NATIONAL EMERGENCY ACTION PLAN FOR POLIO ERADICATION

ISLAMIC REPUBLIC OF AFGHANISTAN

2016-2017

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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
ICM	Intra-campaign monitor/monitoring
ICN	Immunization Communication Network
IPV	Inactivated polio vaccine
IVR	Interactive Voice Response
LPD	Low-performing district
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

For NEAP 2016-2017:

- LPD 1 and 2 districts have been renamed "very high-risk (VHR) districts" and LPD 3 "high-risk districts"; and
- Post-campaign assessment has been renamed "post-campaign monitoring".

Preface

2015/2016 was a challenging year for polio eradication in Afghanistan, with the country still reporting cases of wild poliovirus. However, reflecting back over the past year, we have witnessed significant progress in our efforts that make us more optimistic than ever before, despite all the challenges we still face.

We are at a critical juncture in the programme and the eyes of the world are on us. I am encouraged to hear that in the past few months there has been unprecedented political commitment under the leadership of His Excellency the President and strong support of His Excellency the Chief Executive to strengthen polio eradication efforts in Afghanistan. With the establishment of the Emergency Operations Centres (EOCs) in late 2015 to drive the implementation of the National Emergency Action Plan for Polio Eradication (NEAP), we have seen unprecedented coordination and oversight of polio efforts. The EOC's mission is to lead and manage Afghanistan's effort to stop poliovirus transmission by the end of 2016 by ensuring every child, every time, everywhere receives polio vaccine as set out in the NEAP. This will be achieved through strong coordination between government and partners, real-time use of data to drive action, and full accountability at all levels of the programme. I am encouraged by the new initiatives that have recently been put in place in an effort to reduce the number of missed children. We are now starting to see results and these efforts must be further strengthened in 2016/2017 to ensure that we put an end to polio in Afghanistan.

As we near the achievement of interrupting wild poliovirus in Afghanistan, the Ministry of Public Health is fully aware of the significance of this historic moment on the global scale and also for the sustained development of improved public health in Afghanistan. We have launched an "all-out" effort to finish polio, with focused attention, resources and activities in the remaining reservoirs of the country. The 2016-2017 NEAP is a significant document for guiding the coordinated efforts of all polio eradication partners. The next year will be one where we focus on consolidating all our efforts. This document is a reflection of the lessons learnt in the past year and it outlines how we intend to build on recent successes, reverse setbacks, measure results, create an enabling environment, and maintain neutrality, underpinned by a strong focus on accountability of all stakeholders. We know that we are still missing too many children to stop transmission. Our vision for the next year is to reach every child, everywhere. Our mission is to reduce chronically missed children and to close persistent immunity gaps.

I would like to appreciate and recognize the efforts of hundreds of thousands of people who are at the frontline of Afghanistan's fight to stop polio. Nearly every month, thousands of health care workers in every corner of the country strive to reach every child, despite the risks and challenges. We must pay special tribute to those who have been injured or 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 honour.

We are committed to re-doubling our efforts to stop transmission of wild poliovirus by the end of 2016, building on recent gains. Afghanistan's fight against polio is at a critical moment and intensified polio eradication activities in the next few months will determine if eradication of the poliovirus will be achieved by end of this year. Working together we must

be more focused on finding concrete and sharp solutions to overcome the remaining bottlenecks. I am optimistic Afghanistan will succeed.

The Government of Afghanistan is grateful for the support of the international community in these efforts. The Ministry of Public Health recognizes that this global effort, with major global implications, requires the intensification of all efforts during this revised NEAP. Working together with our partners, I am confident that we will soon deliver on our promise of a polio-free world.

Sincerely,

Dr. Ferozuddin Feroz
Minister of Public Health

Executive summary

Afghanistan and Pakistan are the two remaining polio endemic countries in the world and form one epidemiological block with two epidemiological corridors, an eastern corridor and a southern corridor. Most areas of Afghanistan are polio-free, but wild poliovirus (WPV) continues to circulate particularly in Eastern and Southern regions. To date Afghanistan has reported a total of six WPV cases in three districts of which four are from a small geographical area of Shigal Wa Sheltan District in Kunar Province of Eastern Region; an area which has remained inaccessible for vaccination activities since 2012.

During implementation of the National Emergency Action Plan for Polio Eradication 2015-2016 (NEAP) an extensive risk categorization process was undertaken and five provinces (i.e. Kandahar, Helmand, Farah, Kunar and Nangarhar) were identified having a higher risk of sustaining poliovirus transmission. Disaggregated district-level analysis shows that 47 districts, which have been responsible for over 84% of cases over the past seven years, are at very high risk. There is also strong indication that mobile populations such nomadic groups and seasonal/economic migrants play an important role in sustaining and spreading poliovirus transmission.

Access to children for vaccination remains a challenge in stopping the transmission of WPV. Districts are classified in four categories as per their access status; category one being fully accessible, two - partially accessible, three - accessible with limitations, and four - fully inaccessible. Although the number of inaccessible children varies from campaign to campaign, over the past year the access deteriorated particularly in Eastern and Northeastern regions.

The national polio eradication programme made significant progress in 2015/2016 through the consistent implementation of the NEAP, guided by strong government leadership and strengthened coordination between partners, following the establishment of the Emergency Operations Centres (EOCs). Since the establishment of the EOCs, a national level and three regional EOCs, coordination with the Pakistan polio eradication programme has also been strengthened at all levels.

In 2015/2016 Afghanistan implemented an intensive SIA schedule and a number of new initiatives to further improve SIA quality were put in place during the second half of the NEAP implementation period. These initiatives included the roll-out of a new FLW training curriculum; a modified revisit strategy; the development of district profiles and district-specific plans; in-depth investigation of reasons for failed lots in LQAS; strategic use of inactivated polio vaccine (IPV); and microplan validation and revision. The national polio eradication programme focused the implementation of these initiatives in the 47 very high risk districts and they are starting to translate into improvements in the quality of SIAs and the immunity profile of non-polio of acute flaccid paralysis cases.

The NEAP for polio eradication has been updated for the July 2016 to June 2017 period, guided by the key lessons learned during the implementation of the previous NEAP. The programme continues to focus attention and resources on high-risk areas and populations to achieve the goal of stopping the transmission in Afghanistan by the end of December 2016, with no further cases from January 2017 onwards.

The strategic approaches to achieve the goal will include maintaining programme neutrality and gaining access to all children with OPV, irrespective of the area where they reside; implementation of alternate strategies in inaccessible areas; focusing on identified high-risk provinces and districts and areas where children are persistently missed; underpinning all strategies by ensuring strong household and community engagement; and enhancing accountability of all stakeholders, at all levels.

Afghanistan's national polio eradication programme continues to enjoy strong support from the country's highest political leadership. At the national level, a number of bodies continue to govern and oversee the implementation of the NEAP including the Polio Steering Committee and Polio High Council. The Ministry of Public Health plays the lead role in polio eradication efforts supported by various line ministries and engagement of provincial and district governors through the Office of the Presidential Focal Point for Polio. The national EOC, led by the National Focal Point for Polio, has overall responsibility for the stewardship of the programme and the EOCs continue to manage the daily operation of Afghanistan's polio eradication programme.

The focus of the NEAP 2016-2017 will be to consolidate and strengthen the quality of the new initiatives that are starting to yield results. While maintaining focus on the very high risk districts, the national polio eradication programme will not lose sight of other high risk districts. An intense OPV SIA schedule and IPV SIA plan will be implemented while aiming to enhance campaign quality and reduce number of missed children. Interventions planned include microplan revision, improved FLW selection, motivation, and capacity building; intensified supportive supervision; further strengthening of the revisit strategy; and enhancing systematic monitoring and coordination during all phases of every campaign. All data collected from the various sources will be analysed and displayed through a series of dashboards to guide evidence-based decision-making.

The national polio eradication programme continues to work towards its aim to vaccinate all children regardless of where they live by maintaining programme neutrality, through continuous mapping of accessibility, and on-going negotiations to gain access. A range of special complementary vaccination activities such as Permanent Polio Teams, Cross-borders Teams, and special campaigns for nomads and other underserved populations will continue being implemented to ensure that both children living in inaccessible areas and children on the move are reached with vaccine.

Intensive efforts will be made to increase household and community engagement to reduce missed children and build demand for immunization through full-time engagement of the Immunization Communication Network in the very high risk districts. Strengthening partnerships with key influences will help to overcome issues of mistrust at the local level.

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

Every new polio case will be responded to as per the existing SOPs and for outbreaks in areas contiguous with Pakistan there will be joint analysis, planning, response, monitoring,

and reporting of case response. The national polio eradication programme will continue to strengthen cross-border coordination with the Pakistan team at all levels through regular face-to-face meetings, VCs, synchronization of SIA dates, streamlined cross-notification of AFP cases, uniform communication interventions of the cross-border transit points, and information sharing on high-risk population movements including returnee refugee populations.

Though Afghanistan still remains polio endemic and is prioritizing the implementing the activities to stop transmission, the country will start planning for the transition of polio assets beyond certification.

Background and context

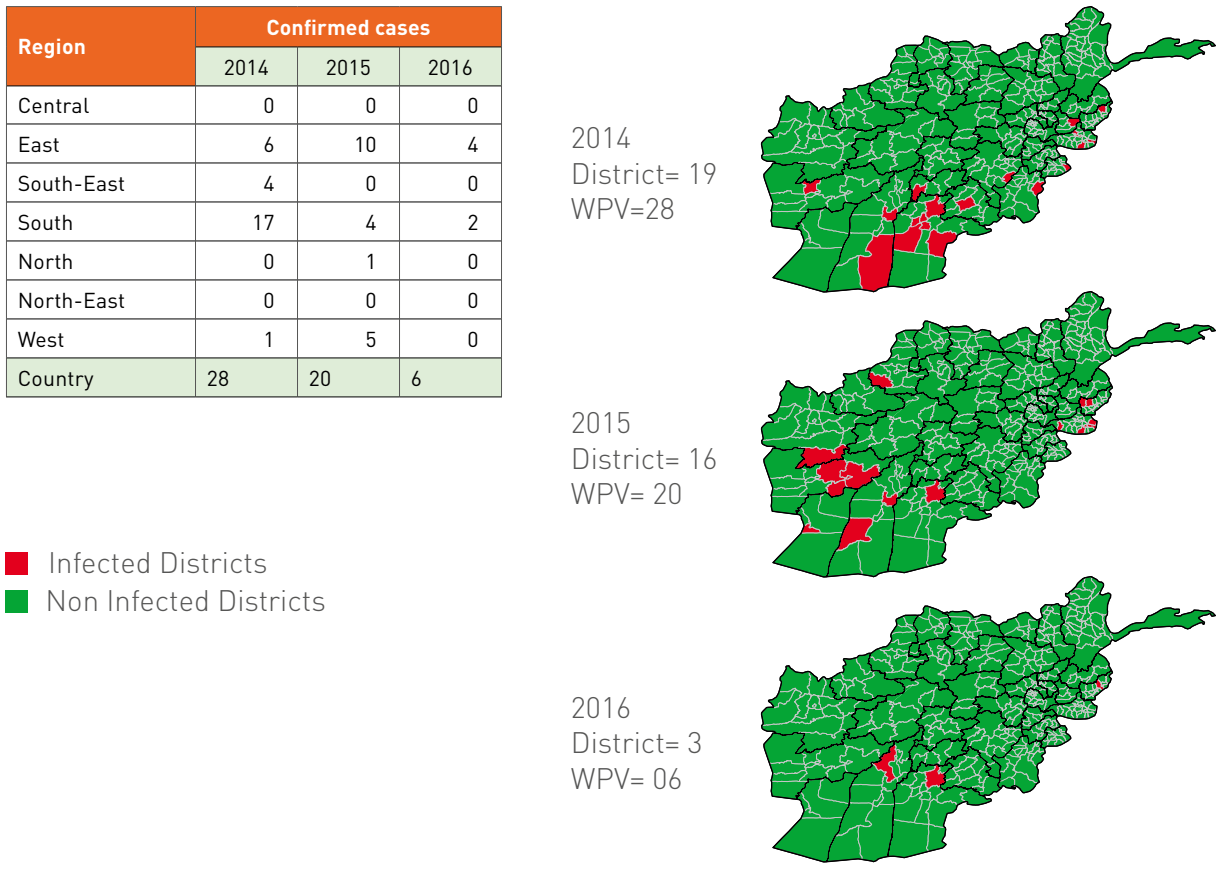
Afghanistan remains one of only two polio endemic countries in the world; the other is Pakistan. The two countries form one epidemiological block. Polio eradication is at the top of Afghanistan's health agenda. In 2015/2016, the Government of Afghanistan scaled up its efforts to accelerate polio eradication in the country amidst multiple, complex challenges, including increasing conflict and insecurity in many parts of the country.

The National Emergency Action Plan for Polio Eradication (NEAP) continues to serve as the guiding document for polio eradication activities in Afghanistan. A number of new developments have taken place during the low season for polio transmission to accelerate progress towards stopping transmission. Emergency Operations Centres (EOC) were established at the national and regional levels in late 2015 to intensify, guide and coordinate the efforts of all partners for NEAP implementation under one roof.

Most areas of Afghanistan are polio-free, but wild poliovirus (WPV) continues to circulate in some parts of the country, particularly in Eastern and Southern regions (Figure 1). In 2015, Afghanistan reported 20 polio cases (due to WPV) in 16 districts of the country, compared to 28 cases in 19 districts in 2014. To date in 2016, the country has reported a total of six WPV cases in three districts. It is important to highlight that four of the cases in 2016 are from a small geographical area of Shigal Wa Sheltan District in Kunar Province (Eastern Region), which has remained inaccessible for vaccination activities since 2012.

Figure 1. Confirmed wild poliovirus cases in Afghanistan by region, 2014-2016.

Region	Confirmed cases		
	2014	2015	2016
Central	0	0	0
East	6	10	4
South-East	4	0	0
South	17	4	2
North	0	1	0
North-East	0	0	0
West	1	5	0
Country	28	20	6

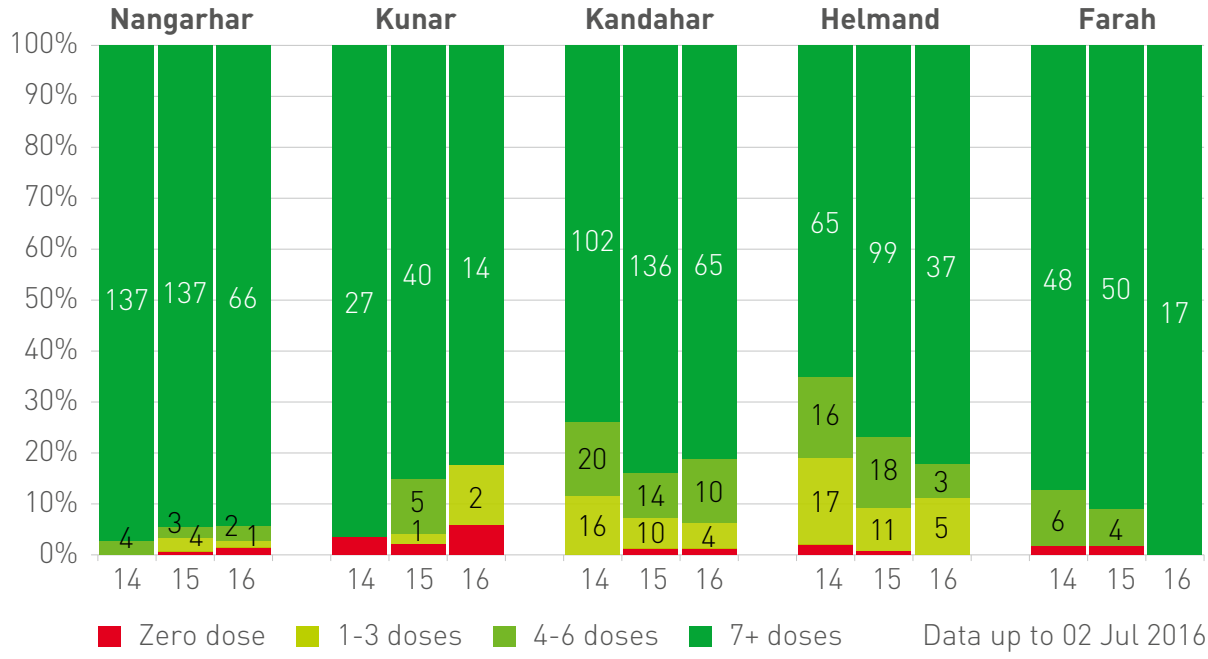


Afghanistan has continued to expand its environmental surveillance system, which now comprises 14 sampling sites in five provinces. In 2015, a total of 19 WPV isolates were reported from environmental samples. To date in 2016, no wild or vaccine-derived poliovirus has been detected in environmental samples.

An extensive risk categorization process was undertaken in 2015, based on poliovirus epidemiology and other factors. A total of 47 districts were classified as low-performing districts (LPDs priority 1 and 2, now renamed "very high-risk districts"), based on the epidemiology of WPV transmission, poor routine immunization and supplementary immunization activity (SIA) coverage, gaps in population immunity and access challenges due to insecurity. These 47 districts have contributed 84% of all WPV polio cases in the past seven years.

Afghanistan continued to implement an intensive SIA schedule in 2015/2016; led by the national EOC, a number of new initiatives to further improve SIA quality were put in place during the low transmission season (end of 2015 and early 2016). These initiatives included the roll-out of a new front-line worker (FLW) training curriculum; a modified revisit strategy; the development of district profiles and district-specific plans; the in-depth investigation of reasons for "lot failure" in Lot Quality Assurance Sampling (LQAS) surveys; the strategic use of inactivated polio vaccine (IPV); and microplan validation and revision.

Figure 2. Vaccination status of non-polio acute flaccid paralysis cases in children aged 6-59 months in high-risk provinces, 2014-2016



The national polio eradication programme has focused the implementation of these initiatives in the 47 prioritized districts. These initiatives are starting to translate into improvements in the quality of SIAs. Between November 2015 and May 2016, the number of failed lots assessed through LQAS in very high-risk districts has decreased from 42% to 17%.

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 shown in Figure 2 for five high-risk provinces.

Afghanistan shares a long border with Pakistan, forming one common reservoir of poliovirus circulation. There are two epidemiological corridors: an eastern 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.

Since the establishment of the polio eradication 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.

The NEAP for polio eradication has been updated for the July 2016 to June 2017 period to further enhance polio eradication efforts and ensure that Afghanistan achieves the goal of stopping WPV transmission. The focus of NEAP 2016-2017 will be to consolidate and strengthen the quality of the new initiatives that are starting to yield results. These initiatives will be supplemented by full-time household and community engagement approaches, prioritizing all activities in the very high-risk (VHR) districts (formerly categorized as LPD 1 and 2). In 2016/2017, emphasis will also be placed on the implementation of an accountability framework at all levels.

Progress during the implementation of NEAP 2015-2016

The national polio eradication programme made significant progress in 2015/2016, through the consistent implementation of the NEAP, guided by strong government leadership and strengthened coordination between partners, following the establishment of the EOCs (Table 1).

During the January 2016 meeting of the Technical Advisory Group (TAG), experts acknowledged the significant improvement in programme oversight, management and coordination through the establishment of national and regional EOCs, which has greatly strengthened the partnership between government, United Nations agencies and other polio partners. The TAG noted significant programmatic progress, while cautioning that eventual interruption of WPV transmission will require progress to be further fast-tracked.

Table 1. Progress of the National Emergency Action Plan 2015-2016

Area	Progress
Governance and coordination	• Polio Steering Committee formed and the first meeting chaired by H.E. the President of the Islamic Republic of Afghanistan • Involvement of line ministries and partnership building with relevant departments enhanced by regular meeting of Polio High Council • EOCs established at the national level and in three high-risk regions, including Eastern, Western and Southern • Governance of the Polio Eradication Initiative restructured to ensure smooth communication between regional and national levels • Roles and responsibilities of Polio High Council, Presidential Focal Point, Minister of Public Health Focal Point and EOCs clearly defined to avoid overlap • Neutrality of the national polio eradication programme maintained • Provincial Polio Coordination units in five high-risk provinces established • Coordination among implementing partners strengthened under government leadership • Various managers at different levels sanctioned and relieved from their positions due to poor performance
Focus on LPDs (very high-risk districts)	• Method of identifying LPDs modified; 47 LPDs identified as very high risk, responsible for 84% of cases in past seven years • Interventions for improving quality of SIAs prioritized and focused particularly on LPDs • District profiles and district-specific plans developed for 47 LPDs 1 and 2
Improving quality of SIAs	• Revisit strategy modified to include a fourth revisit day, and scaled up nationally • Microplan validation and revision completed in 37 of 47 LPDs • FLW training module revised, and FLWs throughout the country trained using the new curriculum • Supportive supervision from the national level standardized and strengthened • Post-campaign review conducted, followed by corrective action to resolve local problems, to improve SIA quality
Monitoring	• Intra-campaign monitoring strengthened, with real-time data transfer using Interactive Voice Response (IVR) technology. • Post-campaign assessment (henceforth called "post-campaign monitoring") strengthened by expanding it to include all clusters in VHR districts • LQAS expanded to all priority VHR districts, wherever feasible and where security permits
Data flow and utilization	• Pre-, intra- and post-campaign evaluation data collected, processed and presented in a timely manner through pre-, intra- and post-campaign dashboards • Administrative coverage data and intra-campaign monitoring information in five priority provinces collected in a timely fashion and used for action • Post-SIA monitoring data available to the national polio eradication programme within 10 days of the end of every campaign
Access in security compromised areas	• Threat of ban on SIAs in Southern Region successfully averted on three occasions • Systematic reporting on accessibility shared with partners • Programme neutrality maintained
Complementary vaccination activities	• Review of Permanent Transit Team (PTT) and Permanent Polio Team (PPT) strategies conducted • PPTs reactivated in Southern Region • PTT strengthened and deployed in newly inaccessible areas • Cross-border Team (CBT) operations harmonized with Pakistan
Communication and social mobilization	• Findings from Harvard "Knowledge, Attitudes and Practices" study used for guiding communication strategy • Immunization Communication Network (ICN) expanded and terms of reference modified to engage for whole month • Religious leaders sensitized through the Ulama Conferences on Polio Eradication at national level and in Southern and Eastern Regions • Ongoing social mobilization embedded in district-specific plans
Cross-border coordination with Pakistan	• Quarterly face-to-face meetings and videoconferences conducted between both national level teams • Monthly meetings conducted at regional and provincial levels • SIA calendar synchronized between both countries
Surveillance	• AFP surveillance sensitivity maintained, with all key indicators meeting global standards at national and regional levels • Reporting network further expanded • AFP focal persons reoriented • Surveillance review conducted in June 2016
Cold chain and vaccine management	• Global guidelines for vaccine vial monitor and cold chain and logistics rolled out • Training of cold chain officers in prioritized regions conducted in June 2016 • Switch from trivalent oral polio vaccine to bivalent oral polio vaccine conducted successfully on 23 April 2016

High-risk areas and population groups

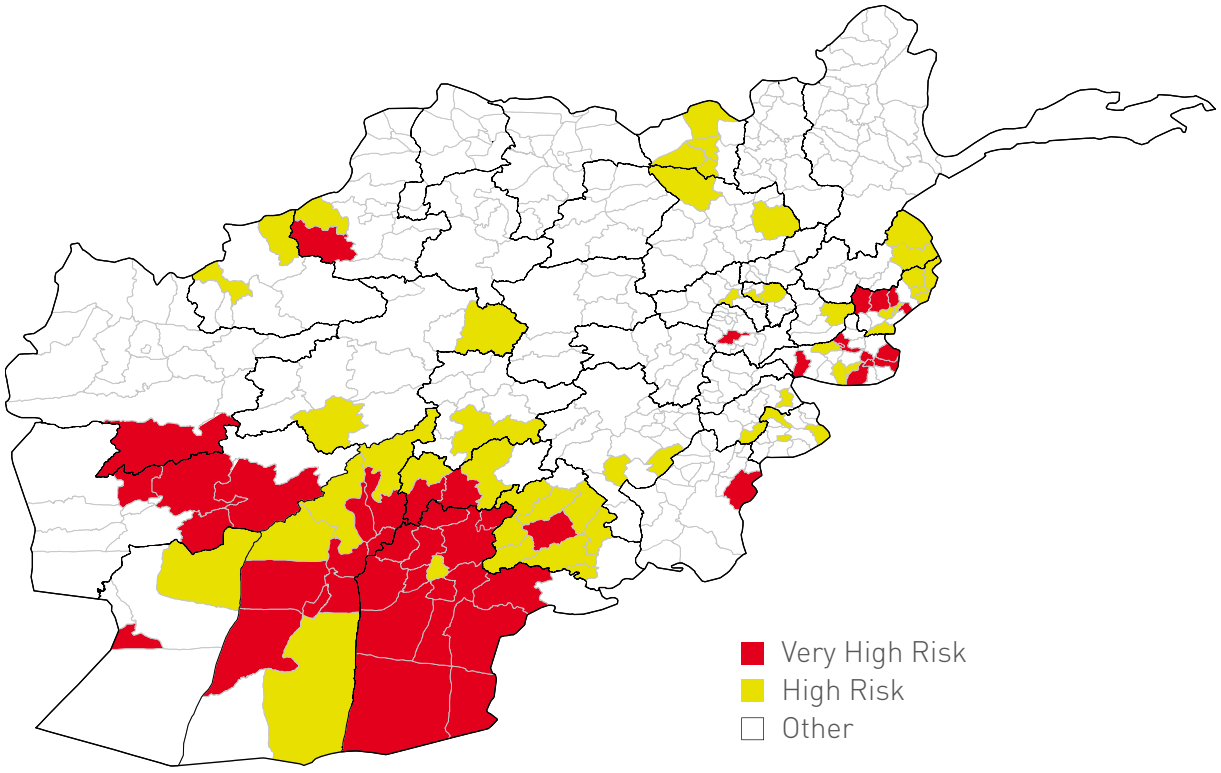
The national polio eradication programme continues to focus attention and resources on high-risk areas and populations to achieve the goal of stopping the transmission of WPV. Certain geographical areas and population groups are more vulnerable to polio transmission and they have played a vital role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

Geographical high-risk areas

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 five provinces that have a higher risk of sustaining poliovirus transmission. The five high-risk provinces that are a priority are: Kandahar, Helmand, Nangarhar, Kunar, and Farah.

Disaggregated district-level analysis shows that certain districts have an increased risk of polio transmission; at very high risk are 47 districts that have been responsible for over 84% of cases over the past seven years (Figure 3).

Figure 3. Risk level in districts of polio transmission, 2016



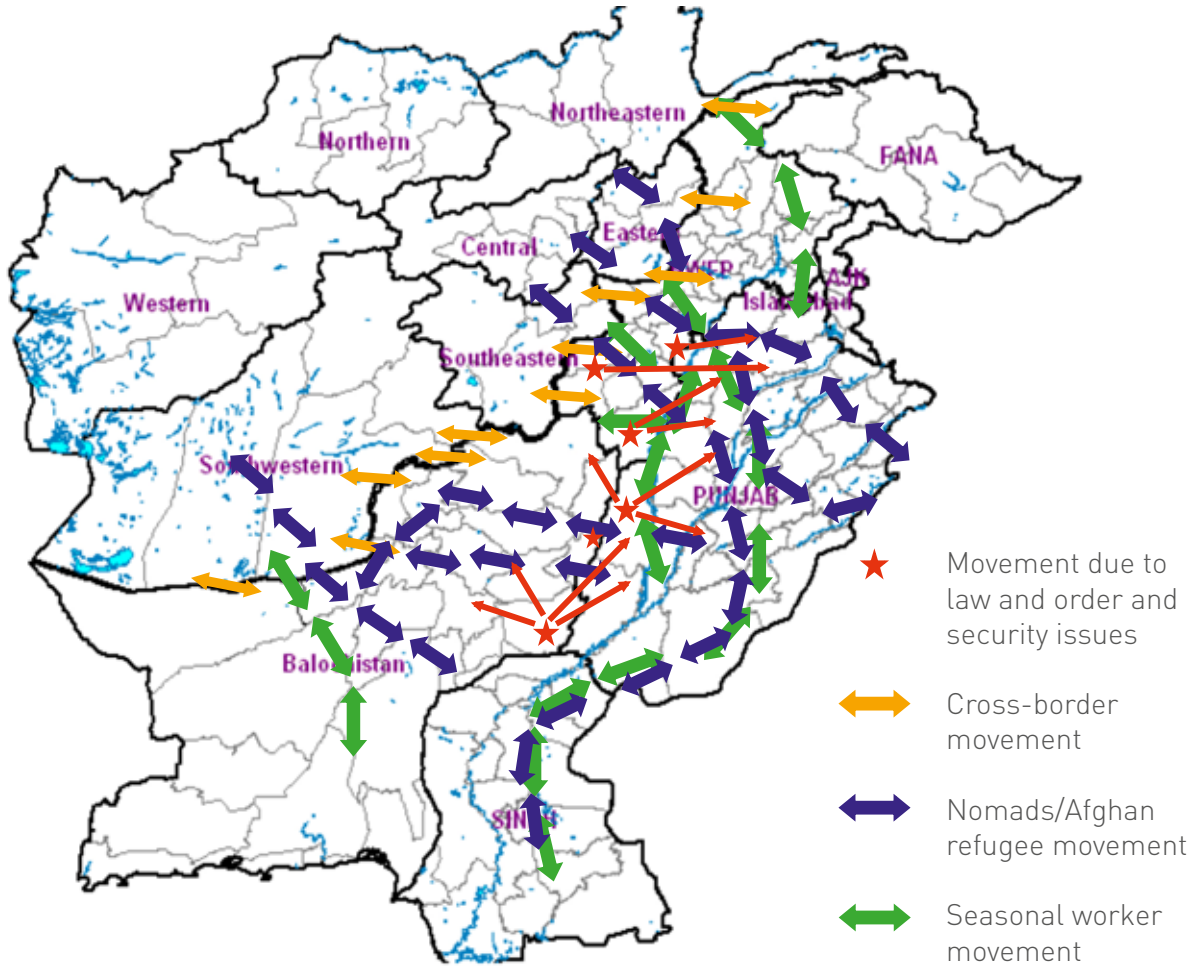
High-risk population groups

Epidemiological data of polio cases and genetic analysis of isolated viruses show that there is sharing of poliovirus circulation among distant areas within the country as well as across the border with Pakistan. This indicates the sustained transmission of the virus. It is being transmitted from one area to another through the different groups of people who are continuously on the move. Strong evidence indicates that mobile/migrant populations play an important role in sustaining and spreading poliovirus transmission.

Mobile and migrant populations vary in different parts of the country (Figure 4). Some common types are:

- nomadic populations – who have low socioeconomic status and are largely dependent on their livestock, moving from one place to another depending on the weather and the availability of silage for their livestock; and
- Seasonal / economic migrants - who belong to varying socio-economic groups and migrate according to the seasons to support their livelihood.

Figure 4. Mobile population movements in Afghanistan.



Challenges in access

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 Category 2 and 4 inaccessibility is usually active fighting nearby or local authorities' "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.

Although the number of inaccessible children varies from campaign to campaign due to the continuously evolving security situation, Table 2 highlights the number of children in inaccessible areas during SIAs over the past year. Access deteriorated in this period, particularly in Eastern and North-Eastern Regions.

Figure 5. Status of accessibility in districts by category, May 2016

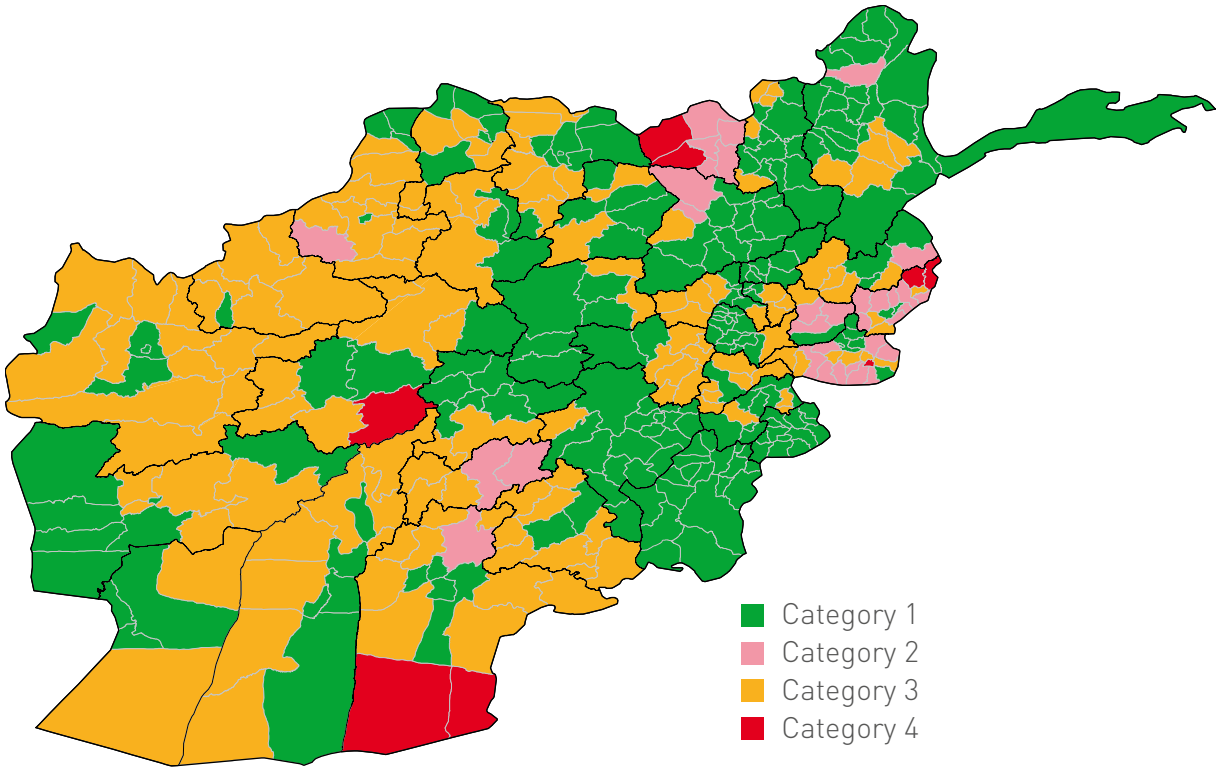


Table 2. Inaccessible children during SIAs, June 2015 to May 2016

Regions	2015					2016				
	June	August	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Central	17 523									
East	32 799	51 327	61 910	57 232	138 359	41 744	22 938	25 869	30 555	131 781
North		18 880		22 756						3 376
North-East		6 386		173 818		65 583	97 997	146 810	106 281	165 332
South	584 751	17 830	15 562	51 105	43 423	12 335	7 079	11 684	56 662	22 811
South-East	450	830	1 793	2 020	91		380		380	400
West	26 935	672								0
AFGHANISTAN	662 458	95 925	79 266	306 931	181 874	119 662	128 394	184 363	193 878	323 700

Lessons learned in the 2015-2016 period

The key lessons learned during the implementation of NEAP 2015-2016 are helping to guide the development of NEAP 2016-2017. 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*.
- The programme needs to continuously adapt to the rapidly changing security context. It must particularly focus on devising and implementing alternative approaches to gain access to children in the inaccessible areas of Eastern and North-Eastern Regions, in view of the developments that have increased inaccessibility in these areas.
- The programme needs to put more emphasis to strictly maintain neutrality.
- Refocusing on programmatic basics and ensuring high-quality of activities yields results. New approaches and innovations are needed to overcome challenges, but they should be targeted to address particular issues.
- Experience from other countries should be adapted to the local context. Tailoring issue-specific plans to the local context is an effective approach to reach more children.
- The programme should strive beyond just gaining access in Southern and Western Regions and focus to a greater degree on rapidly improving quality in all security-challenged areas.
- FLWs are the cornerstone of high-quality campaigns. Continued focus and accountability should be placed on ensuring the right selection, providing high-quality training and sustaining their motivation.

Challenges for NEAP 2016-2017

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

- a volatile security situation in many areas, resulting in the inability to access children in key regions of the country, particularly in Eastern, Southern and North-Eastern Regions;
- the maintenance of strict programme neutrality to ensure vaccination activities reach every child across the country;
- limited supervision and monitoring in certain areas of high-risk provinces, resulting in suboptimal campaign quality;
- the full implementation of the accountability framework at all levels;
- the sustained motivation and commitment of FLWs and of all stakeholders; and
- a possible funding gap.

Goal

To stop WPV transmission in Afghanistan by the end of December 2016, with no new wild poliovirus type 1 (WPV1) cases from January 2017 onwards.

Strategic approach

1. Maintain programme neutrality and gain access to **all children with OPV, irrespective of the area where they reside**;
2. Implement alternate strategies, i.e. use PolioPlus interventions and the PTT, particularly in inaccessible areas;
3. Focus on identified **high-risk provinces and districts** and areas where children are **persistently** missed;
4. Underpin all strategies by ensuring strong household and community engagement; and
5. Enhance accountability of all stakeholders, at all levels.

Objectives

1. To interrupt the circulation of indigenous WPV1 in Southern Region, Afghanistan by the end of December 2016;
2. To interrupt WPV1 circulation in Eastern Region by the end of December 2016;
3. To rapidly increase population immunity in high-risk provinces and districts by conducting high-quality SIAs and complementary vaccination activities;
4. To rapidly and effectively respond, in coordination with Pakistan, to any importation of WPV1 and/or emergence of vaccine-derived poliovirus type 2 into polio-free areas of Afghanistan to prevent the establishment of virus circulation; and
5. To maintain high-quality surveillance across the country, and to ensure all provinces reach and maintain surveillance quality indicators that meet global standards.

Targets and milestones

1. Conduct five SIAs in the second half of 2016 and five in the first half of 2017:
   a. reaching over 90% of children during each SIA as per the monitoring data; and
   b. improving the quality of campaigns particularly in very high risk districts, with >90% LQAS lots accepted at 80% and <5% missed children;
2. Complete one IPV-OPV SIA in all VHR districts by the end of September 2016;
3. Revise microplans of all VHR districts by the end of September 2016;
4. Fully operationalize a full-time Immunization Communication Network (ICN) in all VHR districts by the end of September 2016;
5. Maintain an annual non-polio AFP rate of >2 cases/100 000 under 15 years of age, with adequate stool specimens collected from >80% of AFP cases in every district across the country; and
6. Fully implement the accountability framework by the end of August 2016.

Governance and coordination

A significant focus of NEAP 2015-2016 was to improve national polio eradication programme management and operational implementation. An overall governance framework for the national Polio Eradication Initiative (PEI) in Afghanistan was established to encourage evidence-based decision-making, improved situational awareness, early problem detection and a coordinated response by both government and partners.

The updated NEAP 2016-2017 strongly emphasizes the importance of PEI governance in Afghanistan, with clearly defined roles and responsibilities, supported by a defined accountability framework.

As highlighted in NEAP 2015-2016, and to ensure data-driven and quick evidence-based decision-making and timely communication, the governance of the PEI was restructured during the second half of 2015, by assigning the core role of PEI management to the national polio EOC. The following section outlines the renewed governance and coordination structure.

Leadership and coordination

At the national level

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 Polio Eradication. In the first Steering Committee meeting of 2016, the President emphasized the importance of maintaining the neutrality of the polio programme and other health initiatives.

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 and cabinet members. 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 whenever and wherever required. The forum brings all involved parties under the umbrella of the accountability framework. It provides overall oversight to the national polio eradication programme in Afghanistan.
- The Polio High Council: The Polio High Council 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 (Table 3), the polio team and representatives of donor and partner agencies.
- 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 multisectoral 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 Ministry of Public Health (MoPH) plays the lead role in polio eradication efforts in the country, with the overall responsibility to coordinate and communicate with all partners. The MoPH ensures the effective leadership and coordination of the bodies established to manage and oversee the national polio eradication programme. The Minister of Public Health has a Senior Adviser acting as Focal Point for PEI, who directly oversees the day-to-day management of the programme on behalf of the Minister of Public Health. The Polio Focal Point ensures that all Ministry of Public Health departments provide full support to the programme. He is authorized to hold everyone in the MoPH structure accountable for their role in polio eradication. The MoPH will continue to provide the overall leadership of the national EOC.

At the regional, provincial and district levels

- Recently, the provincial and district governors' engagement in the polio programme has increased, particularly in the high-risk provinces of Southern, Eastern and Western Regions. Multisectoral meetings chaired by the provincial governors have been conducted before each campaign round in Kandahar, Helmand, Nangarhar and Kunar.
- During the second half of 2016, the polio team will ensure that provincial and district polio task forces (multisectoral meetings) are fully functional in all five priority provinces and 47 VHR districts. The terms of reference for provincial and district task forces will be revised and operationalization will begin by the August NIDs.

Table 3. Engagement of line ministries and departments in the national polio eradication programme

Line Department	Area of Engagement
Ministry of Public Health Malaria Department	• Bednet distribution to the community will be coupled with vaccination in very high-risk and high-risk districts
Basic Package of Health Services (BPHS) implementer nongovernmental organizations (NGOs)	• Conducting PolioPlus and health camp interventions in Category 2 and Category 4 inaccessible districts • Increasing the number of outreach and mobiles sessions in areas where house-to-house vaccination is not possible • Working closely with BPHS implementer NGOs to improve routine immunization coverage in the 47 VHR districts
Ministry of Education	• Engaging school students and teachers in the social mobilization and tracking of missed children at the community level • Engaging Village Education Shuras in the monitoring and accountability of the programme
Afghan Red Crescent Society	• Introducing M&A officers in VHR districts • Health camps and mobile clinic activities in the inaccessible areas
Afghanistan Telecommunication Regulation Authority	• Supporting remote monitoring through mobile technology • Tracking post-campaign monitors in the field through mobile technology
Ministry of Rural Rehabilitation	• Supporting the EOC in recruiting M&A officers • Engaging village Shuras in polio SIAs
Ministry of Hajj and Awqaf (Religious Affairs)	• Helping the PEI to clear misconceptions based on religion and persuading communities to accept vaccination through the engagement of religious scholars

Management of the Polio Eradication Initiative

Emergency Operations Centres

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. Three regional EOCs are functional in Eastern, Southern 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).

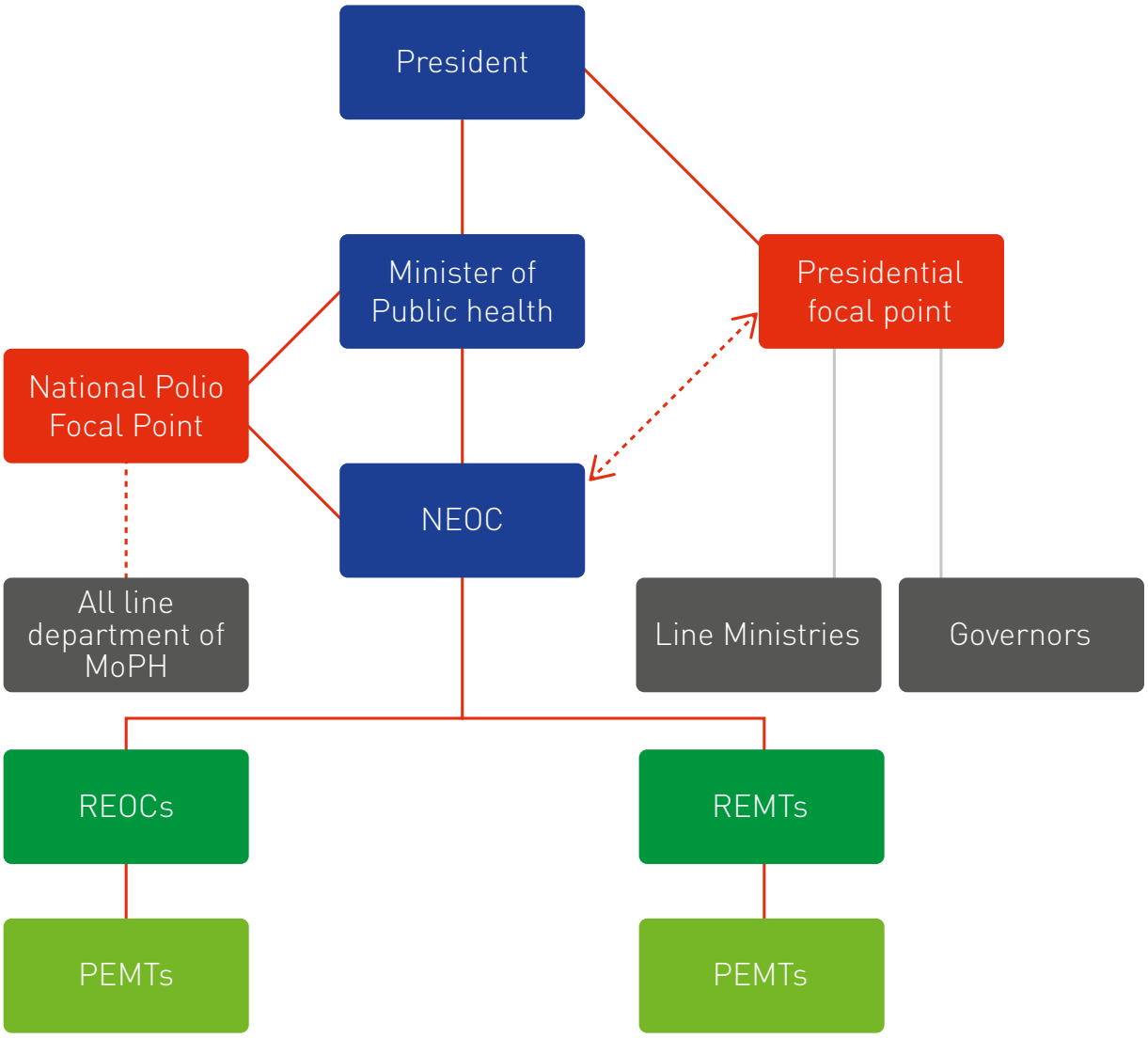
The national EOC has overall responsibility for the stewardship of the national polio eradication programme. It defines the strategies, identifies the high-risk areas, develops the tools needed, evaluates the programme and tracks the performance of districts. It will continue to ensure that all the strategies 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 set at the national level.

The EOC structure will be further strengthened by

- consolidating task team modality at national level
- conducting weekly videoconferences between National and Regional EOCs
- monthly tracking of NEAPimplementation status

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.

Figure 6. Governance framework for the national Polio Eradication Initiative in Afghanistan.



Key strategies

Focus on high-risk areas

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

Further disaggregated district level analysis shows that 47 of the country's districts have been responsible for 84% of cases over the past seven years. These districts have thus been categorized as the VHR districts. Another 49 districts are at relatively lower risk; they are considered the high-risk (HR) districts.

The geographical focus for NEAP 2016-2017 takes into consideration this risk categorization. The five high-risk provinces and 47 VHR districts will receive special focus and will be given priority for the key strategic interventions. District profiles and district-specific action plans have been developed, based on the particular local issues and challenges. The district profiles and specific plans will be further strengthened and updated after every SIA, to address the challenges and/or bottlenecks identified during each campaign.

While maintaining focus on the VHR districts, the programme will not lose sight of the 49 high risk and the non-high risk districts and will continue to improve quality in these areas.

An analysis to identify the high-risk districts will be conducted again in December 2016 to adjust to changing epidemiology and emerging scenarios.

Supplementary immunization activities

In 2016/2017, the national polio eradication programme will continue to follow an intense OPV SIA schedule: two NIDs and three Subnational Immunization Days (SNIDs) in the second half of 2016, and two NIDs and three SNIDs in the first half of 2017. The SIA dates will be synchronized with Pakistan.

For every new case, the programme will conduct three case response campaigns targeting at least 500 000 children surrounding the area where the case was detected.

Inactivated polio vaccine

All the VHR districts that have IPV SIAs planned for 2015/2016 will complete them by the third quarter of 2016. IPV campaigns will also be planned for every newly accessible area that has been inaccessible for more than six months and/or missed three vaccination opportunities. Currently, 276 000 target children aged less than 5 years in 31 districts meet this criterion. The programme will also consider using IPV in selected areas, if any new transmission is detected in a high-risk area with security challenges.

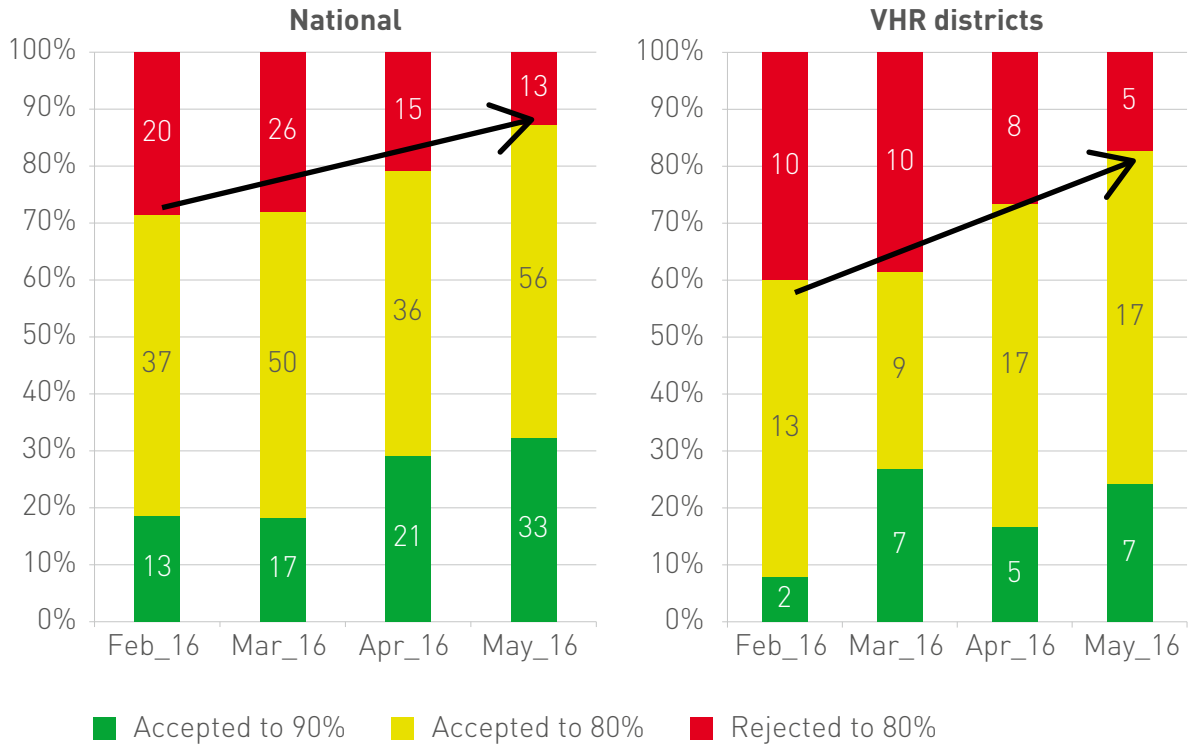
In 2017, the programme aims to conduct IPV-OPV SIAs in the VHR districts where these campaigns have not been conducted in 2015-2016, including selected parts of Kabul.

Enhancing campaign quality

Figures from the post-campaign monitoring survey show that, in 2015, around 7% of target children were missed owing to gaps in the quality of campaigns. The proportion of missed children was even higher in Southern Region where approximately 10% of children were missed during each round of SIA. LQAS results show that around 30% of lots across the country were rejected during any given round of SIAs in 2015.

Improvement in the recent past has been significant with the proportion of rejected lots reduced from 30% to 12% in the country while, in focused areas, the proportion of failed lots was reduced from 40% to less than 20% (Figure 7).

Figure 7. Progressive improvement in SIA quality LQAS results, Quarter 1-Quarter 2, 2016



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

The focus of the programme is now 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

Microplans of all the districts will be updated regularly to include new settlements. In all 47 VHR districts, they are being revised using geographic information system maps and field validation. The aim of this exercise is to ensure that:

- all the settlements are included in microplans;
- there is a rational distribution of workload of vaccination teams, supervisors and district coordinators;
- team and supervisor maps are available for all areas, including major landmarks and social components, i.e. the location of key influencers and mobilizers, important sites (mosques, schools, markets, gathering places), high-risk population groups, etc.; and
- the microplans include information and plans for vaccination at major transit points as well as for mobile population groups where applicable.

In June 2016, the process of updating the microplans in the VHR districts had been completed in 37 districts and was under way in 10. The process will be completed in the remaining VHR districts by the end of the third quarter of 2016.

The microplan validation process will be reviewed and strengthened even further in 2016/2017 to improve quality. Microplan validation using the revised methodology will be conducted in a phased manner in all 49 high-risk districts in the last quarter of 2016 and repeated in the 47 VHR districts in the first quarter of 2017.

Front-line worker selection, motivation and capacity building

Front-line workers (FLWs) and their supervisors are the key polio field staff, who actually deliver polio immunization services to the population. Poor team performance often manifests itself as recordings of "child absent" and "household not visited" during campaigns. Efforts in the next year will focus on improving team performance by ensuring FLWs are carefully selected using a transparent and criteria-based approach, are equipped with the appropriate skills, information and materials to optimally perform their job, and are kept motivated.

In the first half of 2016, the FLW training curriculum was revised based on the results of a training needs assessment undertaken in 2015. All FLWs across the national polio eradication programme were trained in this new curriculum, which was founded on adult learning principles.

In 2016/2017, the programme will pay particular attention to improving the selection process of FLWs and enhancing their capacity through ongoing training. Major relevant activities will include:

Improving team selection

All FLWs should be selected from and within communities based on merit. This prerequisite applies to both accessible and access compromised areas.

Efforts will be made to engage female vaccinators, preferably community health workers (CHWs) wherever available and feasible.

Each two-member team should comprise at least one member who can read and write.

Improving the quality of training

- All vaccinators will be trained, using the revised curriculum, ahead of every second SIA.
- The quality of training in VHR districts will be monitored from the provincial and regional levels with feedback to the national level; and
- The national EOC will track training attendance and quality (training attendance must be over 90%).

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 incentivized and the poor performers will be sanctioned.

Ensuring the timely payment of FLWs

There have been concerns regarding payment to FLWs both in the terms of the amount and timeliness of distribution. FLW rates were therefore revised in the second quarter of 2016 to ensure parity across the country.

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. Currently 17% of beneficiaries are paid through the DDM. The distribution of cash to FLWs in provinces and localities should only be undertaken in the presence of financial committee representatives.

In 2016/2017, the national polio eradication programme will:

- 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 action in case of delayed payment;
- apply a strict "zero-tolerance" policy related to any misappropriation of payments and PEI resources; and
- continue expanding DDM in phase-wise manner where feasible.

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 VHR districts. 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 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).

Revisit strategy

In early 2016, as recommended by the TAG, 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. Key changes in the revised revisit strategy include:

- strengthening the team revisit during campaign days through improved planning, closer monitoring and supervision; and
- increasing the time gap between the first visit and revisits during and after campaigns:
  - days 1-3: campaign days – the team is to return to follow up and vaccinate all missed children in the afternoon after a break (after 14:00), following the same route as in the morning to maximize the amount of time to reach missed children and/or for the caregiver to return;
  - day 4: one-day break – to ensure adequate planning for the post-campaign revisit;
  - day 5: post-campaign revisit day – to fall on a Friday to maximize the number of children and caregivers found at home; and

- before the next campaign – ICN mobilizers to follow up on outstanding missed children.

Supervision and ICM have been modified to incorporate the revised revisit strategy.

The national polio eradication programme will further strengthen the revisit strategy by:

- fully implementing this strategy across the country; and
- tracking the impact of the revisit strategy by performing a disaggregated data analysis and taking corrective action as required.

Enhanced monitoring

It is very important to systematically monitor all phases of every campaign (pre-, intra- and post-campaign) to take corrective action to improve the quality of SIAs in ongoing and subsequent campaigns.

There is an established system of ICM and of post-campaign monitoring which includes post-campaign monitoring surveys, LQAS surveys and "out-of-house" surveys. The latter check the vaccination status of children found out of their homes (i.e. at school, in markets, etc.).

The national polio eradication programme has strengthened monitoring through the:

- use of IVR technology for real-time data collection from ICM;
- 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;
- monitoring of monitors performing PCM;
- detailed field investigation of all lots failed in LQAS and the team areas where more than three children were missed among the 10 houses surveyed by a PCM;
- 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
- deployment of M&A officers in selected VHR districts.

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, M&A officers are being deployed in the VHR districts. 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. These independent officers are being deployed to collect and verify timely and reliable information in the districts for transmission directly to the national EOC.

To date, 11 M&A officers are working in selected districts of Kandahar and there is a plan to fast-track expansion to all 47 VHR districts. The national EOC will have four M&A focal persons to collect, compile and present the information to the EOC for corrective action.

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

- Pre-campaign monitoring:
  - National-level monitors will be deployed to priority provinces and VHR districts

to monitor the pre- and intra-campaign phases during every SIA.
- Standardized checklists will be used and the concurrent feedback system will be further strengthened.
- Pre-campaign dashboard: The national EOC will receive regular feedback from regions and provinces on the preparatory status of campaigns and ensure corrective action is taken as needed, including possible postponement of a campaign based on preparedness.

- **Intra-campaign monitoring:**
  - The selection and training of ICM staff will be improved to ensure well-trained, high-quality ICM.
  - The number of ICMs in the 47 VHR districts will be increased to have one per five cluster supervisors.
  - ICM data will be collected in real time using IVR technology in the VHR districts and shared immediately for corrective action.
  - Intra-campaign dashboards will be made fully functional and used for corrective action on a daily basis.
  - Complete ICM data will be collected and analysed at the national and regional levels for corrective action in subsequent campaigns.
  - ICM data will be used during the evening meeting and post-campaign review meetings.

- **Post-campaign monitoring:**
  - PCM will continue to target 100% of clusters in the 47 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 level.
  - The system of monitoring the monitors (in-process and after the monitoring) will be institutionalized to ensure quality. This will include using mobile technology to verify the quality of monitoring. A total of 5% of monitors/surveyors will be cross-checked by provincial polio officers/provincial communication officers and district polio officers/district communication officers 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.
  - In any team area where PCM detects >3 missed children among the 10 houses surveyed, a detailed field investigation will be conducted by a joint team (UNICEF, WHO, MoPH) 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. The concerned area will be recovered to reach the children missed.
  - In districts containing areas with both government and anti-government elements, the PCM will be conducted in both areas of influence (if allowed) and the results will be analysed separately.

- **LQAS:**
  - LQAS will be further expanded to include all VHR and HR districts wherever the security situation allows.
  - The current system of LQAS surveyor engagement will be reviewed; if necessary and feasible, third parties (contractors) will be engaged.

- To ensure high quality LQAS, 10% of surveyors will be cross-checked by provincial polio officers/provincial communication officers 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:**
  - Out-of-house surveys at marketplaces or other public areas will be continued and enhanced in the five high-risk provinces.
  - They are particularly important in access-challenged areas where they will be emphasized.

- **Innovative technology for monitoring:**
  - Mobile technology will be used to monitor the post-campaign and LQAS monitors.
  - IVR technology will be used to collect real-time information from ICMs.
  - Mobile technology will be used to fast-track PCM and LQAS data from the five high-risk provinces.
  - Remote monitoring using telephonic surveys will be conducted in access-compromised areas to assess coverage.
  - Mobile technology will be used to track the performance of ICM.

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.
- At the national level, the meetings will focus on:
  - support to regions and provinces to ensure good quality preparation;
  - lessons learned from past campaigns and corrective action to be taken;
  - the calendar of activities at the national and regional levels; and
  - the deployment of national monitors to provide support in the preparatory phase.

- Pre-campaign preparedness will be monitored on a daily basis by the national EOC, using the pre-campaign dashboard.
  - The key components tracked will be microplanning, FLW training, social mobilization and vaccine and logistics availability.
  - The state of readiness will be assessed 10, seven, three and one day(s) prior to every campaign.
  - The required corrective action will be taken with support from the national EOC and will include the deployment of additional national monitors.

> 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.

- At the regional level, the meetings will focus on:
  > the development of a schedule of activities, including training plans;
  > a plan of action to address the challenges identified in previous campaigns; and
  > 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 task force meetings will be held before every campaign, chaired by provincial and district governors, respectively.
  > Participants in the provincial task force will include the PEI/EPI team, the provincial public health director, representatives of line ministries and departments, 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.

- 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, 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.
- In the first half of 2016, the programme enhanced its focus on closely tracking the evening review meetings. The focus in 2016/2017 will be to improve the quality of these meetings. A standard matrix will be used to record the findings of the evening review meetings and to note the actions to be taken to respond to the reported issues and problems.
- 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 five 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. These plans will be shared with the national EOC. These meetings will also serve to update the district profiles and district specific action plans for each of the 47 VHR districts.
- The national EOC will track the outcomes of these meetings and follow up on progress and the support required.

Community health volunteer strategy

The national polio eradication programme has initiated an innovative approach to improve the quality of campaigns in selected areas. The community health volunteer approach deploys local female and male permanent community volunteers to conduct social mobilization and to reach and vaccinate continuously missed children.

This strategy is being piloted in Behsud district in Nangarhar province with promising results. As recommended by the TAG in January 2016, another pilot is being planned in Spin Boldak in Kandahar province, which exemplifies the challenges of VHR districts.

The TAG also recommended that the results of these pilots should inform the decisions regarding possible future expansion.

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 (Table 4).

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

- Pre-campaign:
  - information on preparations, including training, microplanning, social mobilization, vaccine and logistics delivery; and
  - pre-campaign coordination meeting information.

- 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.

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

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

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.

Use of mobile technology to fast-track data transmission

The national polio eradication programme has started using IVR technology to transfer data in real time from ICM in selected areas. The use of mobile technology for the real-time data transfer of administrative coverage, ICM, PCM and LQAS will be explored and expanded by December 2016.

Strategies for access-challenged areas

The national polio eradication programme has worked towards its aim to vaccinate all children regardless of where they live by maintaining programme neutrality, negotiating at different levels through local mediators, conducting catch-up campaigns in newly accessible areas, establishing permanent vaccination points around inaccessible areas and implementing PolioPlus initiatives.

In 2016/2017, 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:

- negotiating at different levels through neutral and credible mediators to help gain access to children in inaccessible areas;
- mapping accessibility at the cluster- and village-levels, and conducting campaigns in all accessible 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;
- using a 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;
- scaling up PolioPlus initiatives (adding other services in conjunction with the polio vaccine, e.g. EPI services, outreach health 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;
- providing IPV-OPV at health facilities surrounding areas inaccessible for more than a year; and
- promoting ongoing community engagement activities, including with local elders.

An updated report will be shared with polio partners after each SIA, highlighting the location and size of the inaccessible areas, the assumed underlying causes, and an outline of actions taken and planned to regain access.

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.

The country will develop a contingency plan to address any increase in inaccessibility.

Areas accessible with limitations

The national polio eradication programme will intensify efforts in the areas where vaccination campaigns are feasible but with limitations in oversight and programme management due to insecurity and interference (Category 3). The main interventions planned are:
- negotiating at all levels with key authorities and stakeholders on the quality of campaigns and the independence of monitoring;
- deploying M&A officers in the 47 VHR districts, including those with the specific challenge of providing information on key indicators;
- sharing feedback on the gaps in quality of operations including reasons thereof with the relevant authority;
- exploring the possibility of engaging other neutral parties for monitoring; and
- monitoring remotely the quality of campaigns using mobile technology.

Complementary vaccination activities

The national polio eradication programme continues to implement a range of special complementary vaccination activities to ensure that specific populations on the move are reached during and between polio campaigns. Complementary vaccination activities include special activities planned around the inaccessible areas, at busy points and at border crossings, and for nomadic populations. Efforts will be made in 2016/2017 to improve the quality of these activities and to expand their scale and scope according to programmatic need. The strategies include:

Permanent Transit Teams

PTTs vaccinate children on the move and those moving in and out of inaccessible areas. PTTs vaccinated a total of 6.3 million children in 2015, whereas they had already vaccinated 3.8 million children in the first four months of 2016. The number of PTTs was revised from 62 in 2015, to 264 in 2016.

In 2016/2017, the national polio eradication programme will:
- continue to assess and modify the number and location of PTTs according to the needs of the programme and the evolving accessibility situation; and
- strengthen PTT supervision and monitoring, closely tracked by the national EOC on a monthly basis.

Permanent Polio Teams

PPTs provide OPV to target age children on a continuous basis in their assigned catchment area, over and above planned house-to-house vaccination during SIAs.

In 2016/2017, the national polio eradication programme will:

- review the performance of the existing PPTs and modify as required; and
- track and monitor the output of PPTs through regional EOCs.

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.

In 2016/2017, the national polio eradication programme aims to:

- continue CBTs;
- modify the number of teams as per workload;
- monitor CBT performance by independent monitors; and
- ensure full synchronization with vaccination operations across the border in Pakistan.

Special campaigns for nomads and other underserved population groups

Special campaigns in South-Eastern, Southern and Western Regions 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.

The programme has also a mechanism in place to vaccinate returnee refugees.

In 2016/2017, the national polio eradication programme aims to:

- develop special population (nomad) plans at the provincial level, shared with the country office, specifying the point of entry to the area, duration of stay, next destination, number of families and number of eligible children;
- conduct specific campaigns targeting this population group; and
- ensure returnee refugee populations will be vaccinated at entry points with OPV and IPV.

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

Building demand in immunization

Intensive efforts will be made to increase household and community engagement approaches in the prioritized high-risk districts to reduce missed children and build demand for overall immunization. Child absence remains the major reason for missing children nationwide and across all priority provinces, according to PCM data. In April 2016, children not available represented around 75% of missed children in Kandahar, 90% in Helmand, 60% in Nangarhar and 75% in Kunar, recognizing that non-availability may be used as an excuse to covertly refuse vaccination in some areas. In Kandahar and Helmand, an alarming number of districts consistently show over 8% absolute refusals (Baghran, Garmser, Reg, Khakrez, Shahwalikot, Panjwayi, Miyanshin, Arghestan, etc.). This is nearly 10 times the global average in polio priority countries. Addressing the unsupportive social context rooting refusals and children not available in Afghanistan, and in particular in Southern Region, will be the number one priority of the communication focus in the coming year.

Afghanistan's polio communication framework identifies the main strategic objectives, principles and approaches that will guide all communications work, including media and advocacy, social mobilization, and household and community engagement, and partnerships with religious leaders and medical professionals, the development of education and edutainment materials, and the training and empowerment of FLWs and civil society. By bringing all communication interventions under one strategic umbrella, the programme will ensure that they are integrated, complementary and mutually supportive of the operational strategies to reduce the number of missed children in Afghanistan.

Understanding that building trust is the cornerstone of successful community engagement, the main strategic thrust will be to create an enabling environment to facilitate acceptance and trust in the vaccine during and between campaigns. Communication activities will aim to shape an environment where continuous vaccination against polio is embraced and accepted as an important social and individual goal by all community stakeholders. Experience has shown that significant impact can be achieved by developing locally appropriate communication plans that include targeted household and community engagement approaches during and between polio campaigns.

Key activities include:

- **focusing on reducing chronically missed children through strengthened household and community engagement approaches that include:**
  - developing an evidence-based communication plan as part of the specific plan in every very high-risk district, including a focus on activities in high-risk clusters to address the locally-specific reasons for missed children;
  - including social elements as part of the integrated microplan as prioritized in the VHR districts;
  - spearheading household and community engagement by the over 8 000 members of the ICN, and conducting field work by fully trusted, capable and professional FLWs to mobilize caregivers, religious and community leaders, and key influencers to understand, accept and support the work of vaccinators and uptake of OPV; this engagement will not only happen during vaccination days, but will be a constant conversation with the community that feeds back into making the programme even more effective (the ICN will not be deployed in areas that are implementing the community health volunteer strategy and vice versa);
  - assessing the impact of ICN on reduction of missed children following October campaign and onwards;
  - following up rigorously on the register of all missed children during and between campaigns by members of the ICN, and ensuring vaccination in coordination with the local health facility; and
  - conducting detailed analysis of children missed due to 'not available', particularly in Kandahar. Sample of these will be surveyed to identify real reasons and to develop an intervention plan.
- **strengthening partnerships with key influencers, including religious leaders, health workers and other stakeholders, to help overcome issues of mistrust and suspicion at the local level by:**
  - in 2016/2017, placing focus on expanding the engagement of religious leaders at all levels in a more systematic way, particularly at the local level in the VHR districts, building on the National Islamic Ulama Group platform that was established in early 2016;

- mapping and including local scholars in the district-specific plans, with district focal persons ensuring the engagement of key religious leaders across the district;
- holding workshops at the national and provincial levels to ensure the consistent engagement of key religious leaders;
- continuing to disseminate programme information and guidance to inform religious leaders about the importance of immunization. Through their Islamic teachings, religious influencers will facilitate broader support for polio and child health;
- strategically incorporating the voices of key religious influencers into mass media content and platforms to expand the public narrative on immunization; and
- organizing workshops to seek the support of doctors and other health workers in the programme at all levels.

- **improving external relations and partnerships to promote an environment of trust by:**
  - creating partnerships with media and other stakeholders to strengthen communication and media interaction to ensure a better understanding of polio eradication, and facilitating improved partnerships with media by:
    - holding regular media briefings and trainings, ensuring regular interactions with key reporters, editors and talk show hosts; and
    - engaging editors of religious publications in social mobilization and advocacy for polio vaccination in high-risk areas to complement the engagement of religious leaders and institutions in advocacy and community engagement;
  - developing and disseminating awareness-raising materials for print and electronic media platforms to encourage increased public trust and support for local health-service delivery, during and between campaigns;
  - placing increased emphasis on creating a truly national programme that incorporates other sectors, stakeholders and voices, including medical professionals, as well as the Ministries of Education and of Rural Development, which have pledged their support to the polio programme through the Polio High Council; efforts will focus on ensuring full support of these and other sectors, including nongovernmental organizations; and
  - focusing on ensuring the participation of community influencers, including medical doctors, religious scholars, community elders and polio survivors and their families.

Data collection and generation of evidence

The effective implementation of the previous components relies on continuously updated evidence. Critical data collection includes the study of the attitudes and behavioural issues that create barriers to the vaccination campaigns, as well as the assessment of the effectiveness of ongoing interventions, especially specific social mobilization models, partnerships and tools, to continuously improve the network's operations. The focus will be on:

- the implementation of a second study to further understand shifts in attitudes and perceptions; and
- third-party monitoring – both qualitative and quantitative – of communication interventions in VHR districts.

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. The findings of an external review of the system in the country, conducted during the second quarter of 2015, confirmed that AFP quality remains strong and exceeds global standards in most areas. However, a number of smaller problems and issues were identified that affect surveillance sensitivity mainly at the provincial level and below.

Certain measures were taken to strengthen the AFP surveillance system, especially in hard-to-reach and security-compromised areas. Also, active AFP case searches were conducted frequently in areas where AFP surveillance is suspected to be weak. The active search for AFP cases has also been introduced as one of the tasks vaccinators and transit teams undertake during vaccination activities.

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 will guide further improvements in the system.

The key interventions planned to strengthen AFP surveillance in 2016/2017 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;
- analysing surveillance data in a disaggregated manner down to the district level and by security status to identify gaps to take corrective action;
- further strengthening of active surveillance visits with closer supervision and tracking from the regional and national levels;
- continuing to search for suspected AFPs during SIAs which will be strengthened further in vaccinator trainings; and
- exploring alternate modes/routes, as a contingency, for specimen shipment to Regional Reference Laboratory.

Environmental surveillance

Currently Afghanistan is conducting environmental surveillance at 14 sites in five provinces as follows: Nangarhar (three), Kunar (one), Kandahar (three), Helmand (four) and Kabul (three).

In 2015, a survey was conducted to investigate the possibility of expanding environmental sampling sites. In 2016-17, the programme will review the existing sites for their appropriateness and explore the possibility of expanding environmental surveillance to the areas surveyed without compromising the quality at existing sites.

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.

Response to any new polio case

A National Rapid Response Team conducts detailed case and epidemiological investigations whenever a polio case is confirmed. The team consists of representatives from the MoPH, WHO, UNICEF, the Centers for Disease Control and Prevention, and the Bill & Melinda Gates Foundation with expertise in epidemiological investigations and the management of outbreak response activities.

The National Rapid Response Team reports to the national EOC and is expected to:

- conduct the detailed investigation of any new polio case within 72 hours of notification by the lab and produce a narrative report within three days of completing the investigation;
- in coordination with the national EOC, support provincial and regional teams in planning for any case response; and
- provide feedback to the national EOC on additional support required.

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

- detailed epidemiological and case investigation;
- 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;
  - > preferably one of the three campaigns to be conducted with IPV, if the area is high risk and has not received an IPV-OPV SIA in 2015/2016;
  - > target age to depend on epidemiology; and
  - > national-level monitors to support and monitor pre-, intra- and post-campaign phases of all response SIAs.

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.

The country will develop a generic response plan for any outbreak in an inaccessible area.

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.

Effective vaccine and cold chain management

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

- task the national vaccine and cold chain management committee to oversee the technical and administrative processes/ procedures to ensure effective vaccine management at all levels;
- ensure forecasting, planning and timely delivery of all vaccines and non-vaccine items to service delivery points;
- secure resources required for all the planned SIAs, including complementary vaccination activities and case responses, as well as cold chain equipment for the entire NEAP implementation period;
- receive regular feedback on vaccines and cold chain from the EOC Vaccine Management Task Team, which will also provide weekly update during the EOC plenary meetings;
- implement global guidelines for cold chain logistics and vaccine management before, during and after polio campaigns for effective vaccine and cold chain management; and
- 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; and
- enhance the skills of cold chain staff at national and provincial levels in vaccine and cold chain management through capacity building.

Cross-border coordination

As already highlighted, 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:

- weekly communication between the identified cross-border focal points of the Afghanistan and Pakistan national EOCs;
- biannual face-to-face meeting and national EOC videoconferences;
- monthly meetings of relevant provincial and regional teams from both countries;
- synchronization of SIA dates and communication of any changes in the dates;
- streamlined cross-notification of AFP cases to ensure timely communication and the sharing of detailed information on WPV case investigations;
- uniform communication interventions of the cross-border transit points and regular sharing of media/communication plans to ensure consistent messaging;
- timely information sharing on high-risk population movements, including nomads, displaced populations, new immigrations and returnees; and
- development of a contingency plan to ensure returnee refugee populations will be vaccinated at entry points with OPV and IPV.

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:

- operational evaluation:
  - internal evaluations of NEAP 2016-2017 progress will be conducted in January 2017 (midterm) and June 2017 (end of term), involving national and international experts and key stakeholders, with the results of the midterm review helping to make mid-course corrections and with the end-of-term evaluation guiding the development of the next NEAP; and
  - a surveillance review will be conducted in June 2017 to assess the ability of the system to detect transmission;
- population immunity evaluation:
  - indirect evaluation through an assessment of the vaccination status of non-polio AFP cases; and
  - direct evaluation through a serological survey conducted in the first quarter of 2017 in Kandahar.

Routine immunization strengthening

Efforts to strengthen routine immunization will sustain the gains achieved by regular supplementary immunization activities through to certification. It is important to highlight that the prioritized VHR districts for polio also report low RI coverage and have high numbers of unimmunized or under-immunized children. Continued emphasis in 2016/2017 will be to

reduce the number of un- and under-immunized children in the prioritized VHR districts by regularly engaging the polio infrastructure and undertaking operations and mobilization efforts. The polio infrastructure will provide support, where feasible, in monitoring, training and mobilization.

Operations

The terms of reference of all polio field staff will be reviewed to ensure that up to 20% of their time is earmarked for RI activity support, in particular for:

- monitoring fixed and outreach sessions; and
- training health workers.
- Staff will receive orientation and training on their responsibilities by the end of the third quarter of 2016 and performance indicators will be set and measured.

Mobilization

Efforts include:

- ensuring that during all relevant meetings with key stakeholders at the community level, information on RI and the scheduled dates of outreach sessions are highlighted;
- identifying the low RI coverage areas during household visits and missed children tracking by FLWs to find areas where RI coverage is low, and informing district and provincial teams; and
- as the role of the ICN will be expanded beyond polio SIAs, focusing on the tracking of newborns by the mobilizers, informing the parents and family members of all newborns about RI vaccines and giving them the details of the EPI fixed centres, vaccinator contacts and dates of outreach.

Transition planning

Although Afghanistan still remains polio endemic and is prioritizing the implementation of activities to achieve Objective 1 of the global Polio Eradication & Endgame Strategic Plan (poliovirus detection and interruption), it is important for the country to start planning for the transition of polio assets beyond certification. Enabling the transition of polio assets to support other basic public health functions, wherever possible, will be a priority. A plan must be put in place 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. Transition Planning Guidelines will be used to develop these plans, with support from the Transition Management Group.

Key actions to achieve this involve the following interventions:

- **structure:** appointing a transition committee before end of quarter three 2016 to oversee the planning, chaired by a senior government representative, which would include participants from implementing partners, donors and other key stakeholders in the health sector;
- **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 first quarter of 2017;
- **asset mapping and stakeholder workshop:** with the support of the PEI implementing partners, ensuring that asset mapping is conducted and a transition planning workshop is held in the fourth quarter of 2016; and
- **follow-up:** ensuring that a draft plan is developed and shared with partners and donors for input by the second quarter of 2017.

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 July 2016 – June 2017
IV. IPV-OPV plan July 2016 – June 2017
V. NEAP 2016-2017 work plan
VI. Accountability framework