VHRDs with ICN.

In 2018, the programme will maintain the catch up of missed children after campaign by ICN.

## **Cluster specific communication approach to address refusals**

There are some of the high risk districts of country which have relatively higher proportion of refusals. Apart from ongoing intensified efforts for demand generation, programme will be focusing on cluster specific communication approach to address refusals. Key interventions are outlined below:

- Identification and mapping of districts and clusters with higher proportion of refusals
- Tracking of refusals over the rounds by ICN to identify chronic refusals
- Engagement of local influential mullah imams, doctors and other influencers for high risk clusters
- Mobilization by a religious mobile team to conduct community meetings with refusals families
- Cluster-level Refusal Resolution Committees in high refusal clusters
- Collation and use of local fatwa of famous religious institutes and supportive letters signed by senior doctors to convince community gatekeepers.
- Additional qualitative analysis to further understand reasons for refusals in areas with chronic challenges

### Enhanced monitoring

There is an established system of ICM and of post-campaign monitoring which includes remote monitoring, post-campaign monitoring surveys, LQAS surveys and “out-of-house” surveys.

During 2016-2017, the national polio eradication programme has strengthened monitoring through the:

- revision of the ICM checklist and guidelines;
- expansion of LQAS to all VHR districts, wherever feasible and where security permits;
- surveying of 100% of the clusters (supervisory area) during the PCM in VHR districts where accessible; sampling of 50% of clusters in other districts;
- validation of LQAS and PCM
- detailed field investigation of all lots failed in LQAS;
- introduction of disaggregated information on “children missed due to refusals” to differentiate between hard-core refusals and children missed due to being “new born, sick or sleeping”;
- availability of PCM and LQAS data to the programme within 10 days of the end of every campaign; and

The programme will continue to systematically monitor key activities throughout the campaign cycle to guide corrective action to improve SIAs in ongoing and subsequent campaigns. The data team at the EOC will collect information from the provinces and update the campaign dashboards on a timely basis.

To further understand the situation on the ground for corrective action, National EOC focal points are being deployed to the FD/VHRDs. This deployment aims to strengthen the monitoring of pre-, intra- and post-campaign activities to ensure that there are no impediments to implementing high-quality SIAs.

To further strengthen the monitoring mechanism and use of information for corrective action, specific activities are envisioned.

### Intra-campaign monitoring:

- The selection and training of ICM staff will be improved to ensure well-trained, high-quality ICM. In areas where suitable institutions are available, the ICMs will be sourced from those institutions (e.g.

Nangarhar, Kandahar and Herat). In other places it will be done through provincial selection committee.

- The number of ICMs in the 50 FD/VHRDs will be increased to have one per district coordinator.
- Complete ICM data will be collected and analysed at the national and regional levels for corrective action in subsequent campaigns.
- Quality of ICM will be monitored by provincial/ regional team, at least 5% of ICM monitors will be checked in field by provincial/regional team. Performance of ICM will be tracked over the rounds and accountability framework will be implemented.

#### Post-campaign monitoring:

- PCM will continue to target 100% of clusters in the VHR districts and 50% of clusters in other districts.
- The selection and training of post-campaign monitors in the five high-risk provinces will be directly overseen at the national/regional level. Wherever feasible, the PCMs will be sourced from institutions/universities.
- The system of monitoring the monitors (in-process and after the monitoring) will be continued. A total of 5% of monitors will be cross-checked by provincial team during monitoring activities. In addition, 5% of forms submitted will be validated in the field for correctness. Any discrepancy will be documented including the corrective action taken. The performance of monitors will be tracked over the rounds and a “zero-tolerance” policy will be applied for any defaulters.
- The PCM data will be made available to the programme within 10 days of the end of campaigns. A detailed analysis of PCM data, including the reasons for missed children by district, will be used during the post-campaign review meeting for corrective action.

#### LQAS:

- LQAS will be further expanded to include all VHR and HR districts wherever the security situation allows.
- The selection and training of LQAS surveyors will be directly overseen by the national/regional level. Wherever feasible, the surveyors will be sourced from institutions/universities.
- To ensure high quality LQAS, 10% of surveyors will be cross-checked by provincial/regional during monitoring activities. In addition, 10% of completed forms will be validated in the field for correctness. Any discrepancy will be documented including the corrective action taken.
- For every failed lot in LQAS, a detailed field investigation will be conducted by a joint team (UNICEF, WHO, MoPH) within seven days using a standardized tool to identify and document the key root causes of the poor performance and to plan for corrective action in subsequent campaigns. Concerned areas will be recovered to reach missed children and lots failing repeatedly will be further investigated and interventions modified to ensure improvement of quality.
- LQAS results will be available to the programme within 10 days of the end of campaigns.

#### Out-of-house surveys:

- Methodology of out of house survey will be reviewed and modified, if needed.

- Out-of-house surveys at marketplaces or other public areas will be continued and conducted in all the districts which are part of SIA.

### Remote monitoring:

The programme conducts remote monitoring using mobile technology in high risk areas of country. This is conducted on evening of day 3 and morning of day 4. The information on missed areas is being shared with provincial teams for verification and corrective actions.

In 2018:

- Remote monitoring will be continued in high risk areas
- New numbers will be taken from ATRA in July 2018
- The management of remote monitoring will be transferred to a formalized call centre within the national EOC

### Campaign coordination and review meetings

Campaign coordination and review meetings are needed during the pre-campaign phase to ensure good preparedness, during the campaign to take concurrent corrective action and after the campaign to review the lessons learned to improve the quality of subsequent campaigns.

#### Pre-campaign coordination meetings

- Prior to a vaccination campaign, coordination meetings will be held at the national, regional and provincial levels, with the participation of polio partners and representatives of the provincial health office and BPHS NGOs.
- Depending on the frequency of campaigns, coordination meetings will be conducted between two and four weeks before each campaign.

#### *National level*

- A meeting will take place at least 2 weeks before the campaign start date. The meeting will focus on 1) support to regions and provinces to ensure good quality preparation; 2) lessons learned from past campaigns and corrective action to be taken; 3) the calendar of activities at the national and regional levels; and 4) the deployment of national monitors to provide support in the preparatory phase.
- The follow up meetings will be held on 10, seven, three and one day(s) prior to every campaign to assess the preparedness. If any district is found to be inadequately prepared by three days before implementation, the national EOC will postpone the campaign and provide support to ensure full preparedness.

#### *Regional level*

- At the regional level, the meetings will focus on 1) the development of a schedule of activities, including training plans; 2) a plan of action to address the challenges identified in previous campaigns; and 3) the deployment of regional and provincial staff to support field preparation.



- The meetings in high-risk regions and provinces will be attended or supported by representatives from the national EOC.

#### *Provincial and district level*

- Provincial and district task force meetings will be held before every campaign, chaired by provincial and district governors, respectively.
- Participants of the provincial task force will include the PEI/EPI team, the provincial public health director, representatives of line ministries and departments, BPHS implementers and the governors of the high-risk districts.
- The primary focus of these task force meetings will be to ensure the full engagement of all line departments and to strengthen accountability at all levels. Provincial task force meetings will be held two weeks before every campaign; and followed by district task force meetings, which will take place one week before every campaign.

#### *Intra-campaign review meetings (evening meetings)*

- The national polio eradication programme has been conducting evening review meetings with campaign organizers and monitors (including intra-campaign monitors) at the district level at the end of each campaign day to review the day's activities and plan corrective action to respond to the problems identified. The focus in 2018 will be to improve the quality of these meetings and provincial level staff will participate in these meetings in FD/VHRDs.
- Intra-campaign reviews will also be conducted at the national, regional and provincial levels, during which the core team will review the progress and key challenges and take necessary corrective action. Daily feedback will be collected from ICM (data) and national and regional monitors in the field, along with operational feedback from EOCs and the PEMT.

#### *Post-campaign review meetings*

- Post-campaign reviews are conducted at the national, regional and provincial levels to identify the key challenges encountered during the campaign and to develop a plan of action to address them in subsequent campaigns.
- It is envisioned that post-campaign review meetings will be conducted at the national, regional and provincial levels within 15 days of the end of each campaign.
- In the high-risk provinces, these meetings will include representatives from the national EOC for support and input.
- The campaign data, including pre-, intra- and post-campaign information, will be reviewed to identify key issues to inform updated plans of action.
- The national EOC will track the outcomes of these meetings and follow up on progress and the support required.

## Data collection, collation, transmission and use

Data and analysis provide the foundation for evidence-based decision-making and corrective action that will address persistent gaps in national polio eradication programme performance. Afghanistan's programme collects different streams of data during the various campaign phases and uses the information for corrective action and accountability. Dashboards have been developed to easily visualize, analyse and track the key indicators in the pre-, intra- and post-campaign phases.

The timeliness of data from high risk provinces was greatly improved from 5 high risk provinces. In 2018, in order to improve the timely flow of data from all provinces, data focal persons will be deployed in all provinces.

The key data streams and information collected and analysed by the national polio eradication programme are as follows:

- Pre-campaign:
  - pre-campaign coordination meeting information.
  - information on preparations, including training, microplanning, social mobilization, access status, vaccine and logistics delivery.
- Intra-campaign:
  - administrative coverage including missed children covered during revisits;
  - intra-campaign monitoring data; and
  - data and information on evening meetings.
- Post-campaign:
  - PCM data;
  - LQAS results;
  - out-of-house survey results; and
  - administrative coverage data
  - Remote monitoring
  - Chronic refusal data from ICN districts
  - Catch up vaccination by ICN

**Table 4. National polio eradication programme data, source and timeline**

Data	Source	Timeline
<b>Pre-campaign</b>		
Campaign preparation	EOC/PEMT	2 weeks, 1 week, daily in last week
Coordination meeting	EOC/PEMT	10 days before SIA
<b>Intra-campaign</b>		
Administrative coverage	EOC/PEMT	Next day afternoon
ICM	EOC/PEMT	Next day afternoon
Evening meeting	EOC/PEMT	Next day afternoon

Data	Source	Timeline
Post-campaign		
Administrative coverage	EOC/PEMT	10 days after SIA
PCM	WHO	10 days after SIA
LQAS	WHO	10 days after SIA
Out-of-house survey	WHO	10 days after SIA
Compiled ICM data	EOC/PEMT	10 days after SIA
Access data	EOC/PEMT	10 days after SIA
Remote monitoring	NEOC	10 days after SIA
Catch up data	ICN	14 days after SIA
Chronic refusal data	ICN	14 days after SIA

### Use of mobile technology

The EOC has started use of mobile technology to fast track flow of information, getting information from the areas with limited access for monitoring as well as for validation of information from other sources.

### Remote monitoring of coverage and operations

In 2018, the EOC will continue to enhance the use of mobile technology to strengthen the timeliness, quality and availability of monitoring data from different sources including information and feedback from the public. EOC's Call Centre with specialized facilities and trained phone operators will further expand the reach to citizens in all high-risk and hard-to-reach districts to verify house-to-house vaccination, gather feedback on campaigns and identification of possible missed areas for immediate revisits. EOC's Hotline will become operational to enable feedback mechanism for all frontline workers as well as for community representatives and the public to report on any suspected cases and feedback on the quality of vaccination services.

### IVR

Interactive Voice Response (IVR) system will be used to enable PEI staff monitoring pre-campaign activities, particularly monitoring trainings, to report data in real-time through IVR even with use of basic mobile phones. IVR will also continue to enable reaching out to frontline workers to obtain their feedback regarding their receipt of pre-campaign trainings, supportive supervisions and last campaigns' payments.

### Data collation, analysis and dashboard

All the data collected from the various sources will be fed into an EOC database where it will be analysed and displayed through a series of dashboards to guide decision-making. The team responsible for the EOC database will include representatives from the government and partners. EOC dashboards will be made fully functional and accessible to all levels particularly REOCs.

### Ensuring data quality

The EOC and its Data/M&E task team continues ensure quality of data through various measures including validation of data in field (e.g. remote monitoring, ICM, PCM, LQAS validation).

## Data triangulation and use

The EOC continues to triangulate multiple data sets to validate the monitoring findings and get comprehensive picture of the programme. The data sets used in this process include administrative coverage, ICM, PCM, LQAS, FM survey, remote monitoring, ICN data and special surveys/investigations (e.g KAP).

In 2018, the programme will further streamline the interpretation and analysis of multiple data sources (ICM, Admin, PCM, LQAS, ICN, TPM and RM) to guide operational strategies.

## Strategies for access-challenged areas

The national polio eradication programme strives to vaccinate all children under five years of age regardless of where they live while ensuring strict programme neutrality. The need to uphold programme neutrality throughout all polio activities and during the day-to-day management is a message that has been reinforced by the highest level of government. One of the top priorities in 2018 as recommended by the TAG is to gain and maintain access while striving to improve quality. The programme will continue to capitalize on any opportunity to immunize as many children as possible and will continue to look for new and innovative approaches to gain access. Given the uncertainty and evolving security situation, the country will maintain a contingency plan to address any increase in inaccessibility.

In 2018, the ground rule of strictly maintaining the neutrality of the programme will be upheld throughout all polio activities and during its day-to-day management.

## Areas inaccessible for vaccination

In Category 2 and 4 districts, the national polio eradication programme will continue to reinforce the following interventions:

- continuing close tracking of the access situation at all levels, including mapping of accessibility at the cluster- and village-levels. The programme will conduct campaigns in all accessible areas and maintain a state of preparedness for capitalizing on any potential windows of opportunity.
- develop a contingency plan for three-phased approach of Short Interval Additional Dose strategy, with one round of OPV-IPV, to boost the immunity of children in the newly opened areas, and increasing the age group of one of the campaigns to target children aged up to 10 years;
- maintain flexible approach for conducting vaccination activities depending on type of access gained while continuing efforts to gain full access
- negotiating at different levels through neutral and credible mediators to help gain access to children in the identified inaccessible areas;
- deploying PTTs at the entry and exit routes of inaccessible areas, and vaccinating all eligible children to create a firewall of immunity around the inaccessible areas;
- scaling up PolioPlus initiatives (adding other services in conjunction with the polio vaccine, e.g. EPI services, health outreach services, hygiene kits and bednets; depending on the local context and

community demand) in and around inaccessible areas to respond to other felt needs in these communities where feasible, and to pull people out of inaccessible areas;

- for areas with continued chronic inaccessibility (particularly in Eastern region), continue PTT strategy, health camps through IFRC/ARCS/Others and other interventions apart from continuing dialogue with key authorities for gaining access.
- providing IPV-OPV at health facilities surrounding areas inaccessible for more than a year; and
- promoting ongoing community engagement activities, including with local elders

Accessibility at cluster level will be tracked over the rounds and areas inaccessible for more than two SIAs will be treated as high risk areas.

### **Areas accessible with limitations**

In areas, which are classified as category 3, where vaccination campaigns are feasible but with limitations in oversight and programme management due to insecurity and interference, more emphasis will be placed on improving the quality of activities.

Keeping in mind that the main priority is gaining and maintaining access, the main interventions planned are:

- maintain regular dialogue with key authorities, particularly at local level to minimize potential access disruptions. Sharing feedback on the gaps in quality and operations with concerned authorities
- dialogue at all levels with key authorities and stakeholders on the quality of campaigns and the importance of independent monitoring to ensure all eligible children are reached.
- deploying appropriate senior national and regional monitors for ensuring proper selection, training of FLWs and monitoring of all phases of campaign implementation.
- remote monitoring of campaign quality using mobile technology and third party monitoring for triangulation of data; and
- maintaining a flexible approach based on the local context. The programme will continue to capitalize on any potential opportunities to reach as many children as possible.

### **Complementary vaccination activities**

Reaching high risk mobile populations, including those traveling from access-compromised areas continues to be a high priority of the Afghanistan programme. A range of special complementary vaccination activities have been initiated to ensure that the four special categories of populations on the move are reached during and between polio campaigns. In 2017, a review of the overall transit strategy was initiated, with new SOPs developed. Focus in 2018 will be on fully implementing the revised SOPs.

Complementary vaccination activities include special activities planned around the inaccessible areas, at busy points and at border crossings, and for nomadic populations. Special efforts will be made in 2018 to monitor the effectiveness of these approaches with a view to improve the quality. The strategies include:

## Permanent Transit Teams

PTTs vaccinate children on the move and those moving in and out of inaccessible areas. In 2017, PTTs vaccinated a total of 13 million children. The number of PTTs was revised from 162 in January 2016, to 390 in December 2017, based on the evolving mapping of special populations, including those moving from access-compromised areas. PTTs are instrumental for vaccination of children moving from inaccessible to accessible areas as well for nomads through nomad specific PTTs deployed in the route of movement.

In 2018, the national polio eradication programme will:

- Continue strategy with flexibility to modify location/number as per changing programme needs, including the evolving accessibility situation, movement of nomads.
- Review of need, placement, FLWs suitability in Q1 2018
- Coordinated joint monitoring and tracking of performance by the national EOC on a monthly basis.
- Ensuring the timely and transparent payment of FLWs to ensure strong motivation.
- Nomad specific PTTs will be reviewed and further strengthened.

## Cross-border Teams

A total of 16 points have been identified along the border with Pakistan where large numbers of children cross on a regular basis. CBTs provide OPV on a permanent basis to all children crossing on either side of the border. The target age for children's vaccination at these points has been increased to those aged 10 years and fingermarks are applied to the left thumb. Given the IHR recommendations, the Afghanistan programme will commence the immunization of all travelers from Pakistan regardless of their age. There is one cross border vaccination point at border with Iran.

In 2018, the national polio eradication programme will:

- continue CBTs with expansion to all age groups of travellers coming into Afghanistan from Pakistan;
- modify the number of teams as per workload and possible identification of new informal CB routes
- review of need, placement, FLWs suitability in Q1 2018
- synchronization of operations and communication at border with Pakistan
- coordinated joint monitoring and tracking of CBT performance by independent monitors; and
- timely and transparent payment

## Vaccination of returnee populations

Afghanistan had seen a surge in returnee population from Pakistan in 2016. The children among returnee were vaccinated with OPV for up to 10 years of age and measles/IPV for less than 5 years. This activity was very well coordinated with UNHCR, IOM, MORR and Pakistan. It is expected that there will be surge in returnee population in 2018 as well and programme will have contingency plan ready and maintain state of preparedness for vaccination of returnees.

Key interventions for 2018 are:

- Develop a contingency plan and maintain state of preparedness
- Close coordination with Pakistan on vaccination at point of origin and advance information
- continue to monitor the flow of returnee populations at border points to ensure the number of teams is modified as per workload; identify possible additional informal CB routes where returnee populations may use;
- continue vaccination with OPV, IPV and Measles till end of Q2
- Vaccination with only OPV from Q3 onwards
- Coordination with MORR, UNHCR and IOM will be continued

### **Additional complementary immunization activities around inaccessible areas**

For areas with continued chronic inaccessibility (particularly in Eastern region), continue PTT strategy, health camps through IFRC/ARCS/Others and other interventions apart from continuing dialogue with key authorities for gaining access.

### **Vaccination as per IHR requirement**

OPV vaccination is made available to all the travelers from Afghanistan to other polio free countries through 8 centers in different parts of the country. This will be continued in 2018 at all the existing centers.

The vaccine utilization reports of the PTTs, PPTs and CBTs and all other complementary immunization activities will be submitted on a monthly basis to ensure the information guides accurate vaccine forecasting and accountability.

### **Special campaigns for nomads**

Special campaigns in South-Eastern region in particular will target the nomads who enter Afghanistan from Pakistan and move widely in the country before returning to Pakistan. Their routes and movement periods are known to regional polio teams so the dates of the special campaigns targeting the children of nomadic groups are adjusted accordingly. In 2018, the national polio eradication programme aims to:

- develop special population (nomad) plans at the provincial level, shared with the country office/ Pakistan programme, specifying the point of entry to the area, duration of stay, next destination, number of families and number of eligible children as part of the HRMP; special emphasis will also be placed on ensuring strong engagement with relevant elders from these communities.
- conduct specific campaigns targeting this population group;

### **High-risk mobile population strategy**

Afghanistan has prioritized HRMPs, given the crucial role in sustaining and spreading polio transmission. These populations are particularly important in the current epidemiological context of Afghanistan as well as Pakistan as they are instrumental in carrying the transmission across border.

## Types of HRMPs

The programme has identified four main categories of HRMPs that are of importance for polio eradication. These are:

1. **Long distance travelers within the reservoir areas;** particularly between Karachi, Quetta, Kandahar, Helmand, Farah and Faryab, and Peshawar, Nangarhar, and further to Northern provinces like Kunduz. These travels are mostly due to social and economic reasons and the travelers are absorbed in the host community as guests.
2. **Straddling populations along the bordering areas;** some tribal communities living around border maintain their living bases on both sides of the border and continuously shift across borders based on their needs and convenience. The straddling populations are predominant in Paktika, Paktia, Khost, Kandahar, Nangarhar and Kunar provinces.
3. **Nomadic populations;** these are population groups which move from one place to other including cross border for livelihood, predominantly for grazing and trading of their livestock. In general, these groups follow a pattern in their movements, both seasonally and geographically.
4. **Returnee refugees;** due to political and other reasons, a huge surge of Afghan refugees returnees has been witnessed since June 2016. More than half a million refugees have returned to Afghanistan in 2016. The registered returnee refugees are given financial assistance by UNHCR while unregistered returnees are given material support by IOM. The returnees mostly settle within the settled host populations, rarely in temporary camps for a short period. Nangarhar, Kabul, Paktika, Baghlan, Kunduz, Kandahar and Helmand are amongst the provinces with highest number of returnee refugees.

## Strategies to vaccinate HRMPs

Specific strategies have been developed for all these four categories of HRMP. Implementation of these strategies is being done in close coordination with Pakistan National EOC. The coordination with Pakistan on HRMP is being further strengthened and joint identification, mapping is being developed.

### *1. Long distance travelers within the reservoir areas:*

Apart from strengthening quality of SIA campaigns in the core reservoir areas, following strategies are being implemented to reach this population group:

#### ***Identification and mapping***

Areas with higher proportion of guest children/visitors are being identified through house to house survey by social mobilizers after every campaign. Information is collected on area of origin, duration and seasonality.

#### ***Focus during the SIA campaigns***

Training and tally sheet is modified to focus on identifying and vaccinating non-resident children. Vaccinators, social mobilizers and supervisors focus on visiting/guest children to ensure that no such child is missed. Intra-campaign and post campaign monitors also focus on the visiting children during process of monitoring.

#### ***Vaccination during movement***

Cross-border vaccination posts and permanent vaccination points vaccinate children travelling across epidemiological corridors between two countries



## *2. Straddling population along the bordering areas*

### ***Identification and mapping***

All settlements with population which frequently moves across the border is identified and mapped focusing on Kunar, Nangarhar, Khost, Paktia, Paktika and Kandahar provinces. Information is also gathered about the movement pattern including relation across the border.

### ***Vaccination during SIAs***

All such identified settlement are included in microplan. These areas are considered as high risk areas and focused for supervision and monitoring.

### ***Vaccination during movement***

Cross border vaccination point and permanent transit points are reassessed and deployed to vaccinate during the movement.

## *3. Nomadic populations*

### ***Identification and mapping***

Programme has identified and mapped nomadic groups, routes, seasonality and places of settlements. This information is further streamlined through inter-regional coordination to get a comprehensive picture for whole of Afghanistan.

### ***Vaccination during the movement***

Nomad specific PTT are deployed along the major movement routes using the information on movement pattern. This is further reviewed and strengthened.

### ***Nomad specific SIA***

Nomad specific SIAs at the place of settlement are being conducted in South-eastern region when the population first enters in Afghanistan. This strategy will be continued and further strengthened.

### ***Inclusion in SIA***

All nomadic settlements are included in SIAs.

## *4. Returnee refugees*

### ***Vaccination at point of entry***

Cross-border posts strengthened to cater to increased flow through borders, particularly Torkham border in Nangarhar and Friendship gate in Kandahar

OPV, IPV and measles vaccination at UNHCR and IOM centers while the returnees visit to collect assistance benefits

### ***Vaccination at place of settlement***

Programme coordinates with UNHCR and IOM to get data on villages/districts of final settlement of returnee populations and flagging areas with high number of returnees for inclusion in microplan.

Survey is being done before campaign in the districts with higher inflow, to identify new settlements.

All newly identifying settlements are included in microplan and are focused during the campaign for supervision and monitoring.

## Cross border coordination

Following steps have been taken for further systemizing coordination between Afghanistan and Pakistan for HRMPs:

1. A HRMP task team comprising of technical officers from both countries has been established
2. Tools for collecting information and mapping are being synchronized
3. Information from each country is integrated at local and national level
4. Strategies of both countries are synchronized

## Summary of strategies for HRMP

Type	Permanent transit teams	Cross border teams	SIA
Long distance travel within reservoir	PTTs strategically placed to vaccinate travellers <10 yrs to/from bordering and/or inaccessible areas	CBTs vaccinate children <10 yrs crossing borders	ICN/other data sources used to identify areas with guests – focused for coverage in SIA (trainings, implementation and monitoring)
Straddling population	PTT on routes of straddling population movement	Vaccination of straddling population while crossing borders	Settlements identified and included in SIA microplans
Nomadic population	Seasonal TTs on nomadic routes deployed during the movement season	Cross border teams on identified border crossing points, strengthened during movement season	Nomad specific SIA conducted during movement season in East Nomadic settlements included in all SIAs
Returnee refugees	PTTs reinforced on travel routes from Torkham and Friendship gates	Vaccination posts at UNHCR/IOM centers and Torkham/Friendship gates vaccinating with OPV (10y), IPV and measles	Villages/districts of final destination identified through UNHCR/IOM data, microplans revised and areas focused in SIAs

In 2018, the programme will:

- Continue focus on 4 HRMP categories 1) Long distance travelers 2) Nomads 3) Straddling populations 4) Returnees and refugees
- Database and mapping of all four categories will be updated in coordination with Pakistan
- Movement patterns of nomads, placement of nomad specific PTTs and inclusion of nomads in SIAs will be reviewed and further strengthened
- Review and modify PTT and CBT plans based on evolving movement patterns
- Identification and inclusion of temporary settlement points in SIA microplans
- Close coordination with the regions, UNHCR, IOM, OCHA and Pakistan. Develop a contingency plan and maintain state of preparedness.

## Building demand for immunization

Research indicates that progress has been made in addressing vaccine acceptance. For example, as demonstrated by data collected in partnership with Harvard University in mid-2017, caregivers' intent to accept OPV increased from 77% in 2015 to 89% in 2017 and belief in destructive rumors about polio decreased from 42% in 2015 to 16% in 2017. Yet challenges remain. Whilst perceptions and attitudes are shifting, efforts to address missed children may need to include reinforcing in new ways a number of persistent problems, including the importance of vaccinating children in each round, the central importance of vaccinating sick, sleeping and newborn children, the importance of vaccinating before traveling, and addressing destructive rumors.

Also, while individual perceptions are shifting, there is a substantial share of caregivers who feel there is not full community support for vaccination efforts; both perceived behavioral and attitudinal norms of acceptance are varied. For example, about a fifth of caregivers (21%) say not all their neighbors accept polio drops every time they are offered, and more than a quarter (27%) say at least some of their neighbors are “against” polio drops. This requires specific messaging to help promote community norms to support and reinforce commitment to accepting vaccination.

The Communication Action Plan for 2018 (separate document available) is focused on addressing these highlighted issues, targeting the Southern corridor, key areas in the East and parts of the Northern corridor. It will also continue to promote national awareness across the country. To eradicate polio in Afghanistan, the programme must know and understand its core audience, and critical influencers. The communications programme will gain insight from communities by moving away from ‘selective hearing’ to ‘active listening’. Every insight creates a clear and actionable reason for engagement and communications in 2018 will seek missed opportunities through new insights.

The process of mapping and identifying key stakeholders in high risk districts has been a priority for some time. Yet the high number of cases in the South has called for renewed attention in that area and a re-evaluation of who is influential. This re-evaluation began in November, 2017. Until now anecdotal evidence has suggested a few key people in these districts play a disproportionate role in enabling change to happen. The programme will prioritise understanding these groups and developing messages and communication initiatives that encourage them to promote the benefits of polio eradication. In 2018, a full stakeholder mapping analysis should be conducted on each group, in each high-priority district or region. At the same time the programme will continue to work with influential Afghans and national media production companies to produce general messages about the importance of vaccination. The programme will continue producing effective messages for national audiences that are easy to understand, relevant and memorable, and which do not require further explanation.

Creating messages and products will be done through a participatory approach with EOC partners as well as regional EOCs. “Draft messages” will also be pre-tested with those who have not been involved in polio campaigns to gain the benefit of fresh eyes and ears and unbiased opinions. All these communications will be in support of campaigns and frontline health workers, including the ICN network. The capacity of ICN staff will be steadily increased through better selection (more local residents) and additional regular trainings in interpersonal communication (IPC).

Research has shown the effectiveness of health workers as frontline behavior and social change agents on health issues in the community. It is vital that the community at large looks upon them with respect and as credible and trustworthy sources of information about polio vaccinations and other healthy practices.

The strategy in 2018 will be focus on a variety of channels:

ICN: In 2017, community engagement was operationalized with the roll-out of full-time Immunization Communication Network (ICN) in feasible high-risk districts, while alternative approaches were adopted

in other districts including the formation of cluster-level refusal-resolution committees to negotiate and convert refusals. In total, 7,500 mobilizers and supervisors were deployed across 45 of 50 very high risk districts (VHRDs). In 2018, community engagement will be spearheaded by the deployment of the 7500+ ICN based on local situations and environments. Alternative approaches will be implemented where full time ICN will not be feasible, or to complement refusal negotiation which is beyond the capacity of the ICN.

For full time ICN deployment, it is estimated that around 5500 mobilizers and supervisors will be deployed in areas where full time work is expected to be feasible. In line with essential components necessary to the success of ICN deployment, full time ICN will only be in the focus districts and Very High Risk districts where the programme will be able to deploy trusted, capable, and professional frontline workers to mobilize caregivers, religious and community leaders, and key influencers to understand, accept and support the work of vaccinators and uptake of OPV. The essential components of full time deployment include suitable recruitment processes, trainings, ability to use tools (Information, education and communication materials, use of register book and referral books, etc.), and ability to apply systems for performance and accountability.

For full time ICN community engagement which involves a constant conversation with the community, there will be a push to focus ICN messages on positive perceptions about polio and vaccinations, addressing destructive rumors, and reinforcing community acceptance while working with and promoting local community influencers in 2018. Special trainings will be conducted with all full time ICN personnel to emphasize their focus messaging for 2018. The trainings will also tackle coordination and linkages with operations teams to address missed children and refusals as an integrated team.

In districts where full time ICN is not feasible, campaign based mobilizers will be identified and trained pre-campaign to mobilize caregivers, religious and community leaders, and key influencers to understand, accept and support the work of vaccinators and uptake of OPV. Where feasible, the campaign based mobilizers will undertake post-campaign catch up to support vaccination of missed children, and reinforce messages on positive perceptions about polio and vaccinations, and address destructive rumors.

In addition to deploying full time and campaign based Immunization Communication Network, alternative strategies will be implemented to complement the ICN in efforts to resolve 'hard' refusals that cannot be resolved by the ICN. The following are the key alternative approaches to be implemented in 2018 tailored towards needs of specific areas:

Southern Corridor: Cluster Refusals Rapid Response Teams will be deployed in the focus districts of Kandahar City, Zheray, Dand, Spinboldak and Panjwayi to complement the work of the social mobilisers by negotiating hard refusals before and during the campaign. These teams will be expanded to all Southern corridor districts if the local context makes it feasible. The teams will be comprised of a Community elder, Local Mullah, Local health worker (if there is a health facility in the cluster) and District Communication Officer and District Polio Officer, adapted to the local acceptance.

Mobile Mullahs (religious mobile team) will be deployed in the focus districts, as required depending on the prevailing local situation. They will organize community meetings to promote community acceptance of vaccine and negotiate with refusals families.

IEC materials: The polio programme has created numerous murals and commissioned billboards, especially targeting cross-border populations. Information Education and Communication (IEC) leaflets are also distributed at border crossings, as well as door-to-door in high risk districts. These will be expanded and updated in 2018. Polio messages will be placed on rickshaw covers and long distance buses operating throughout the south. Special IEC products for illiterate populations are also being planned for nomad populations.

Media engagement: The programme intends to dramatically scale-up its engagement with local media in 2018. The programme will begin hosting monthly training sessions with all TV and radio reporters in priority areas and will form an Association of Journalists for Polio, an organization that will offer monthly prizes for polio reporting. Moreover, through the BBC and VOA, organizations with whom the polio programme already has an association, the programme is already able to reach a high percentage of the prime-time radio listening audience of the South. The programme intends to use these platforms to sharpen coverage of polio-related themes and to help strengthen understanding on the means of transmission, the importance of repeated doses, and give platforms to credible influencers who can address local audiences convincingly.

Local events: The polio programme has deployed a children's circus to clusters with high rates of refusals in Nangarhar and Kandahar. Each performance is about 45 minutes and includes a 10-minute skit on the importance of polio vaccinations. Following performances vaccinators have had success in immediately vaccinating child spectators. In 2018, the polio programme will assess the impact of these educational events to determine whether they need to be adapted for specific contexts.

100% national sport endorsement: By early 2018, nearly every professional televised domestic sports event in Afghanistan will feature endorsement from players in support of polio vaccination. As a way to normalize the polio vaccine experience and highlight the importance of repeated doses, each sporting event will feature moments where star athletes vaccinate children on air, either at the start of events or at halftime. This will include national and regional cricket events, football, mixed martial arts, and potentially Pashto Wrestling, said to be the most popular sport in the rural south.

Existing structures: In 2018, we will scale-up communications material at key institutions where influencers are present: health centres, schools, universities and mosques. Each message will be tailored for the target audience.

Influencers: The programme will continue to reach out to well-known and liked Afghan so they can speak out in support of polio vaccinations. These influencers will be non-political figures who have built up a degree of trust, prestige, and goodwill with Afghans, including religious figures, star athletes, and doctors. The goal is to turn such figures into "brand ambassadors" for polio. This type of engagement has already been occurring but 2018 will see more of this type of promotion of polio vaccination by such

figures – through social media, through earned media testimonials, through one-on-one conversations at the household level. While many of the athletes and doctors do not possess individual influence, when they unite into a community that is aligned to the goal of polio eradication, that community can wield more influence.

## Response to any new polio event

Every new polio case will be responded to according to the following approach:

- detailed epidemiological and case investigation by RRRT (Regional rapid response team) and NRRT (National rapid response team) within 3 days and 5 days respectively from notification;
- action plan from regional level to address gaps identified by RRRT and NRRT
- Vaccination response
  - three SIAs after the date of onset, covering at least 500 000 children in the surrounding area
  - first campaign to be conducted within two weeks
  - second campaign targeting <10 years, if in area with proven low population immunity
  - preferably one of the three campaigns to be conducted with IPV, if the area is high risk, newly accessible and has not received an IPV-OPV SIA in 2015/2016
- National-level monitors to support and monitor pre-, intra- and post-campaign phases of all response SIAs

For any new isolate detected in the environment, the following steps will be taken:

- detailed investigation of the catchment area by the RRRT, including a survey for any change in population profile, recent campaign quality, presence of high risk populations and population movement patterns;
- Active case search in health facilities in the catchment area and community based active case search among high risk population groups
- Vaccination response: 3 SIAs in the catchment area after the date of collection of sample.

The national EOC will produce a report on the outbreak response after the completion of three SIA campaigns after the last case in the area has been detected.

For outbreaks in areas contiguous with Pakistan, there will be joint analysis, planning, response, monitoring, and reporting of case response.

## Response to detection of poliovirus type 2

In line with the global guidelines, the detection of any poliovirus type 2 – wild, vaccine-derived or even Sabin (four months post-switch) – will be notified as required under the International Health Regulations (2005).

In response to the detection of any type 2 poliovirus, the following actions will be taken:

- investigation and risk assessment:
  - enhancing surveillance in all the concerned areas;
  - conducting a rapid field investigation;
  - conducting a risk assessment as per the global Standard Operating Procedures, with the nature of the virus (e.g. WPV, vaccine-derived or Sabin) and strength of evidence of circulation (e.g. confirmed, probable or possible) determining the potential risk of further poliovirus type 2 transmission (for type 2 isolates, unlike type 1 or 3 isolates, the transmission classification (not typology) determines response); and
  - conducting an additional investigation to determine whether trivalent OPV or monovalent oral polio vaccine type 2 (mOPV2) is still being used, or the potential for a containment breach;
- response:
  - beginning preparations for a vaccination response upon receiving initial sequencing results (not waiting for a complete epidemiologic investigation or final classification of an isolate);
  - implementing an initial vaccination response using mOPV2 (from a global stockpile), targeting 500 000 children aged under 5 years, within 14 days of receiving the initial sequencing results;
  - depending on the further classification of the virus and the transmission risk analysis, conducting additional SIAs targeting a minimum of 2 million children approximately every two to three weeks; and
  - using IPV-mOPV2 in one of the SIAs in the outbreak area and IPV alone for an expanded high-risk subpopulation.

To conduct the response vaccination as described above, Afghanistan will apply to WHO to access mOPV2 and IPV from the global stockpile.

## Surveillance

### Acute flaccid paralysis surveillance

Surveillance for AFP is the gold standard for detecting cases of poliomyelitis. Environmental surveillance adds to the sensitivity and detection of WPV.

The AFP surveillance system in Afghanistan generally meets global standards. An external surveillance review was conducted in June 2016 and the review team concluded that *'circulation of WPV/cVDPV is unlikely to be missed in Afghanistan'*. The recommendations made by the review team have guided further improvements in the system.

Certain measures were taken to strengthen the AFP surveillance system, especially in hard-to-reach and security-compromised areas. Healthy children sampling was initiated to collect stool samples from 5 healthy children in the districts not reporting AFP cases for more than 6 months.

The key interventions planned to strengthen AFP surveillance in 2018 are:

- review and expansion of the reporting network as needed, with emphasis placed on health-care service providers catering to high-risk population groups, insecure areas, high-risk areas and districts with a low non-polio AFP rate, and conducting a health facility contact analysis of all AFP cases, particularly inadequate cases, to guide the expansion of the reporting network;
- Regular review of surveillance status in sub district access compromised areas to inform corrective actions
- Internal surveillance review to cover all regions in 2018 / all districts which have not reported AFP cases in 2017
- For districts with chronic inaccessibility, conduct desk review and also survey using third party to identify any potential missed cases
- Explore alternate modes/routes, as a contingency, for specimen shipment to Regional Reference Laboratory.
- Re-assess the need and impact of healthy children sampling and decide on the need to continue

### **Environmental surveillance**

In 2016-17, Afghanistan conducted an assessment of the suitability of existing sites and possible expansion. Following this exercise, the number of environmental surveillance sites was expanded from 14 sites in 2015 to 20 in 2017 to cover all the major urban areas and all regions of the country.

In 2018, the programme will continue to conduct ES from all the current sites and will conduct field investigations where any sample has a 'NVI' result.

### **National Certification Committee**

The National Certification Committee (NCC) is composed of independent experts, as outlined in the terms of reference adopted by the Eastern Mediterranean Regional Certification Commission. The NCC meets twice a year to review the overall polio situation, assess the status of requirements for the certification process and prepare for the eventual presentation of national polio-free documentation to the Regional Certification Commission (RCC).

The NCC will continue to undertake field visits in keeping with the RCC protocol, will prepare and submit the *Afghanistan Annual Progress Report on Certification* to the RCC, and will participate in and present the report during the RCC annual meetings.

### **Effective vaccine and cold chain management**

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

- Strengthen the functioning and capacity of VCCM committee which is the platform for providing oversight for both PEI and EPI vaccines and cold chain systems in the country. These committees will also be strengthened at regional levels.



- Continued strengthening of the cold chain system for PEI based on regular cold chain equipment inventory and gap analysis will be done in 2018. PEI-related CCE gaps will be addressed in collaboration with National EPI Programme, within the context of Afghanistan Polio transition.
- The programme will sustain trainings and refresher on vaccine and cold chain management at all levels, with special emphasis during training of FLWs for SIAs. Based on lessons learnt over the recent years and campaigns, focus will be made to strengthen capacity for vaccine distribution and logistics planning and management at the lower levels of service delivery during SIAs – at district, cluster and FLW levels.
- Ensure vaccine utilization reports are submitted by the PEMTs to National EPI within 14 days of implementation of SIAs and on monthly basis for complementary vaccination activities, to be able to assess the vaccine wastage rates and provide feedback as needed.

## Monitoring and evaluation

In view of the current critical stage of the national polio eradication programme, to ensure that progress is being made against the NEAP, the programme's performance will be evaluated using the following methods:

- Monitoring NEAP implementation:
  - Monthly tracking of the NEAP work plan for corrective actions
  - Quarterly NEAP review
- Assessment and documentation of the impact of initiatives, using all available data, to inform programme decisions on which initiatives should be retained or expanded.
- Sero-prevalence survey:
  - Regional/Provincial Hospitals in Helmand, Paktika, Paktia, Nangarhar, Kunduz, Khost, Herat, Balkh, Ghazni and Indira Gandhi Hospital in Kabul
- Periodic tracking of acceptance through mini-KAP in VHRDs
- Communication review to be conducted in Q3 2018

## Routine immunization strengthening

Routine immunization is extremely important in contributing to, and sustaining WPV interruption in Afghanistan. During 2017, Routine Immunization has made reasonable progress with services delivered by BPHS NGOs through contracts with GCMU of MOPH. The progress however is still inadequate, as evidenced by outbreaks of measles and other vaccine preventable diseases in some parts of the country during the year.

The PEI Programme continues to emphasize RI/EPI in all its activities. The support for EPI includes the Mobile Health Outreach teams targeting inaccessible and difficult to reach communities of the country where access to RI services are low, monitoring of RI services and sessions, training on PEI and EPI, and regular information- and evidence-sharing on vaccination status of children from AFP surveillance.

BPHS NGOs are members of the National, regional and provincial teams. During the last quarter of 2016, the National EOC engaged with, and agreed on an SOP for involvement of BPHS NGO in Polio Eradication, and the PEI Support to EPI. The SOP detailed out the roles of BPHS in Polio and how PEI can support strengthening RI services in the country, initially focusing on 5 provinces – where RI coverage is suboptimal and are also considered high risk for PEI. In 2017, implementation of the agreement was done, with PEI field staff providing at least 20% of their time towards EPI services, including monitoring of RI fixed, outreach and mobile services and providing supportive feedback to EPI at provincial, regional and national levels. An NEOC working group (PEI to EPI) provides technical guidance and oversight to the regions and provinces on PEI-EPI Coordination.

Priorities for 2018 NEAP include the following:

1. Polio workers to spend 20% of their time on routine immunization
2. Strengthened coordination with BPHS implementers in 6 priority provinces, including developing and implementing accountability framework for holding the EPI implementers also accountable for involvement in the programme and improvement in EPI coverage
3. Routine immunization improvement plan for 15 focus districts of south region should be developed and implemented.
4. Evaluate the implementation of the SOPs and findings should be applied in the upcoming 2018 round of NGO contracting
5. Fully implement the SOP for PEI support to EPI with special focus on 1) Planning routine immunization sessions, 2) Monitoring of fixed and outreach sessions, 3) Mobilization of families through ICN 4) newborn and defaulters tracking
6. Regular monthly/quarterly meeting and feedback to BPHS NGOs on RI service findings and follow up for action to address challenges and weaknesses observed during monitoring.
7. Joint monthly review of EPI-PEI coordination at national level for tracking follow up actions
8. Develop clear indicators to monitor progress in EPI on a quarterly basis.

## Transition planning

As a polio-endemic country, Afghanistan will continue to prioritize the implementation of activities to achieve Objective 1 of the global Polio Eradication & Endgame Strategic Plan (poliovirus detection and interruption). However the Ministry of Public Health and all partners recognize the importance of initiating the planning for the transition of polio assets beyond certification, while not distracting from the focus on stopping poliovirus transmission. Enabling the transition of polio assets to support other basic public health functions, wherever possible, will be a priority. A plan must be initiated to guide the transition of polio staff and infrastructure to support the country's other health priorities, with governmental or other sources of funding.

The National EPI, MoPH, will take the lead in developing these plans, engaging donors and other key stakeholders in the process. This process will be guided by the Transition Planning Guidelines with support from the Transition Management Group. The guiding principle of the efforts to initiate transition planning will be that the activities will not distract from the priority of stopping polio. The people involved should not be involved in polio activities on a day to day basis.

Key actions to achieve this involve the following interventions:

- **structure:** establishing a national governing body for transition planning under government leadership before end of quarter one 2018. This body would include members from donors, partners, other key stakeholders in health sector and representatives from other ministries (finance and planning)
- **management:** identifying a focal person within the national EPI to manage the development of the transition plan and ensure that a work plan is in place by the second quarter of 2018;
- **asset mapping and stakeholder workshop:** with the support of the PEI implementing partners, ensuring that asset mapping is initiated across the partnership and within individual agencies using the templates provided by the global transition management team by the end of the fourth quarter of 2018; and
- **follow-up:** ensuring that a draft plan for transition planning is developed and shared with partners and donors for input by the first quarter of 2019.
- **Documentation of best practices – ongoing**

## **List of annexes**

- I. Very high risk districts and high risk districts map
- II. Very high risk districts and high risk districts list
- III. SIA calendar 2018
- IV. Afghanistan-Pakistan synchronized SIA calendar
- V. NEAP 2018 work plan
- VI. Accountability framework