WHO-EM/POL/403/E

Summary report on the

Second meeting of the Technical Advisory Group on Poliomyelitis Eradication in Afghanistan

Kabul, Afghanistan
27–28 November 2012

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1. Introduction

The Afghanistan Technical Advisory Group (TAG) on Poliomyelitis Eradication convened its second meeting in Kabul on 26–27 November 2012. The objectives of the meeting were to review progress towards interrupting wild poliovirus transmission in Afghanistan and to make recommendations to improve technical and managerial aspects of the programme in Afghanistan. The meeting was attended by members of the TAG, staff of the Ministry of Public Health of Afghanistan, representatives of partners and donor agencies, and WHO and UNICEF staff from headquarters, WHO Regional Office for the Eastern Mediterranean, and Afghanistan and Pakistan country offices.

The meeting of the TAG was held at a time when international expectations for rapidly interrupting poliovirus transmission are at an all-time high. Only four countries have reported wild poliovirus in the past four months and global case reporting is at its lowest level ever. From the global perspective, polio is now essentially a rare disease, with virus circulation being sustained in reservoir areas of the three remaining endemic countries. As a result, there is increasing discussion at the international level on further measures to protect polio-free countries. Recognizing the risk to polio-free countries, the Independent Monitoring Board (IMB) of the Global Polio Eradication Initiative recommended at their November 2012 meeting that “the International Health Regulations Expert Review Committee urgently issue a standing recommendation by May 2013 that will introduce pre-travel vaccination or vaccination checks in each endemic country until national transmission is stopped”.

The Afghanistan programme now has a window of opportunity to achieve interruption of transmission. The low transmission season for wild poliovirus is coming in the first six months of 2013 and there is unprecedented national and international commitment to overcome the remaining challenges and achieve success. This window of opportunity

needs to be seized as significant uncertainties lie beyond with national elections and withdrawal of international forces foreseen in 2014.

2. Summary of discussions

Current epidemiological situation

As of 27 November 2012, Afghanistan has reported 31 cases of polio, all due to wild poliovirus (WPV) type 1. This compares to 58 cases for the same period in 2011, the year with the largest outbreak recorded in a decade. The most recent WPV type 3 case was reported in April 2010 and the last case due to circulating vaccine-derived poliovirus type 2 (cVDPV2) was from a small outbreak in September 2011. However, an explosive outbreak of cVDPV2 cases has been identified in Quetta block, Pakistan which poses a very real threat of cVDPV2 spread into southern provinces of Afghanistan.

In 2012, WPV cases in Afghanistan continue to be concentrated in the known endemic transmission zone in the south of the country, which accounts for 22 of the 31 cases reported as of 27 November 2012 (71%). In particular, transmission is concentrated in the provinces of Helmand and Kandahar, which have reported 21 cases in total. Outside this endemic zone, cases have been concentrated in provinces bordering Federally Administered Tribal Areas (FATA) in Pakistan, in particular Kunar which has reported four cases, as well as Khost and Paktya. A single case was also reported from Ghor in the central region in August. Genetic data show a reduction in genetic transmission clusters in 2012 compared to 2011 and confirm the southern endemic zone as the main source of continued wild poliovirus transmission in Afghanistan, with only sporadic cross border transmission to and from Pakistan (especially FATA) continuing in non-endemic parts of the country.

During the lower transmission months, January to May 2012, 10 confirmed cases were reported, 9 of which were in the southern transmission zone. In the five months since, a further 21 cases have been confirmed, 15 in the transmission zone and 6 in non-endemic areas. To date, the highest number of cases per month was recorded in September (7 cases).

Polio cases continue to occur in young children: 70% of cases in 2012 are among children under 2 years of age and less than 10% are in children above the age of 3 years. Most cases are among males (63%). In 2012, polio cases were under-immunized, with approximately 35% (11/31) of cases reported to have never received a dose of oral poliovaccine (OPV) and nearly two-thirds of cases reported to have received less than three doses. The median OPV dose of all confirmed polio cases is two (range 0–7+ doses), while among non-polio AFP cases it is 13.

Conclusions

After review of the evidence presented by the programme, the TAG re-affirmed that the core strategies for polio eradication, as outlined in the National Emergency Action Plan (NEAP), remain valid for Afghanistan. These strategies have resulted in the majority of the country successfully interrupting circulation of wild poliovirus transmission, although the large outbreak of last year emphasizes that significant vulnerability remains as long as polio continues to circulate anywhere in the country. Complete interruption of WPV transmission depends on successfully implementing the successful strategies in the core southern endemic zone, particularly the provinces of Kandahar and Helmand. Data presented to the TAG show that too many children continue to be under-immunized or missed in these two provinces. This is supported by the fact that two-thirds of the polio cases have received less than three OPV doses and an

overall declining trend in immunity status of non-polio AFP cases over the last12 months.

The TAG commended the Afghanistan programme for its analysis of missed children and accessibility in Kandahar and Helmand, which clearly demonstrates that the majority of children are being missed due to continued operational weaknesses: inadequate team selection, training, performance and supervision; ineffective strategies to access all children both inside and outside households; and overall deficiencies in monitoring and accountability of programme performance. A minority of children are missed due to location in areas of insecurity and conflict that prevent immunization activities from proceeding. Success with polio eradication in Afghanistan is dependent on the ability of the Government of Afghanistan and its partners to identify solutions for areas of insecurity and conflict and to overcome the longstanding programmatic weaknesses in Kandahar and Helmand.

Developments in Kunar province in the eastern region and Paktiya and Khost provinces in the south-eastern region emphasize the principle that all areas remain at risk as long as one area continues to support WPV transmission. Multiple WPV cases have been reported from these districts and circulation has been allowed to persist for a period approaching six months. The TAG was alarmed to hear reports of unpaid vaccinators, emerging security challenges and a growing pocket of susceptible children in neighbouring areas of Pakistan that have links with these provinces. The TAG concluded that there is considerable potential for emergence of new polio reservoirs in these areas unless effective action is taken to immediately reverse the trend.

The TAG commended the Government of Afghanistan for establishing high-level government commitment, evident with the endorsement of the NEAP by President and appointment of the President Focal Person. These are important steps in the right direction. As noted by the TAG in its May

2012 meeting, the NEAP provides a solid framework to ensure that Afghanistan can reach and immunize all children and become polio-free. The challenge for the government and partners is to increase the pace and scale of implementing the NEAP. **To date, none of the major NEAP indicators are on track and formal engagement of the government is only very recent at all levels.** The NEAP was finalized in June 2012 and it is clear that the objectives will not be achieved with the current rate of implementation. The full range of NEAP activities needs to be urgently implemented down to the sub-national level, particularly in Kandahar and Helmand provinces. The programme will continue to be hampered by a lack of strong oversight and accountability until this can be achieved.

The TAG also considered the current mechanisms for cross-border coordination with Pakistan, which remains important given the long history of shared virus circulation. Mechanisms for cross-border coordination need to be focused on the district level with clear responsibilities outlined for who should meet whom and for information that should be shared, and with clear protocols for cross-border outbreak response. The TAG requests the programme to provide these details for their next meeting along with the plan for how they will be monitored and supervised.

The TAG commended the strong coordination and collaboration between the Government of Afghanistan, UNICEF, and WHO and the continued spirit of problem-solving and innovation that has led to district EPI management teams (DEMTs), permanent polio teams, district focus campaigns, and other ways to address the challenges the programme faces. The strength of working as one team and continued problem-solving and innovation are critical ingredients for success.

The TAG would particularly like to draw attention to and applaud the courage of everyone working on polio eradication in the country, from vaccinators to programme managers.

As noted by the TAG in its meeting of May 2012, the main risk to polio eradication in Afghanistan remains unchanged: failing to rapidly improve coverage in the high risk districts in the south, east and south-east transmission zone. The strategies for improving coverage in these areas are: a) ensuring the basic elements of team selection, training, performance, supervision and management; b) improving governance and accountability of local authorities for ensuring communities are immunized; c) reaching inaccessible children through negotiation and innovation; d) addressing the declining routine immunization coverage; and e) creating demand for immunization. The TAG concludes that transmission can be rapidly interrupted with focus and determination by national government and partners to overcome these problems and deliver high quality campaigns during the low transmission season in the first half of 2013.

Responses to specific questions to the TAG

The TAG endorses efforts to engage all parties for immunization and protection of children and notes that efforts are already under way to obtain the support from the Immam-e-Ka'aba in Saudi Arabia along with important leaders in Pakistan.

The TAG endorses the principle of the district focused campaigns with the following modifications: flexible timing should be limited to areas where access seriously complicates operations; and regardless of campaign timing, all areas should aim to deliver 6 doses of OPV before the end of June 2013. With regard to the permanent polio teams, the TAG concludes that there is some evidence that unreached children are being immunized, however permanent polio teams cannot and will not replace

multiple high quality supplementary immunization activities, as the activities are essentially an opportunity for supplemental doses in areas where campaign quality is compromised by insecurity and conflict. Many operational details remain to be improved including effective supervision and cold chain. The difficulties of ensuring vaccine supply and cold chain to permanent polio teams in areas with no electricity should be overcome through the combination of cold boxes, reliance on the vaccine vial monitor and dedicated re-supply schedules. Organizations such as PATH should be consulted to determine recommendations on the best cold box equipment for this situation.

In the TAG report, specific recommendations were made on communications. In general, the TAG agrees that the programme needs more refined data on missed children and that this disaggregation should be added to a revised post-campaign assessment form. The TAG also considers that interpersonal communications and mass media are both needed for a comprehensive social mobilization strategy: one cannot succeed without the other.

Overall, the TAG concludes that additional Afghan national staff need to be identified and trained by the programme to improve monitoring and accountability in all areas. There is no replacement for direct supervision in the field. In areas where this is simply not possible, mobile phone reporting or supervision may be the only remaining choice.

3. Recommendations

The recommendations of the TAG below lay out the overall strategy for supplementary immunization activities and proposed schedule for 2013, followed by recommendations specific to the priority provinces of Kandahar and Helmand, those for other areas and cross-cutting issues.

Supplementary immunization strategy and schedule 2013

1. The supplementary immunization strategy for 2013 is recommended to take full advantage of the low transmission season in order to achieve the objective of breaking the continued transmission in the endemic southern region by June 2013 and protecting polio-free areas.
2. According to each objective, the time-frame for supplementary immunization activities should be as follows.
    - Protect polio free areas: 2 NIDs January–June 2013 plus 2 after
    - Mitigate consequence of WPV spread to vulnerable areas: 2 SNIDs January–June 2013 covering at least the southern, south-eastern, and eastern regions along with any other infected areas.
    - Interrupt transmission in low-performing districts: 2 SIAD campaigns to be conducted in the low-performing districts in the period January–June 2013 in addition to the above SNIDs and NIDs for a total of six doses in the six month period. In sub-district areas with significant access issues, the timing of campaigns (including NIDs, and SNIDs) can be flexible to accommodate local timing preferences as long as the overall objective of delivering six doses by end of June 2013 is maintained.
    - Outbreak response: Any WPV detected outside the two provinces of Helmand and Kandahar should be treated as a national emergency and responded to as an outbreak. This includes three large scale (multi-district or bigger), short interval (SIAD) mop-up immunization activities (previously scheduled campaigns can be included as part of the three round case response)
        - A national rapid response team of experienced polio workers should be established. They should visit any infected province/district within seven days of notification of confirmed polio case and develop and implement case response plan to be presented directly to the provincial governor.

- A buffer stock of bivalent OPV (bOPV) should be established with sufficient quantity to rapidly conduct the first multi-district SIAD outbreak response activity.

3. bOPV should be the default vaccine for supplementary immunization activities and outbreak response. Trivalent OPV (tOPV) should be urgently used in across Kandahar and Helmand provinces in light of the cVDPV type 2 outbreak in Quetta block of Pakistan. In addition, at least one of the NIDs in the first half of 2013 should use tOPV.

Objective	**Activity**	**Areas to be covered**	**Total doses January–June 2013**
Protect polio-free areas	NIDs	All districts	2 (2 NID)
Prevent and mitigate consequences of WPV spread to vulnerable areas	SNIDs	All districts of southern, south-eastern, and eastern regions	4 doses (2 SNID + 2 NID)
Interrupt transmission in low performing districts	SIADs	All low performing districts	6 doses* (2 SIAD + 2 SNID + 2 NID)
Outbreak response	SIADs	Multi-district area centered on the district reporting the case	3 outbreak response SIAD rounds**

*In areas of low-performing districts with access limitations that significantly compromise operations, the timing of all rounds (NID, SNID) can be flexible to accommodate local needs provided that the objective of delivering 6 doses before end of June 2013 is maintained

**The 3 outbreak response SIADs can include pre-planned activities (NIDs, SNIDs)

Specific recommendations for Kandahar and Helmand

4. Overcoming the remaining challenges to polio eradication in Kandahar and Helmand should become a national priority. This

should involve regular (monthly) direct reporting (not just a written report but a real interaction either face to face or via teleconferencing) of the Governors of Kandahar and Helmand to the President level on actions they have taken on implementing the NEAP and polio eradication activities in general. Similarly, provincial governors should receive regular, direct reports from district governors on actions taken.

5. Polio control rooms should be established, by end December 2012, at provincial and district levels and chaired by respective governors or by their direct representatives. All infected and low-performing districts should report directly to the polio control rooms. These control rooms should be provided actionable information on a standardized format used at all levels that should include data on a) accessibility 2) pre-campaign indicators 3) intra campaign indicators, and 4) missed children and operations.
6. The programme should review, finalize and use dashboards for action at district levels of the two provinces by December 2012.
7. All clusters should be categorized according to their accessibility with clear identification of exactly “who” has access in each area – an overview of this should be mapped at the district and province levels. Each cluster/village should specify the challenges to be tackled. This should all be incorporated into joint operational/social mobilization microplans with copies available for review at the provincial level.
8. Team selection is not a responsibility of the provincial level. All teams should be selected at district level by the district EPI management team along with communities and the immunization communication network. Team members should be accountable to the local authorities, whoever they may be, so that performance issues can be addressed.
9. The polio eradication programme in Kandahar and Helmand, supported by the national programme should:
    - Define and implement a re-visit strategy with clear standard operating procedures.

- Add additional mobile teams and consider addition of a third team member whose purpose would be to sweep and immunize children in the street.
- Implement the standardized special investigations in areas with high proportions of chronically missed children to have data to guide problem solving.

10. One of the most important challenges to be overcome in the southern provinces is to improve access to all children inside compounds. The TAG urges consideration of the following as approaches to be tried where addition of women on the teams is difficult:
    - Identify and engage traditional birth attendant (*daya*) to help to access the children inside houses
    - Identify and use incentives that can be carried by teams to encourage mothers to make sure their newborns and other children are all presented to the team.
11. Expand the community mobilization network to include full time mobilizers in the priority districts. Two types of mobilizers should be considered for recruitment: those who can access mothers and those who can interact with senior community influencers and fathers. Recruitment targets should be established in each of the priority districts of the two provinces for rural and urban areas that specify the type of mobilize: female mobilizers, females accompanied by male family members, youths or any other composition that is acceptable to households. The progress towards recruitment should be tracked by NEAP monitoring dashboards.
12. Specific communication strategies should be designed to reach women, considering their critical role in reaching all children.
13. Additional strategies should be identified and used to reach absent children, including the following:
    - Scale up dot marking of households.
    - Identify social gatherings of celebrations, festivals, shrines, where children and women can be reached outside the household and include them in microplans.

- Document local engagement strategies that have successfully reduced social barriers in key challenging districts of Shawalikot, Spin Boldak, Maiwand, etc.
- Roll out revised interpersonal communication (IPC) training for all frontline workers in all high risk districts by January 2013.

14. The TAG endorses the analysis conducted by the southern region team and recommends that it be systematically adopted by all provinces. As described in the analysis, all clusters within a district should be categorized using standardized definitions on who has access and this should be reported on a regular and defined basis to polio control rooms. Provincial overview maps should be developed to guide programme decision making.
15. Efforts for dialogue and negotiation should continue building on successes achieved through different groups, including the Afghanistan International Committee of the Red Cross.
16. For all areas where access is limited, a systematic package of innovations should be deployed to minimize to the lowest extent possible the number of unimmunized children. These include permanent polio teams, the use of local vaccinators and community guides and exploration of the acceptability of alternate vaccine delivery methods in place of house to house (booths at mosques only or clinics).
17. Short interval additional dose (SIAD) strategies should be employed in all limited access areas when access is gained.
18. Delivery of additional health interventions should be considered in all areas with limited access.
19. District EPI management teams should be trained by January 2013 and equipped with standardized reporting formats. They should be empowered to solve local problems.
20. The government and partners should ensure that full staffing needs are identified and met in order to rapidly address the challenges in Kandahar and Helmand, and that the maximum number of human

resources that will be effective in the local context are dedicated to these two priority provinces.

Recommendations for other areas: Kunar, Paktiya and Khost

21. These three provinces should be treated as emergency outbreaks at the national level resulting in monthly direct reports of both provincial and infected district governors reporting progress on polio eradication directly to the president focal point.
22. Delay in vaccinator payments is an avoidable problem for the programme. All payments should be rectified on a priority basis by the end of 2012 with measures established to ensure that payments in 2013 are received on a timely basis.
23. Strong cross-border coordination with Pakistan for operations and advocacy should be ensured. The focus should be on mapping and immunization of migrant and nomadic populations and increasing district transit teams.
24. Permanent polio teams and other approaches for areas with limited access should be considered and implemented in similar areas of Kunar province.

Cross-cutting issues

25. Low levels of routine immunization, particularly in the priority southern region provinces, continue to hamper progress towards polio eradication. The TAG endorses the recommendation of the in-depth EPI review and national EPI workshop to urgently develop a national routine immunization acceleration plan and requests an update on the status of this plan at the next meeting of the TAG.
26. The post-campaign assessment procedures should be revised taking into consideration new global polio monitoring guidelines that best practice forms, methodologies and training. In particular, post-campaign assessment data should disaggregate the reasons for missed

children so that they can be addressed, in line with the global guidelines.

27. Lot quality assurance sampling, as an additional methodology to determine the quality of campaigns, should be piloted in a few districts of the southern region to determine the feasibility in that context. Results from the pilot should be reported to the TAG at its next meeting along with lessons learned and next steps.
28. High-risk districts (HRDs) should be re-designated as low-performance districts (LPDs) to more accurately reflect the situation. The list of LPDs needs to be responsive to evolving epidemiology. A new list should be deployed by 1 January 2013 composed of the 13 core LPDs plus any other newly emergent problem district and all newly infected districts. The programme should be able to modify its standard analyses and reports to accommodate changes to the list of LPDs.
29. Mechanisms for cross-border coordination need to be focused on the district level with clear responsibilities outlined for who should meet whom and information that should be shared, and with protocols for cross-border outbreak response. The TAG requests the programme to provide these details for its next meeting along with the plan for how they will be monitored and supervised.
30. The TAG endorses the national priorities plan for the first 6 months of 2013 presented by the Government of Afghanistan, noting that its overlap with the recommendations of the TAG, further confirming the direction the programme needs to move towards successfully interrupting WPV transmission.

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