Polio Eradication Initiative, Afghanistan

National Emergency Action Plan (NEAP), July 2013-June 2014

Ministry of Public Health
Islamic Republic of Afghanistan

World Health Organization

unicef

PEI-AFGHANISTAN

EXECUTIVE SUMMARY

Afghanistan PEI has reached to a very critical stage in eradicating polio virus transmission. The first half of year 2013 has been a turning point by having only 3 cases; moreover no cases from the traditionally infected region of the South, in where all of the Low [Performing Districts (LPDs) are located. However having seen the same trends in the past, Afghanistan PEI is taking a very cautious stand in order to avoid any setbacks, which the program cannot afford anymore. This one-in-a-generation opportunity will be tapped into to assure the confidence in polio program in Afghanistan being well on track.

The polio program has concentrated on conducting frequently and closely spaced campaigns during the low transmission season of January-June 2013 in order to fill the immunity gaps and catch the missed children in one or more rounds, which have remained unvaccinated previously. Although immediate outputs of this repositioning signals some degree of success, the concrete outcome remain to be assessed during the transmission season of the 2nd half of the year.

Therefore Afghanistan polio program has revised the National Emergency Action Plan (NEAP) to strategically prioritize areas of interventions and plan for the activities within that framework. In order to ensure the achievement of the ultimate goal of "interrupting wild polio virus transmission in Afghanistan by the end of 2013", three key guiding principles have been identified for program to focus as follows:

1. To speed up the implementation of all polio activities.
2. To translate National level of commitments into action which further should be transferred to the sub-national, more specifically to district levels, where the field operations are taking place
3. To improve the quality of implementation of polio activities.

Polio program in Afghanistan has identified 6 key intervention areas that will be essential to assure the implementation of strategies:

1. Low Performing Districts
2. Special Focus on Missed Children
3. Communication directed to increased community demand and ownership
4. Management and Accountability
5. Strengthening AFP Surveillance
6. Routine EPI

The Low Performing Districts (LPDs), the total number of which is now 30 and located in the Southern and Eastern Regions following a revision based on the emerging trends in polio epidemiology, will continue to be the geographical focus for all interventions.

There will be a results based monitoring to assess the performance against key indicators and measure the achievements for milestones. The program will make sure that various new approaches and techniques will be streamlined to focus on the issues that really matter. Regular reviews and evaluations will be conducted including reviews on AFP surveillance and Permanent Polio Teams (PPTs) to identify the successes as well as loopholes in order to share best practices and take corrective actions alike.

The NEAP July-December 2013 will be revisited regularly to adapt any changes that might happen to keep up with the dynamics of polio epidemiology. An end year evaluation will be carried out to revise and introduce changes to the NEAP as per the accomplishments/achievements and issues remained partially and/or completely unmet.

PART A:

I. SITUATION ANALYSIS

1. Current Situation:

- Afghanistan reported total of 37 confirmed polio cases in 2012 compared to 80 cases reported in 2011; a decrease of more than 50% in cases accompanied with a reduction in the number of infected districts from 34 in 2011 to 21 districts in 2012. The number of cases decreased further down to 3 in the first 6 months of 2013 with only 3 districts infected. In comparison to last year's (2012) same period the reduction in the number of cases is 80%.
- Epidemiological data of 2012 shows that 65% of the cases (24/37) were reported from the three provinces of Southern region; Kandahar (11 cases), Helmand (11 cases) and Uruzgan (2 Cases). In 2013 the only 3 cases were reported from two provinces in the Eastern Region, two from Nangarhar and one from Kunar while none from the Southern Region, which was traditionally perceived as the endemic zone in the country.
- Detailed investigation has revealed that two of the cases in this year are from partially inaccessible clusters due to insecurity and has remained so over a long period of time, while one was from accessible area.
- There is a country wide network of AFP Focal Points (FP) linked with community-based reporting volunteers. There are 535 focal points and over 12,000 community-based reporting volunteers all over the country.
- Expected annual number of AFP cases for Afghanistan was at least 368 @ of 2/100,000 children below 15 years of age. Total of 1829 AFP cases were reported during 2012, compared to 1,830 AFP cases in 2011.
- Out of total 1,829 in 2012, there were 37 confirmed, 7 compatibles and 1,785 were discarded as non-polio. In the first six months of 2013 a total of 945 AFP cases were reported, 20% more than the number of AFP cases for the same period of last year, while showing fluctuations by months. Out of 945, three were confirmed as WPV, 3 as cVDPV, no compatible and 805 disregarded as non-polio. Yet a total number of 134 cases are pending in the laboratory for final diagnosis, out of which 18 were labelled as "hot
- Analysis of AFP surveillance indicators at national and regional levels shows the system is achieving the desired level of targets for Non Polio AFP rate, 9.9 per 100,000 children below 15 years of age and percentage of adequate specimens 92% during the year 2012. The same indicators during the 1st half of 2013 were 2.3 per 100,000 children under-15 years of age and 95% of specimens were adequate. The Southern Region has the lowest adequate stool specimen collection rate with 86%, the South-Eastern Region with 91% comes next low and the rest of the regions well above 95%.
- Percentage of specimens with Entero-Virus was well above the required level, 20% and 13% at country level with above 10% in all regions in 2012 and the first 6-months of 2013,

respectively. Sabin like (SL) was isolated from at least 5% and 7% of specimens in the country in 2012 and 2013 (Jan-Jun), respectively. Both these indicators show that the technique and process of stool specimen collection and shipment is over all satisfactory.

- Early case detection rate (Cases detected within 7 days of onset of paralysis) has improved to 85% in 2012 and further to 85% in the 1st six months of 2013. The regional breakdown indicates a satisfactory performance in all regions, but Badakshan, which has shown a decline from 89% to 76%, apparently requires further investigation. The Southern Region has shown a significant increase from 66% in 2011 to 70% in 2012 and a leap to 82% in the first 6 months of 2013. This indicates the integrity of community based referral system in most part of the country, which has improved over time.
- Vaccination of status of Non-Polio AFP cases of age 6-23 months reported from Southern region in 2012 shows that 64% did not receive any routine OPV dose, 22% received 1-2 doses and only 14% received at least 3OPV doses through routine. In the first half of 2013, the number of AFP cases of same criteria shows a decline in the proportion of those who did not receive any routine dose (56%). All in all this indicates a very low EPI coverage in Southern region with slight improvement in 2013.
- Analysis of all Non-Polio AFP cases reported from Southern region of age less than 5 years shows that 13% of them did not receive any dose of OPV; neither through SIAs nor through Routine. However, in first 6 months of 2013 this proportion reduced significantly in Southern region and only 5% of non-polio AFP cases in Southern region did not receive any dose of OPV. This indicates that the quality of vaccination campaigns in these areas has improved and has reached to vaccinate more children. However, presence of AFP case with no OPV doses clearly indicates that there are still pockets in Southern region that are missed by both SIAs and Routine.
- Analysis of Post Campaign Assessment data shows that estimated number of children missed for vaccination in Southern region has reduced from 335,000 children in March 2012 to 234,000 in April 2013. Although number of children vaccinated in each campaign is increasing but more than 200,000 children in Southern region are still missed, on average in each campaign indicating the presence of persistent low performing districts. These, mainly, include Shahwalikot, Panjwai, Maiwand in Kandahar while Nehr-e-Siraj and Sangin districts in Helmand while Shaheed Hasas and Trinkkot in Uruzgan province
- In Summary, the vaccination status of AFP cases for routine and SIAs and Post campaign assessment data shows an improvement in Southern region but presence of unvaccinated AFP cases, and also missing more than 200,000 during the campaign indicates that persistence of gaps in population immunity that continue to pose risk in terms of poliovirus circulation in Southern region.

2. Emerging trends

- In 2012 a new epidemiological situation emerged with the occurrence of sporadic cases followed by secondary cases in East and South Eastern regions. There were 6 cases reported from the Eastern Region (Kunar, and Nangarhar) while 5 cases were reported from South-Eastern Region (Paktia and Khost provinces). One case was reported from the Ghor province of West region.
- In 2013 this new trend of 2012 has continued in the Eastern Region. While the genetic lineage of first case was indicated the one isolated from environmental sampling in Pakistan the second case was linked to the first case within the Eastern Region indicating the signs of establishment of the virus in the region.
- Another new epidemiological challenge during 2012 was the outbreak of cVDPV2 in the Southern region whereby eleven cases of cVDPV2 were reported from Helmand (7 cases) and Kandahar (4 cases) provinces. Ten out of eleven cases had zero OPV doses for routine (90%) and one case had received only 1 dose. Four out of eleven cases were zero dose for SIAs (36 %). cVDPV2 occurs in populations with very low vaccination coverage persistent over a long period of time, particularly the low routine EPI coverage and less frequent use of tOPV in campaigns and lastly is the constant presence of inaccessible pockets of populations.
- In Jan-June 2013, three cases of cVDPV2 (2 Helmand, 1 Kandahar) have been identified. All of the 3 cVDPV cases had zero dose routine OPV and reported from security compromised districts.

3. Successes

- One of the key successes of the program is that program has prevented establishment of circulation in most of the country after large outbreak in 2011 with occurrence of cases in North, North-East, West and Central regions. No case of Poliomyelitis is reported in 2012 and 2013(Jan-Jun) from these regions which constitute almost 75-80% of the total population of the country.
- Although there has been significant improvement in decreasing the number of cases in the Southern Region which has reported none in the first 6 months of 2013 it is still too early to speak about significant achievement. The presence of cVDPV cases and some cluster based analysis of PCA coverage both indicate immunity gaps that need to be addressed in the forthcoming months.

4. Challenges:

- Main reason for the prevailing immunity gap in the localized area of Southern region is due to consistent compromised quality of campaigns compounded with very low routine EPI coverage. Our analysis of missed children shows that most of the children missed in a campaign are in areas where teams have the access. This indicates main challenge of improving gaps in planning, management and accountability and low community awareness and demand**.**
- However the reasons for missing children in the Eastern Region show a different pattern then the South so does the approaches in addressing the challenges and developing strategies as such. In the Eastern Region the sole reason for missed children is the inaccessibility in some certain districts either totally or partially. The frequent cross border population movement between Pakistan and Afghanistan contributes to the increased risk of virus circulation as well as missing children in one or the other country.
- The South-Eastern region is also having the same type of risks as the Eastern although no cases have been reported from the former so far. However, the increased number of cVDPV cases over the other side of the border in the North Waziristan adds on to the overall risks in the bordering provinces of the South Eastern Region, some of which have reported cases in the previous years.
- The mobile populations such as nomads, gypsies and returnees constitute another group of population at risk and targeted strategies are needed to reach out them. In addition the deterioration of the security, cross border tensions, the 2014 year that is seen by many as a turning point in the country have all potential risks of mass population movements, thus require special focus hence mitigation measures to be taken.

II. ASSESSMENT OF NEAP 2012-13 (Jan-June)

1. Update on implementation of National Emergency Action Plan, 2012-13 (Jan-Jun)

a) Enhance Advocacy, Ownership and Oversight:

- Political commitment in Afghanistan remains strong at the national level, however turning the commitments into action at the provincial and field level requires extra efforts.
- High level advocacy meeting all of which are expected to add value to the programme activities such as Inter Ministerial Task Force has taken place but level of participation and regularity need improvement. Similarly the formal meeting of Provincial Governors of high risk province with H.E President on Polio Eradication has to take place. The impact of the aforementioned meetings on strengthening coordination and cooperation would have been huge.
- Regional/Provincial level ownership seems to be picking up but varies and need to be more regular and uniform with reporting to the office of H.E President in monthly basis.

- The ownership at District levels in Low Performing Districts is improving gradually but differs from one district to another and from one round of the campaigns to the other as such.
- It is very essential to assess the community level ownership however there has not been any data readily available to look into this particular area of importance. One small scale investigation through using globally developed questionnaires has indicated a huge potential to obtain ownership by the communities at households and by the religious and elders of the communities. However these results need to be interpreted cautiously and can't be generalized since they have based on perceptions of the few interviewees in a district of Nangarhar province.
- Increased ownership and creating demand by communities and parents are essential for polio program in Afghanistan for the success of eradicating polio, specifically at a time when Afghanistan is seen "on the brink of eradicating polio" by the May 2013 IMB.

b) Strengthen Management and Accountability: District EPI Management Teams;

- The District level interventions and actions have been found the key for achievements/accomplishments of the PEI both in quality and quantity terms.
- In each of the low performing districts in Southern region, District EPI Management Teams (DEMTs) are constituted as part of structural and functional reforms to improve and strengthen SIAs management and service delivery at district and sub-district levels.
- In order to enhance the capacity of provincial and district mid-level SIAs manager formal trainings were conducted in the Southern and Eastern Regions. This is a 5-day training package constituted of 3 days for Management and Accountability and 2 days for IPC and has been found very beneficial both by the trainers and trainees. The profile of participants included Ministry of Public Health, NGOs, UNICEF and WHO staff at all levels from regional to provincial and down to district.
- An accountability framework, with tasks to be performed, key monitoring indicators of performance for all relevant personnel at all provincial and district levels, line supervisors, frequency of appraisal has been developed and is being used in LPDs.
- Number of actions taken by each level towards campaign personnel due to lack of improvement in performance is partially done and remains a major challenge, particularly in some of the districts of Helmand and Kandahar.

c) Increase Access to all children in conflict affected areas:

- Engaging ICRC and local level access negotiations were used as basic strategy and local access negotiators from within the communities who are acceptable to various parties were recruited. More than 10 meetings arranged by ICRC during the period August 2012 to January 2013 in order to ensure to gain access to some security compromised areas during the 1st half of 2013.

- As a result of all these concerted efforts along with some improvements in the management of the campaigns the average number of missed children has decreased from 61,500 in June 2012 down to 12,500 in March 2013 in LPDs in the Southern Region, a significant decrease by approximately 80%. However the Eastern Region has not been able to show any progress while having around 15,500 missed children in June 2012 it has increased to 17,000 in March 2013 by around 20%. Nonetheless these results need to be interpreted cautiously since the number of places differ from one round to the other thus affecting the denominator but still is important to monitor the trends and give hints for in depth analysis.
- Another indication of reaching out more children and missing less is the decrease in the number of zero-dose OPV for non-polio APF cases, especially in the Southern Region, which has been 30, 19 and 1 in 2011, 2012 and the first six months of 2013, respectively.
- What is continuing to happen in Nangarhar, Kunar and Nooristan provinces of Eastern region is that around 20,000 children remain inaccessible in each campaign.
- Several initiatives have taken place in order to gain access in the Eastern Region, a region of which has increasingly become a serious concern.
- Mapping of children by clusters/villages and by reasons has been carried out, which helped understand the causes at different levels such as immediate, intermediate and root causes in the Southern Region and the same experience has been applied in the Eastern Region and in the other areas of concern.
- Special investigations through using globally developed but locally adopted questionnaires have also contributed to all those in depth analysis.
- All of these efforts have made it possible to understand the dynamics of the inaccessibility due to security and to develop strategies for each of the clusters/villages as per their unique situation.
- It has become clear that “One size does not fit all”. A strategy that has worked in the Southern Region apparently has had little or no chances to be implemented in the East.
- In the Southern Region the problems in insecure areas were mostly around the conflict of interest in the selection of campaigners while in the East they were related to misperceptions and ill beliefs of the OPV and immunization.

d) Increase Community Demand:

- The new polio communication campaign with a motto “Ending Polio is MY RESPONSIBILITY” has been launched with over 8 times increase in the airtime use on both radio and television for PSAs; over 25 radio and 12 television channels broadcast Polio messages in SNIDS and over 50 radio and 19 television challenges do so in NIDs, expansion of use to include all varieties of programs and active involvement of media personnel.
- Polio/ Immunization Communication Network restructuring to increase linkages between operations and communication workers has been completed. By end 2012, the

social mobilization network covered 80% of the low performing clusters in Southern Region. Provincial Polio Communication Teams comprised of representatives of departments of education, religious affairs, women affairs, youth/ sports have been constituted in Kandahar and Helmand and are working on active involvement of these departments in awareness raising, community involvement and monitoring of communication activities

- The Inter Personal Communication (IPC) training module for Polio campaigns was revised and training of all vaccinators, social mobilizers and cluster supervisors in the Low Performing Districts has been completed.
- Community Sensitization sessions with mullah imams, ulema-i-shura and other community elders organized in LPDs of Southern Region.
- Sporting events including football tournaments were organized to promote the cause of Polio eradication in Southern region
- According to a KAP survey conducted in 2012, in the 13 high risk districts of Southern region 73% of caregivers had heard of polio campaigns while 83% of caregivers were aware that OPV can prevent polio.

e) Strengthen Routine EPI:

- A comprehensive EPI review has been conducted and an action plan is being prepared on the basis of findings and recommendations.
- GCMU has been engaged to review the performance of the NGOs however corrective actions for under performance are still pending.
- A joint review meeting of EPI and PEI has taken place with the participation of National, Regional, and Provincial EPI/PEI staff along with donor community, NGOs, UNICEF and WHO.
- The well-established infrastructure of AFP surveillance system is contributing the improvement of the EPI activities, including the epidemiological surveillance of measles. AFP surveillance data has been and is still being used to identify the low coverage areas and as a result districts have been mapped to conduct additional EPI interventions such as RED approach and measles and TT immunization campaigns.
- Two major vaccination campaigns have been conducted one for measles to control the outbreak and the other for TT to eliminate the NNT, both of which though have applied a different strategy compared to polio campaigns, have been paired with OPV. The measles plus OPV campaign targeted 0-10 years of age for OPV in 34 provinces and according to a PCA survey 94% coverage was obtained. A total of 96 districts have been targeted in all regions for TT campaign.

2. **Positioning the PEI Program for low transmission season, Jan-June 2013:**
    - Based on recommendations of the November 2012 Technical Advisory Group (TAG) and also in the light of November 2012 IMB Report, Afghanistan PEI program has developed an accelerated plan for 6 months of 2013. The objective is to take full advantage of low transmission season to stop the poliovirus circulation.
    - The key strategy for repositioning during this period was to conduct frequent and closely spaced campaigns in LPDs to boost the immunization levels of target children, which is knows as Short Interval Additional Dose (SIAD) campaigns along with usual NIDs and SNIDs in the other parts of the country or nationwide. In between when and as a WPV was confirmed case response campaigns were also conducted.
    - The PEI has re-strategized the campaign interventions by taking a proactive stand against the cVDPV cases in neighbouring Pakistan and conducted campaigns in the bordering areas of Southern Eastern Region.
    - Intense Focus and increase schedule of SIAs (Kandahar, Helmand, Kunar, Nangarhar); In order to achieve the maximum benefit of low transmission season with the aim to stop poliovirus circulation it was planned to administer at least 8 doses of OPV in LPDs during period of January-June 2013. Nine rounds of SIAs are completed by end of June in 11 LPDs. Additional rounds are administered in Kunar, Nangarhar, Khost and Paktia as case response.

3. **Revision of high-risk districts and rename as Low Performing Districts (LPDs):**

    An exercise was undertaken in January 2013, using set criteria to list low performing districts. There were 31 districts in the country under LPDs. Out of the total 31, there are 11 districts in south (7 in Kandahar and 4 in Helmand) which were taken as category 1 for operational purposes and were the main reservoirs (sanctuaries) while rest of the 20 are in Category 2.

4. **Enhance Capacity of DEMTs**
    - A five days training was held in January 2013 to train 70 personnel at district level from the 11 LPDs. The training plans aimed at improving management, planning, supervision and monitoring. For the first time pre- and post- tests were conducted, which had shown significant improvement in knowledge. Also district and cluster specific plans are updated in these trainings.
    - One of the factors that was presumably contributed to the increase in coverage of vaccination campaign in the LPDs was the capacity development of the DEMTs, which has made them better equipped with knowledge and skills

5. **Strengthen Monitoring, establish dashboard system and Polio Control Rooms:**
   - Real time monitoring and provision of proper feedback to the field through functional Polio Control Rooms and dashboard system to link them with governors was another priority to improve the quality of campaigns.
   - Dashboard system has started in some selected districts of the then HRDs, while Polio Control rooms (PCR) have started to function since April NIDs. In the first phase PCRs are established at National level, in 11 LPDs of 4 provinces in the Southern region. However despite efforts PCRs have yet to become fully functional due to different reasons including management and administrative issues. Refresher trainings and close monitoring and oversight efforts have resulted in regaining momentum for PCRs to fulfil the requirements.
   - Afghanistan also started, for the first time, LQAS since April. Results of the first LQAS was critical in terms of campaign coverage in most of the LOTS (Districts). Out of 24 LOTS only 3 have been accepted at 90%, while 6 at 80% and the rest of 15 LOTS have been rejected at 80%. Eastern and South Eastern regions with virus circulation in 2012 and 2013 have particularly low performance, both of which have 4 out of 5 LOTs rejected at 80% and only 1 LOT in each has been accepted at 80% while none at 90%. In the rest of the Regions there has been at least 1 LOT rejected at 80% and none has more than 1 LOT accepted at 90%. While the results of the Eastern and South Eastern Regions are troublesome all of the regions have results of serious concern.
   - In June, 10 out of 20 LOTs have been rejected at 80%, 9 have been accepted at 80% and only 1 LOT has been accepted at 90%, which happened to be from the Southern Region (Kandahar city/Manzil Bagh). The Eastern and South Eastern Regions have continued to give low results without any LOTs have been accepted at 90% though the Eastern Region has shown some progress.

6. **Identify and surge HR needs in LPDs:**

   Since January 2013, additional 24 staff is placed by MoPH (including staff at national, provincial and district Polio Control Rooms, National and Provincial SIAs coordinators and national communication coordinator), WHO has recruited additional 13 District Polio Officers and 8 Provincial Polio Officers in Southern region, Kunar, Nangarhar Khost and Paktia. UNICEF conducted an HR needs assessment and recruited an immunization communication network manager and grants management officer at the national level, supported recruitment of Provincial Communication teams in Kandahar and Helmand, 4 provincial and 6 District Polio Communication Officers have also been recruited.

7. **Increasing immunization communication network:**
   - Polio/ Immunization Communication Network restructuring has been completed. By end 2012, immunization communication network covered 80% of the low performing clusters for communication in Southern Region. The awareness levels in the then 13 HRDs in

Southern Region increased from 55% in April to 64% in October 2012 and 84% in February 2013 polio campaign.

8. Missed children due to management related issues:

- The Southern Region has missed children between 8-10% during a period of January 2012-April 2013.
- In the LPDs of the Southern Region the proportion of missed children differed from 12% in January 2012 to 6% in May 2013 with a peak of 20% in December 2012. In comparison to the overall Southern Region the LPDs all of which have also located in the South has shown a noticeable improvement by reducing the number of missed children by 50%. This may be contributed enhanced efforts and focus in the LPDs
- Amongst all, Musa Qala and Nawzad LPDs are the only ones which have achieved having less than 5% missed children due to no team visit across all rounds. The rest of LPDs have not shown the same level of performance with Nadali and Shahwalikot showing the worst. Shahwalikot is constantly not performing well both in no team visit and awareness indicators.
- Half of the missed children in LPDs were due to child not home while the other half was shared between team did not visit and all kind of refusals including hidden ones. This a trend has not changed for over a long period of time thus indicates redirecting efforts towards different causes with tailored strategies.
- It is interesting to observe that the Eastern Region has shown the same trend though the scope of the problem differed in proportional terms. The percentage of missed children was over 2% in September 2012 and April 2012 with a peak doubled more than 4% in December 2012. It is worth looking at what has happened in December 2012 while both of the priority regions (East and LPDs of the South) have shown a significant increase in the numbers of missed children.
- Unlike the Southern Region the great majority of the missed children were due to child not home with approximately 90%. The team did not come has been around 2% while the hidden refusals (sick, sleep, newborn) made the second cause with 8%. It is interesting to observe that the open refusals have never been a cause of missed children always differed between 0 to 0.5%.
- The results of all analysis have once more shown that “one size does not fit all” and every region, province, district even most of the time cluster requires tailored approaches.

9. New approaches:

- New tactics like Permanent Polio Teams are functional in 10 of the 11 low performing districts. These serve as permanent vaccination teams that supplement vaccine delivery outside normal campaign schedules. Almost 195,000 children vaccinated by these teams from April to September 2012 and 6% of them received OPV for the first time. Short Interval Additional Dose Strategy (SIADs), District Focus Campaign, high risk cluster

approach, integration of communication at cluster level with operations and “window of opportunity” in conflict affected areas are adapted during 2012.

- Afghanistan pioneered, yet another intervention, where OPV was administered with Measles vaccine, in all over the country to all children of age up to 10 years. This was done in two phase; first phase was for 17 provinces in July 2012 while second phase was in December 2012 for remaining 17 provinces.

10. Result based Monitoring:

- There is recent indication of increase coverage in low performing districts. Nine of the 11 LPDs had coverage above 80% in recent SIAs compared to 5 districts in December 2012. Four of the 9 LPDs even reached coverage over 90% while only two remained below 80% one of which unfortunately was not able to conduct the campaign.
- Needless to say this improvement provides a promising situation the ups and downs have become a serious issue to be dealt with from a sustainability point of view.
- Nonetheless, the National milestones are also showing steady progress.

PART B:

III. NEAP July 2013-June 2014: Afghanistan polio program has revised the National Emergency Action Plan (NEAP) and as a result of the revision the achievements and challenges have been identified. Based on the findings 3 key guiding principles and 6 areas of interventions have been identified

a. Goal: Interrupt wild polio virus transmission in Afghanistan by end-2013

Milestones

1. All stake holders are well aware of the NEAP at national and sub-national levels by end July 2013
2. Overall estimated number of missed children in accessible areas reduced by 25% by end June 2014 in the Southern Region
3. Estimated number of children missed due to child not home is reduced by 50% by end June 2014 in the Southern Region.
4. Estimated number of children missed due to no team visit is reduced by 50% amongst all missed by end June 2014 in LPDs.
5. Estimated number of children missed due to refusals, hidden(child sick, sleep, new-born) and open together reduced by 50% by end June 2014 in LPDs
6. Estimated number of missed children due to inaccessibility caused by insecurity reduced by 50% by end June 2014.
7. Percentage of zero dose non-polio AFP cases among children less than 5 year of age in Southern and Eastern Regions reduced by 50% by end June 2014
8. 50% of LOTS assessed through LQAS is accepted at 90% and other 50% at 80% by end June 2014
9. By June 2014, over 95 % of parents/caregivers are aware of the upcoming campaign.
10. By June 2014, a 20% increase in the percentage of parents/caregivers who have knowledge about OPV as the only means to prevent polio.
11. By June 2014, over 90% parents/caregivers in LPDs are willing to accept OPV each time it is offered to their children
12. By June 2014, a 10% increase in the number os parents/caregivers in LPDs who know the number of times they need to visit the RI site for routine immunization before the child reaches the age of one year.
13. By June 2014, a 10% increase in the ppercentage of parents/caregivers in LPDs who are aware of the nearest immunization site (health facility/outreach).

b. Objectives

1. Interrupt indigenous poliovirus circulation in Southern Region of Afghanistan by the end of 2013 (zero cases for at least 4 months by the end of 2013)

2. Stop current outbreak in the Eastern Region by the third quarter of 2013 (zero cases for at least 4 months by the end of Q3-2013)
3. Respond rapidly and effectively to any importation of WPV or cVDPV to polio free areas in the rest of the country, and prevent establishment of poliovirus circulation (respond within 2 weeks- by at least conducting 3 rounds of case response campaign)
4. Stop circulation of cVDPV by end 2013 (no cVDPV cases for at least 4 months by the end of 2013)

c. Strategic Priorities

- The polio program in Afghanistan has made a remarkable progress since the shocking outbreak in 2011. The re-positioning of the program in the 1st half of 2013 has made it possible to bring down the number of confirmed polio cases to only 3 with a significant improvement in the traditionally endemic zone of the Southern Region for having reported none. While this achievement can be as a result of concerted efforts in the LPDs in particular with the introduction of innovative approaches, Afghanistan PEI cannot afford any setbacks any more.
- There again is a golden window of opportunity that Afghanistan polio program has to use provided that there will be a careful identification of guiding principles and within that framework key interventions that would bring the success towards the end game.
- Three key guiding principles have been identified that polio program in Afghanistan must and will focus are as follows:
    1. The speed of implementation of activities has to be increased tremendously. This acceleration will not only ensure the accomplishment of key interventions, at the same time is expected to have a multiplier effect.
    2. While the national level commitments need to be translated into concrete and timely action, simultaneously these national commitments should be transferred down to the sub-national levels, specifically to the district/local levels
    3. The improvement of the quality of interventions yet to be improved albeit the quantity has been satisfactory in some key areas.
- The revised NEAP 2013 has grouped key intervention areas in the light of above priorities into 2; the first one is essential activities and the second is the supporting ones. While the essential activities will be the core of the NEAP, the supporting activities continue to be implemented in a way that the former ones are accomplished and progress has been made.
- Six key intervention areas have been identified as essential in line with the 3 key guiding principles are as follows:

Essential Activities

1. **Intense Focus on Low Performing Districts(LPDs)**
   - The changing epidemiological trends has made it necessary to re-visit the list of LPDs and re-set the criteria to identify new LPDs taking into account new emerging issues and epidemiological blocs both in country and cross border with Pakistan.
   - As a result there will be 30 LPDs with a regional breakdown; 9 in the Southern, 21 in the Eastern Regions. The total number of clusters in LPDs is 379 with a total target population of 898,502 under-5s.
   - LPDs will continue to be in focus for all PEI activities including SIAs; aggressive vaccination campaigns will be carried out in the LPDs such as 2 rounds of NIDs, 2 rounds of SNIDs and 3 passages of SIADs. The choice of vaccine will be bOPV but also tOPV will be used in selected LPDs during 1-2 rounds.
   - Service delivery will be reformed and strengthened in the LPDs; the current structure will be assessed to identify the gaps and capitalize on the good practices. As such measures will be taken to increase the efficacy of the service delivery during the vaccination campaigns. The results will inform whether there is a need to revise the current ratio of District Coordinator to Supervisor in the Southern Region LPDs, in case of requirement the ratio will be changed from 1:8 to 1:4. The ratio of Supervisor to Teams will be 1:3-5 maximum.
   - The ratios will similarly be assessed in the Eastern Region LPDs to check the performances and adjustments will be made accordingly.
   - The existing structures of Community Health Workers (CHWs) will be utilized during the campaigns. CHWs will be selected to serve as campaign workers during the vaccination campaigns especially in the LPDs and inaccessible areas.
   - There will be a review of Permanent Polio Teams to measure the achievements and identify loopholes. Corrective action will be taken in case of need. Based on the results there will be an expansion within the Southern Region by the end of September and replication in the Eastern Region LPDs by October 2013, the latter is subject to the agreement with AGEs and availability of funds.
   - Communication will shift focus from raising awareness to community demand and ownership through
     - ICN engagement in the LPDs will go beyond campaign activities to include house to house IPC with parents/caregivers between campaigns focusing on missed children, refusals, identification of new born, and messaging on RI, hand-washing and breastfeeding.
     - ICN will engage key community leaders, local religious leaders, schools/teachers and CBOs in meetings and events to promote social and behaviour change; which will further increase awareness level, knowledge and commitment to immunization and related services.

- Mass media, extensively engaging regional and local media, will integrate relevant messages about importance of immunization, hand-washing and exclusive breastfeeding.
- Polio campaign visibility materials to integrate relevant messages about importance of immunization, hand-washing and exclusive breastfeeding.
- Build capacity of media professionals and journalists on a quarterly basis, especially at the regional level, to highlight the importance of immunization and promote healthy behaviours.

- Management of the program in LPDs will receive a thorough revision and enhancement along with clear cut assigned responsibilities and accountabilities:
  - Update of the micro plans and training plans will be carried out.
  - As mapping has been identified a very useful tool to understand and better visualize the program requirements as well as implications, cluster/village levels will be developed through digital software (ArcGIS) in the Southern Region by the end of September 2013 and will be expanded to the Eastern and South-Eastern Regions by the end-year provided that satellite images are made available in a timely manner.
  - The existing DEMTs will be strengthened in the Southern Region and new ones will be established in the East. However in the Eastern Region the composition of DEMTs will differ from the South to include District Coordinator, District Polio Officer and District Communication Officer.

2. Special Focus on Missed Children

There are 2 major reasons for missed children during the vaccination campaigns. One group is related to the management and the other is caused by insecurity. While there are multiple factors leading to the missed children only the important ones are listed below.

The activities that are mentioned under each section here are not stand-alone activities per se. They are inter-related and mutually support and complement each other.

2.1 Revisit strategy:

- Revisit strategy mostly targets the children who are not at home during the visits of the teams. Since approximately 50% of all missed children were due to child not home the Polio program will look into where these children are.
- The tally sheet and daily record/reports will be taken into account while taking re-visit action during the campaign
- PCA form has been revised which now includes reasons for missed children in more details , including the children not at home during the visits of teams
- Analysis of PCA and Special Investigation for missed children will be taken into account while planning for the subsequent campaigns
- Re-visit strategy in Kandahar and Helmand will be piloted commencing in August;

- Introduction of an additional day (3 + 1 = 4 days)
- Increase the incentives of volunteers by US$1 per day, which will be US$5 per day
- Training sessions will be adapted to include re-visit, separate recording and reporting for the re-visits.
- A targeted training for communications will be included in the package
- Roll out the re-visit strategy based on lessons learned commencing in Q3 2013

- Transit Teams will be deployed to the market places, bus stations to vaccinate the in-transit children.
  - The location of Transit Teams will be informed by the analysis of various forms and investigation tools

2.2 Missed children due to refusals including hidden ones:

- The open refusals have never been an issue of major concern in proportional terms within the overall missed children. The overall open refusals have always been around 2-3%. However a new school of thought has brought the importance of the hidden refusals such as “sick, sleep and new born”, which has triggered of new ways of thinking as regard to the refusals. The refusals combined make approximately 20-25% of all missed children.
- In line with global indicators, Afghanistan PEI has re-categorized the refusals to include the hidden ones and within that thinking to develop strategies for action including re-visit strategy and re-tailor communication activities.
- Interpersonal communication (IPC) skills of the frontline workers will be strengthened
  - Vaccinators, supervisors, health workers and community influencers will undergo exclusive one-day training on IPC skills.
  - The ICN social mobilizers will undergo two days detailed training with refreshers every quarter.
  - Vaccinators and mobilizers will be equipped with appropriate IEC materials
- Focused messages on vaccinating new-born will be disseminated through engagement of religious leaders and Community Health Workers and Skilled Birth Attendants’ networks.
- ICN’s community level interventions:
  - Pre-campaign house to house visits for IPC and dot marking (new and updated ones)
  - Recording of new born that will feed into Microplans
  - Social Mobilizer (SM) to accompany vaccination team as part of the revisit strategy.
  - Collect the list of missed children and refusals compiled by the vaccination team in their assigned area at the end of the campaign, share with Cluster supervisors (ICN) and follow up for actual vaccination of child through RI.

- Community meetings to create awareness and increase knowledge level of mothers and caretakers

2.3 Missed children due to Team did not come*:*

- 20-25% of all missed children is due to team did not come during the campaign.
- Investigation and identification of clusters of missed children to find the causes why team did not come /miss the area. All Regions will have completed this exercise before the NIDs in August.
- Revision and update of micro plans will be done every round to reflect the findings of investigations and ensure every community is covered
- Training of supervisors and volunteers on micro planning, with a specific focus on crossing points between clusters & bordering areas between teams
- Supervisors are the game changers; close supervision and monitoring of the teams in the field will be emphasized
- Proper selection of volunteers is a prerequisite. Volunteers should be from the areas that they will be in charge. No volunteers will be selected amongst less than 18 years of age.
- Special emphasis will be given to the no team visited areas in order to recover/redo.

2.4 Improve cluster level micro planning

- Micro plans at cluster levels will be reviewed
- While doing so, team performances will be taken into account as per the expected levels according to the requirements and characteristics of GI-G2-G3 locations. The target population per team will be re-visited and adjusted according to the characteristics of the population and geography and do-ability will be taken into account.
- There used to be 1 District Coordinator responsible for 8 clusters which will now be 4 clusters in LPDs in Southern Region
- Cluster Supervisors the previous ratio of 1 Cluster Supervisor for 6 Teams will be again halved to 3 Teams in LPDs in Southern Region.
- The DEMTs is assigned to play a key role and will be assessed against a defined set of indicators
- Mapping farther down to cluster and village levels will be developed in the Southern Region in July 2013 which then will be rolled out to the Eastern Region in August and then to Southern Regions in September 2013. For that purpose ArcGIS is being introduced and IT hardware and software have already been made available

2.5 Special Investigation of missed children

- The National Rapid Response Team (NRRT) as part of its tasks to conduct detailed case investigation as and when a WPV/cVDPV case is confirmed will continue to undertake special investigation of missed children through using the global questionnaire.
- The NRRT will start using cumulative clusters of missed children as a trigger in order to undertake special investigation which is expected to facilitate in reducing the number.
- Findings will be fed back into all relevant activities including microplan revision

2.6 Missed children in insecurity locations;

- Although the proportion of missed children due to insecurity is relatively low it changes from one location to another as well as from one round to another where it could become high. Quite high percentage of those children are confined geographically into the low performing districts and continue to possess a high risk due to accumulated pool of susceptible children.
- Cluster level analysis will be done every round in Southern and Eastern Regions to map affected areas and identify specific causes of inaccessibility
- Local level efforts/negotiations will include:
    - Negotiating access through ICRC (SR) & local access negotiators
    - In the Eastern Region a low profile approach will be adopted through the engagement of Community leaders, Religious leaders to gain access to insecure locations
    - Special attention will be given for the selection of the campaign staff (safety of polio workers will be given utmost importance)
- Polio activities will be paired with other health/socio-economic interventions in LPDs
- Campaign schedule will be communicated National Police Forces (ANP/ALP) and AGE as and when applicable and useful
- There will be flexibility in conducting the campaigns as the access is gained the window of opportunity will be used
- Transit teams in entry and exit points of the inaccessible areas will be deployed
- Maintaining the neutrality of the program is a ground rule that the program will keep up
- Identify PCOs and DCOs and train them on techniques and strategies of access dialogue in inaccessible communities/clusters

3. **Communication for increased community demand and ownership**
    - **ICN will continue to create awareness at community level and expand their activities beyond the campaign period in all 30 LPDs to:**
        - Include house to house IPC with parents/caregivers between campaigns focusing on missed children, refusals, identification of new born, and messaging on RI and hand-washing.
        - Engage key community leaders, local religious leaders, schools/teachers and CBOs in meetings and events to promote social and behaviour change; which will further increase awareness level, knowledge and commitment to immunization and related services.
        - Ensure parents/caregivers seek for services through engagement of gate keepers at the community level, skilled birth attendants and community health workers where they exist.
    - Strengthened capacity building of the ICN personnel based on rapid learning needs assessment at all levels of the ICN.
    - Establishment of Standard Operating Procedure (SOP) for the ICN in the provinces with 30 LPDs
    - Provincial Social Mobilization Groups (PSMG) in all provinces with the 30 LPDs will be established by September 2013. The groups will be orientated to ensure they function effectively and efficiently with clear guidelines and verifiable deliverables.
    - Mass media, extensively engaging regional and local media, will integrate relevant messages about importance of immunization, hand-washing and exclusive breastfeeding.
    - Polio campaign visibility materials to integrate relevant messages about importance of immunization, hand-washing and exclusive breastfeeding.
    - Mobile technology will be employed to broadcast polio related messages before and during the campaigns through SMS/Outbound calls/IVR

4. **Management and Accountability**

    The existing management capacities will be strengthened in order to enhance the service delivery. The capabilities of polio staff especially at district levels will be in focus along with accountabilities assigned to each and every level.

    - Training on Management and Accountability and IPC will be conducted in the South- Eastern Region in August 2013
    - Southern and Eastern Regions which have already received training will receive refresher trainings in the 2nd half 2013
    - While DEMTs will be strengthened in the Eastern Region, new DEMTs will be established in the Eastern and South Eastern LPDs but with a different

composition. The new DEMTs will be comprised of District Coordinator, District Polio Officer and District Communication Officer.

- District Coordination Committees consisting of all line departments that exist in the district will be established in all LPDs & meet prior to every round
- District Governors of LPDs will receive trainings/orientation sessions by October 2013
- The ICN cluster supervisor will supervise the social mobilizers (SMs) in the LPDs
- New financial mechanisms (including direct disbursement) will be introduced in 4 districts in August and a roll out plan will be developed based on experience
- A policy that no position should remain vacant more than 1 month has been adopted.
- Quarterly appraisals against set of indicators on standard forms will be carried out

5. Strengthening Surveillance:

i. AFP Surveillance:

- A surveillance review will take place in Q3 2013, focusing specifically on insecure areas to assure the quality of AFP surveillance
- Based on the findings of the review corrective actions will be taken
- Orientation seminars will be conducted for reporting volunteers at district level and formal training for AFP focal persons and Provincial Polio Officers/District Polio Officers in the second half of 2013

ii. Environmental Surveillance:

- PEI Afghanistan is introducing environmental surveillance to better understand the virus transmission patterns and re-tailor the strategies in interrupting it.
- Kandahar and Helmand in the Southern Region will start the environmental surveillance in the 3rd Quarter while Nangarhar and Kunar of the Eastern Region will do so in the 4th Quarter 2013

6. Routine EPI

- Active surveillance visits will be used to monitor and provide regular feedback on RI fixed and outreach sessions. Polio staff will monitor at least 30% of out-reach and fixed EPI sessions particularly in non-transmission zones.
- EPI performance will be reviewed in Quarterly EPI meetings and monthly coordination and dialogue between national EPI and GCMU on BPHS NGOs' performance.
- Clear linkages between polio and routine immunizations will be established through shared micro planning and where feasible through joint micro planning in selected districts.

- Active surveillance visits will be used to monitor and provide regular feedback on RI fixed and outreach sessions. Polio staff will monitor at least 30% of outreach and fixed EPI sessions particularly in non-transmission zones.
- The AFP surveillance system infrastructure will be paired with other disease surveillance systems such as measles and NNT as well as Disease early Warning Systems (DEWS), commencing in selected provinces from October 2013 onwards.
- AFP surveillance data will be used to strengthen RI in low coverage areas.
- Capacity building of PEI Staff on Routine EPI/RED; Key polio field staff will be trained on outreach/pulse immunization strategies/activities.
- BPHS NGOs will ensure that 80% of all outreach vaccination activities are realized in the Southern, Eastern and South Eastern Regions. In order to do so there will be proper micro planning and deployment of vaccinators in sufficient numbers.
- PEI Communication network will be used to increase community demand and ownership.
- Training of ICN (PCO and DCO) on RI with focus on IPC with parents/caregivers for RI including the diseases, type/name of vaccines used, schedules, AEFIs, vaccine administration routes, RI card retention.
- ICN in 30 LPDs will mobilize parents/caregivers to take their children to the nearest immunization centers by providing information on location, date/day time.
- ICN Cluster Supervisor in 30 LPDs will report on sessions held vs. planned in their areas of coverage and provide feedback to the appropriate level for action.

Supporting Activities

1. **Oversight, Ownership and Political Commitment**

- The program will ensure that quarterly meetings such as HE President's Meeting with Governors, HPC, IMTF will be conducted as scheduled
- The Polio Policy Dialogue will meet every other months under the Chair of the Minister of Public Health
- Provincial Governors of LPDs will organize and chair inter sectoral meetings prior to the each and every SIAs

2. **Strengthening Monitoring:** At the outset it is important to note that all of these new approaches are meant to complement each other rather than compete against. All of these important and impressive initiatives are to serve for one single purpose which is to get each and every child vaccinated.

i. Introduction of LQAS:

- In follow up to the initial implementation, LQAS will be conducted in all Regions following all NIDs and in Southern, Eastern, South-Eastern and Western Regions after SNIDs.
- As more and more results start reaching it will become possible to undertake trajectory analysis.

ii. Ensuring independency/quality of Post campaign assessment:

- Contracting out: In Kandahar province of the Southern Region the PCA has been outsourced to the Kandahar University for quality assurance and efficiency. This model has been agreed to be replicated in Nangarhar province of the Eastern Region with the Nangarhar University during July SNIDs.
- The replication in other regions will be decided based on lessons learned by the end of July and a roll out plan will be developed by then.
- NGOs will be involved in the campaign planning and monitoring activities

iii. Polio Control Rooms (PCRs):

Polio Control Rooms (PCRs) will become fully functional at National level as well as at province level in the Southern, Eastern and South-Eastern Regions, which will be in total number of 11.

iv. Dashboards

- Dashboards will continue to be produced at National Level and District Levels for LPDs and will be fully taken over by the PCRs
- Development of web-based Dashboard for wider dissemination.

v. Mobile technologies

- Use of mobile technologies for monitoring of ICN activities in 30 LPDs.
- Mobile technologies will be initiated to collect real time data on timely availability of vaccine and IEC materials, timely payments and spot checks for missed areas and children.
- SMS data query to facilitate immediate availability of data from the central server.

vi. Polio Info

- Use of polio info database to provide hub for different data set of PEI Afghanistan for partner and public consumption.
- This digital platform will provide data and information on several polio program indicators with facts, figures, maps, and graphics by regional, provincial, district

breakdowns, individually or in groups and will become fully available in the 2nd half of the year.

vii. Harvard KAP Polling

KAP survey in the 30 LPDs with full ICN structure using Harvard Polling methodology by Q4 of 2013

3. Advocacy and Social Mobilization

- Advocacy initiatives at the national level involving the Presidential Focal Person, the Policy Dialogue Group, High-level Council and briefings to the Cabinet.
- Quarterly review meetings with the donors supporting polio eradication initiative and routine immunization.
- Establishment of the national Islamic Advisory Group to support PEI efforts and preparation of a six months work plan.
- Provincial Social Mobilization Groups (PSMG) to mobilize various line ministries in all provinces with LPDs will be established by September 2013. The groups will be orientated to ensure they function effectively and efficiently with clear guidelines and verifiable deliverables.
- Regional and provincial level advocacy meetings under the leadership of the Governor.
- Continue advocacy with non-State entities to facilitate access in security challenged areas in collaboration with ICRC and other partners.

4. Vaccine & Cold Chain Management

- Vaccine and cold chain management review to facilitate development of a roadmap to improve vaccine management, decrease wastage rates and better cold chain management by end of September 2013.
- Better reporting of vaccine utilization and wastage rates after each Supplementary Immunization Activities
- Capacity development on improved vaccine and cold chain management for all campaign personnel by end 2013.
- Coordinate with supplies team to ensure timely receipt of vaccines and ensuring polio vaccine buffer stock in view of global shortages.

5. Cross border coordination

- Cross border transit teams will continue to function in border gates around the clock on permanent basis. The composition of teams will be driven by the volume of people crossing the border on regular basis. However the challenge

will remain how to cope with in case a mass population movement and/or displacement takes place due to unforeseen incidents.

- Regular cross border meetings will be held between bordering district teams to share the plans before each campaign: Peshawar and Jalalabad teams meet at Torkham border while Spin Boldak and Killa Abdullah team will hold their meetings at Friendship Gate.
- Already a decision has been made to have two regional cross-border meetings one in Afghanistan/ Jalalabad city and the second one in Quetta of Pakistan. As regard to have a national meeting it has yet to be decided.
- Build IPC skills of cross-border, transit and transport hub teams.
- Close monitoring of negative propaganda and rumours by media across borders.

IV. CONCLUSION

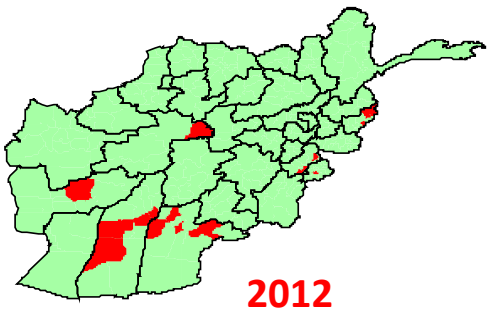
- While developing the NEAP Afghanistan PEI has taken into consideration all of the comments and recommendation of global, regional and national advisory and monitoring bodies and adopt them after having tested the affordability, acceptability and applicability.
- In addition Afghanistan PEI builds on the program's accomplishments, achievements, lessons learned successes and failures alike and to develop new strategies accordingly based on all.
- This very National Emergency Action Plan is meant to provide a frame work which must be considered a Master Plan of Operations. Needless to say for it to become realistic and operational there is a need to draw operational matrices at national and regional levels.
- When looking at some of the set milestones to be achieved it might be considered ambitious for different reasons, however no matter how ambitious they are in fact realistic and doable provided that the commitments turn into actions and implementation takes a fast track.
- Apparently some of the strategies and actions in this NEAP are based on predictions, which may not keep up with the happenings. Therefore it is important to keep the NEAP flexible enough to adapt according to the changing environment no matter whether the changes are epidemiological and health related or socio economic or both. The extrinsic and intrinsic factors that affect polio dynamics need to be well understood, internalized and adopted. Only by this way it will be possible to keep up with the dynamics of PEI and assure the end game strategy to free Afghanistan from poliomyelitis.
- Last not least this NEAP intends to tap into a new era of making sure that "the country's goal of stopping transmission is not just a target on paper, but a genuine deadline to be respected" (IMB Report June 2013)

V. ANNEXES

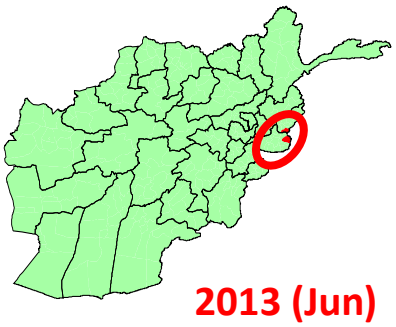
I. List of Acronyms
II. Maps, Graphics, Charts, Tables
III. SIAs Schedules
IV. Chronology of LPDs
V. Milestones Monitoring Framework
VI. Action Plan

Annex-2
Distribution of Polio Cases, 2012-2013 (Jan-June), Afghanistan

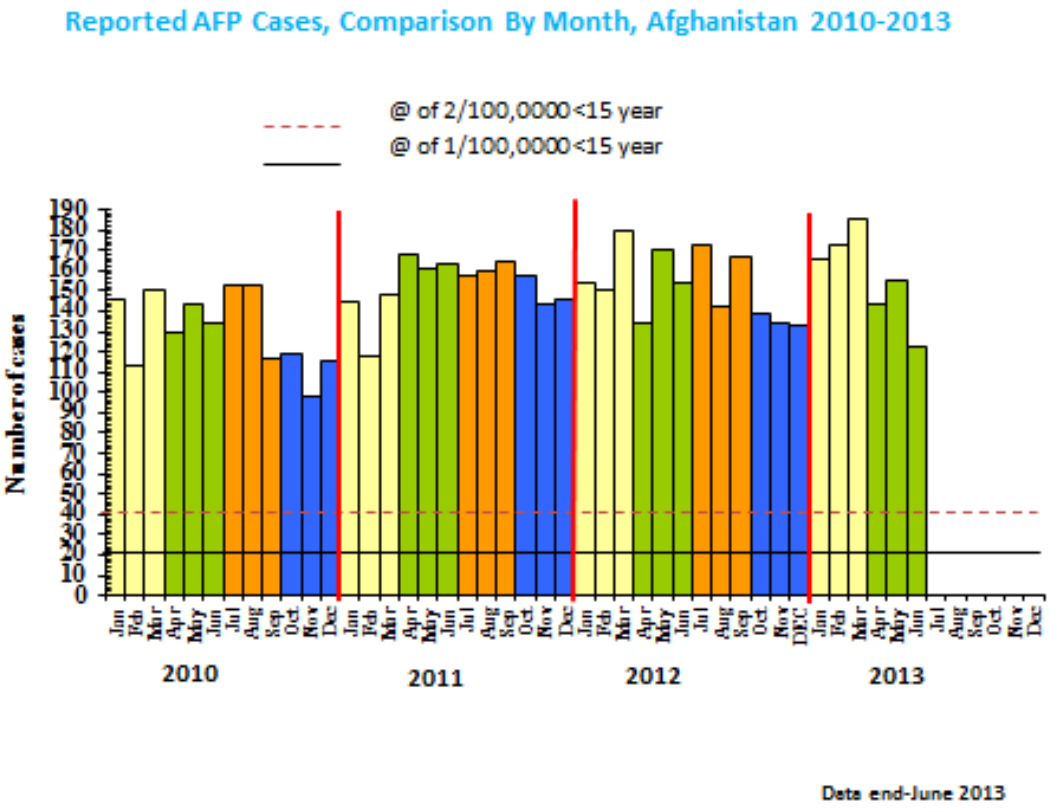
Region	Confirmed cases		cVDPV2	
	2012	2013*	2012	2013*
South-Farah	26	0	11	03
South east	5	0	0	0
East	6	3	0	0
Country	37	3	11	03



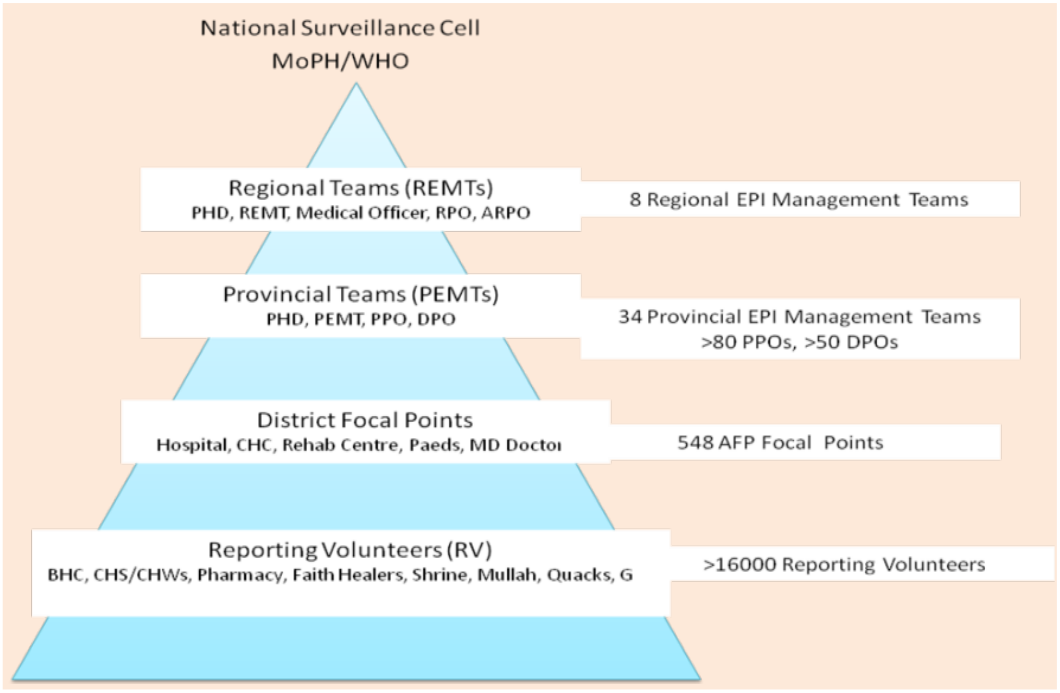
2012
Dist=21
WPV1=37



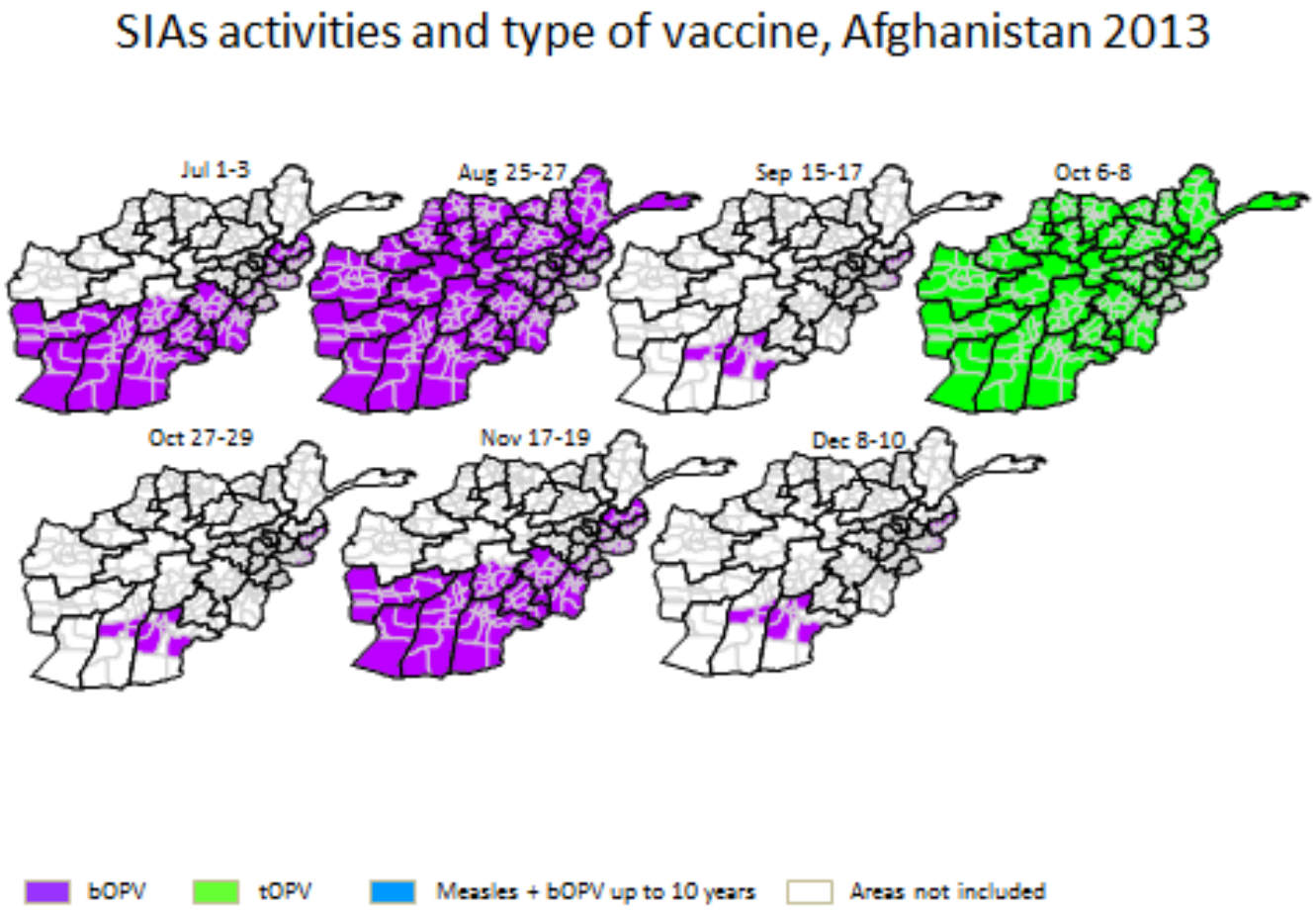
2013 (Jun)
Dist=3
WPV1=3



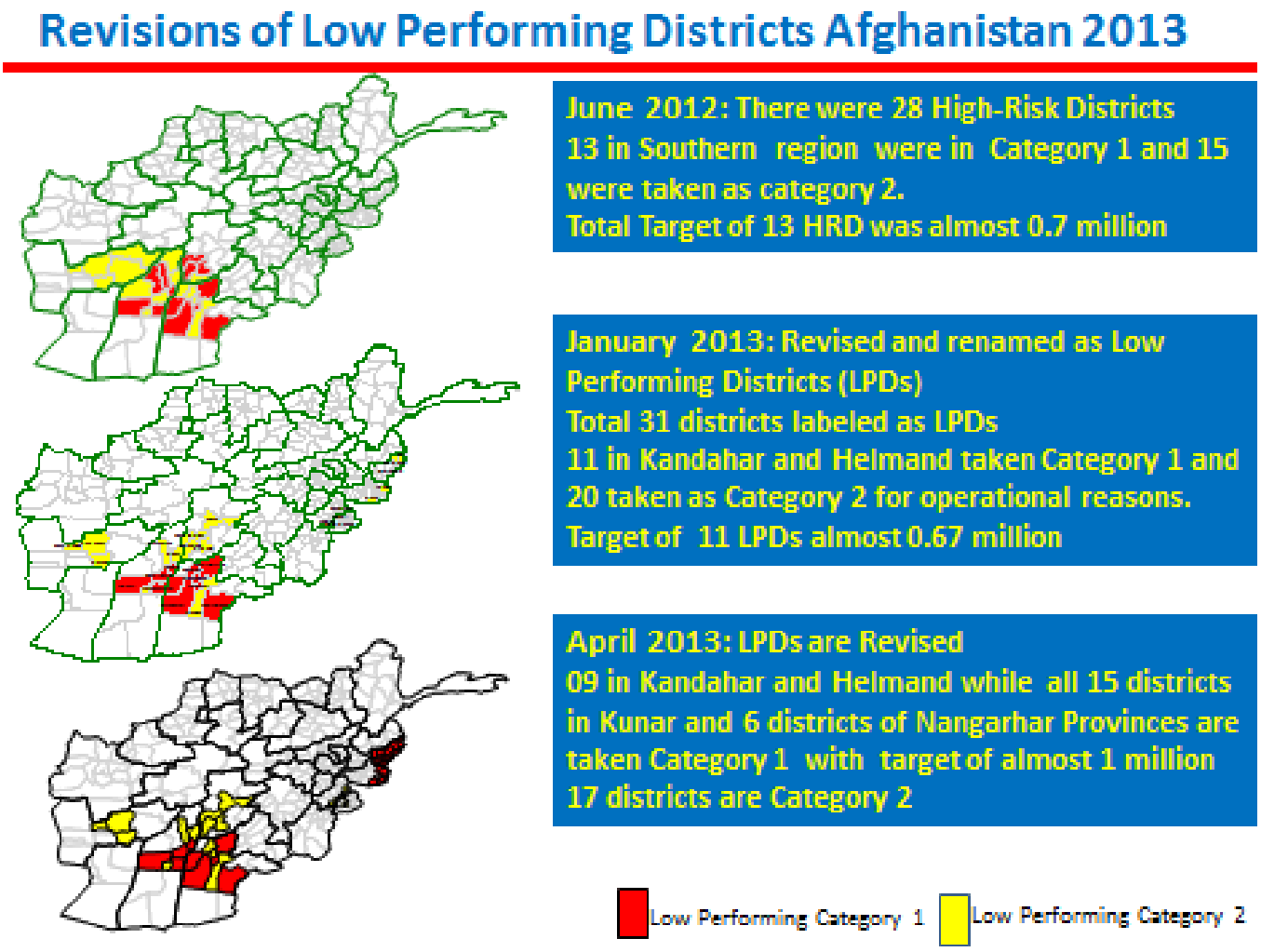
AFP Surveillance Structure in Afghanistan



Annex-3
SIAs Schedules, July-December 2013



Annex- 4
Chronology of LPDs



Annex-5

PEI Afghanistan-NEAP July 2013-June 2014
Monitoring Framework July – December 2013

Key Milestones	Baseline	Target	Source of data	Status
1. All stake holders are aware of NEAP at Nat'l/Reg'l/Provincial Levels	0%	100%	MoPH/WHO/ UNICEF	
2. Overall estimated number of missed children in accessible areas reduced by 25% in the Southern Region by the end of June 2014			PCA	
3. Estimated number of children missed due to child not home is reduced by 50% by the end of June 2014 in the Southern Region.			PCA	
4. Estimated number of children missed due to no team visit is reduced by 50% amongst all missed by the end of June 2014 in LPDs.			PCA	
5. Estimated number of children missed due to refusals, hidden(child sick, sleep, new-born) and open together reduced by 50% by end June 2014 in LPDs			PCA	
6. Estimated number of missed children due to inaccessibility caused by insecurity reduced by 50% by end 2013.			PCA	
7. Percentage of zero dose non-polio AFP cases among children less than 5 year of age in Southern and Eastern Regions reduced by 50% by end June 2014			WHO	
8. 50% of LOTS assessed through LQAS is accepted at 90% and other 50% at 80% by end June 2014			WHO	
9. Level of community ownership increased at 90% by end June 2014 in all LPDs			UNICEF	

PEI AFGHANISTAN-NEAP July 2013-June 2014

Action Plan-June-December 2013

Type	Activity	Level	Frequency	Responsible Person	Timeline						Status	Remarks
					Jul	Aug	Sep	Oct	Nov	Dec		
Advocacy, Management, Oversight	President Meeting w/Governors	Nat'l	Quarterly	Dr Kakar President's FP			■			■		
	Governor Reports to President	Nat'l	Monthly	LPD Governors	■	■	■	■	■	■		
	Feedback to Governors	Nat'l	Monthly	Dr Kakar President's FP	■	■	■	■	■	■		
	Inter Ministerial Task Force Meeting with engagement of Education, MRRD and Nutrition Program	Nat'l	Quarterly	Dr Mashal, DGPM			■			■		
	Polio Policy Dialogue Group Meeting	Nat'l	Quaterly	Dr Mashal, DGPM			■			■		
	Nat'l EPI/PEI Task Force Meeting	Nat'l	Weekly	Dr Dost NEPI Manager	■	■	■	■	■	■		
	Provincial Inter-Sectoral Coordination Committee Meeting	Provincial	Campaign wise	Prov Governors								
	EPI/PEI Standing Committee Mtg in LPDs	Provincial	Weekly	PHDs in LPDs	■	■	■	■	■	■		
	USE OF ACCOUNTATBILITY FRAMEWORK???											
	Provision of basics/refresher trainings on Management and Accountability in focus provinces	Pilot Districts	From Aug to Oct	Dr. Wasim, NEPI Dr. Ali Zahed, WHO Dr. Khalil, UNICEF		■	■	■				
	Implement direct disbursement/payment	in Kandahar	Campaign wise	WHO Finance UNICEF Finance		■						
Missed Children	Revised PCA Checklist with information on missed children reason	National	Once	Dr. Hanif Niazi, NEPI Dr. Arshad, WHO PEI/TL Mr. Zahed Shah, UNICEF	■							
	Analysis of Missed Children	Nat'l	Campaign wise	Laurence, WHO D/PEI/TL Zahed Shah, UNICEF	■	■	■	■	■	■		
	Plan and Implement re-visit strategy	Kandahar & Helmand	Campaign wise	MoPH/WHO/UNICEF		■						
	Digital Mapping at Cluster/Village Levels	LPDs	Once	Dr Magdi/Mr Haroon, WHO Dr. Khalil/Zahed Shah, UNICEF		■	■	■				
	Special Investigation of Missed Childen	Nat'l	As per triggers	Dr Akif, WHO, D/PEI/TL								
SIAs	Finalize The Timetable	National	6 monthly	Dr. Dost, NEPI Manager Dr. Arshad, WHO, PEI/TL Ms. Carmen, UNICEF, PEI/TL	■					■		
	Vaccine Suppy and other Logistics	National	Campaign wise	Mr. Mateen NEPI, CC Manager Dr. Khalil, UNICEF	■	■	■	■	■	■		
	Finger Marker Supplies	National	Campaign wise	Dr. Habib, WHO Mr. Mateen NEPI, CC Manager	■		■		■			
Routine EPI	EPI Review Meetings with NGOs implementing RI	National/ Provincial	Twice a year	Dr Dost, NEPI Manager PHD of provinces								Quarterly at Provincial level
	EPI Performance Review	National	Quarterly	GCMU/MoPH								
	Training on ICN on routine EPI (basics to endhance social mobilization/messages	Provincial/LPDs	Every 6 months	Jones, UNICEF Khalil, UNICEF		■	■					
	Develop RI messages/illustrations for use with polio SIA IEC Materials	National Provincial	Twice a year	Mr. Joshi, UNICEF		■						
	Conduct 80% of outreach immunization	LPDs	Monthly	BPHS NGOs	■	■	■	■	■	■		
	Monitoring RI and Surveillance by PEI Staff	National	Monthly	MoPH PPO/WHO UNICEF	■	■	■	■	■			

PPTs	Review of PPTs	LPDs	once	Ms Laurence, WHO Dr. Arshad, WHO								
	PPTs Roll-out to ER	ER	once	Ms Laurence, WHO Dr Arshad, WHO PEMT								
LPDs	Review LPDs	National	Year End	Dr Akif, WHO, D/PEI/TL								
Strengthening Monitoring	Outsourcing Intra and Post Campaign Assessment to Universities	ER, SR, SER and Farah	Campaign wise	Dr Arshad, WHO Dr Akram, WHO								
	Conduct LQAS after NID/SNIDs	National	Campaign wise	Ms Laurence, WHO Dr. Habib, WHO								
	Polio Control Rooms are functional at	National	Once	Dr Omar NPCR Coordinator								
		LPDs Provinces		Dr Hanif NPCR Coordinator								
		LPDs		Dr Samiullah M. WHO								
	Polio Control Rooms established in East	National	Once	Dr. Omar, NPCR Coordinator Dr. Niazi, NPCR Coordinator Dr. Akif/Dr. Sami, WHO								
	Development of Dashboards	National LPD's Provinces LPDs	Campaign wise	Dr. Magdi, WHO Dr. Esmat, WHO PEI Kandahar								
	Post Campaign Communication/operation review	LPDs	Quarterly	Mr. Zahed Shah, UNICEF								
	Use of Mobile Technology for Monitoring of PEI	LPDs	Campaign wise	Dr. S. Farouq Sadat, MT Coord. Zahed Shah, UNICEF								
	Operationalization of Polio Info Data Base for Afghanistan (with special focus on priority provinces)	National	Campaign wise	Mr. Mussadiq (temp), BMGF Mr Zahid Shah, UNICEF								
	Monitoring of Implementation of Media Plan during campaigns	National	Campaign wise	Dr. Maiwand, NEPI Mr. Zahed Shah, UNICEF								
	Conducting KAP Survey (using Harvard Poll methodology)	LPDs		Mr. Zahed Shah, UNICEF								
Communication and SM	Mass Media Communication Campaign - continued	National/ Provincia	Campaign wise	Dr. Maiwand, NEPI Mr. Joshi, UNICEF								
	Production of new branded IEC Materials for communication Materials	National/ Provincia	Campaign wise	Dr. Maiwand, NEPI								
	ToT on communication for communication Teams	National/ Focus Provinces		Dr. Maiwand, NEPI Mr. Joshi, UNICEF								
	Orientation/Sensetization trainings of Media Personnel	National and Regional		Dr. Maiwand, NEPI Mr. Joshi, UNICEF								
	Establishment of Provincial Social Mobilization Groups	LPDs		Dr. Gula Khan, NEPI Mr Joshi, UNICEF								
	Training of ICN (PCOs and DCOs) on development of communication plans	Provincial /LPDs	Every 6 months	Mr. Jones, UNICEF Mr. Joshi, UNICEF								
	ToT on IPC for Coordinators, Monitors and cluster supervisors of NIDs/SNIDs	LPDs Provinces	Every 6 months	Mr. Jones UNICEF								
	Production of training modules for pre-campaign training (operation and IPC)	National and Provincial level	Campaign wise	Dr. Samiullah, WHO Dr. Wasim, NEPI Mr. Joshi, UNICEF								
	Quarterly review of ICN at regional level	Regional	Quarterly	Mr. Jones, UNiCEF								
Strengthening Surveillance	Review of AFP Surveillance	National	August	Dr. Samiullah, WHO Dr. Ali Zahed, WHO								
	Initiation of environmental surveillance	Kandahar,	once	Dr. Ali Zahed, WHO								
		Helmand		Dr. Ali Zahed, WHO								
		Nangarhar		Dr. Ali Zahed, WHO								
		Kunar		Dr. Ali Zahed, WHO								
Vaccine & Cold Chain Management	OPV Management Review	Polio Priority Provinces	once	Haji Mateen, NEPI Dr. Khalil, UNICEF Consultant from HQ								
	Adaptation of global guidelines on Vaccine management and Cold Chain for Campaigns	National	once	Dr Khalil, UNICEF Haji Mateen, NEPI								
	Training of mid-level managers on VM&CC management	National	Once	Dr. Khalil, UNICEF								
	Role out of improved vaccine management practice in the campaigns			Dr. Khalil, UNICEF								
	Timely supply of vaccine for every province	National level	Ongoing	Haji Mateen, NEPI, Dr. Fauzia, UNICEF								
	Inventory of PEI Cold Chain Equipment	National level	Once	Haji Mateen, NEPI								
Cross Border Coordination	Regional Cross-border meetings in Jalalabad and Quetta	Regional	once	Dr. Ali Zahed, WHO Dr. Khalil, UNICEF								
	Regular Info sharing	National	Monthly	Dr. Ali Zahed, WHO Dr. Hanif Niazi, NEPI								