WHO-EM/POL/430/E

Report on the

Technical consultation on poliomyelitis eradication in Afghanistan

Kabul, Afghanistan
12–13 July 2016

World Health Organization
Regional Office for the Eastern Mediterranean

WHO-EM/POL/430/E

Report on the

Technical consultation on poliomyelitis eradication in Afghanistan

Kabul, Afghanistan
12–13 July 2016

World Health Organization
Regional Office for the Eastern Mediterranean

Document WHO-EM/POL/430/E

CONTENTS

EXECUTIVE SUMMARY

A meeting of the Afghanistan Technical Advisory Group (TAG) on poliomyelitis eradication was held on 12–13 July 2016 in Kabul, Afghanistan. The meeting was chaired by Dr Jean-Marc Olivé and opened by H.E. Dr Ferozuddin Feroz, Minister of Public Health. In the context of completion of the National Emergency Action Plan (NEAP) for polio 2015–2016 and development of the new NEAP for 2016–2017, the TAG meeting had two key objectives:

- to review the progress in polio eradication activities since the last TAG meeting, particularly the implementation of the NEAP 2015–2016;
- to review and comment on the newly drafted NEAP 2016–2017 and make recommendations to achieve the interruption of transmission by December 2016.

There is significant progress in the polio eradication programme in Afghanistan as evidenced by epidemiology, improvement in population immunity and improvement in quality of supplementary immunization activities. The TAG appreciates the progress on implementation of the NEAP 2015–2016 and the development of a robust NEAP for 2016–2017.

Most of the recommendations made during the last TAG meeting have been implemented. TAG remains supportive of initiatives to improve the quality of front-line workers and hopes that key elements of the community health volunteer model may be incorporated in ongoing programme implementation.

In Afghanistan, the transmission of wild poliovirus (WPV) is now limited to a small geographical area in the eastern region and northern parts of the southern region. No WPV has been detected in environmental samples in 2016, showing reduced virus load in the country. There is improved vaccination status and evidence of vaccine reach as seen in Sabin-like isolation in high-risk areas of Afghanistan.

Overall campaign quality has improved as reflected by lot quality assurance sampling (LQAS) data, which show a significant decrease in the proportion of lots rejected. This may be attributed to seven new initiatives aiming to improve the quality of campaigns and to reduce the number of children missed. However, the TAG notes that there are still significant gains to be made in reducing missed children through further tightening of quality in the basic components of supplementary immunization activities.

Afghanistan has a strong and highly sensitive surveillance system in place, despite all the challenges with insecurity.

The TAG expressed deep regret regarding the tragedies that continue to affect polio workers and acknowledged the extremely challenging context in Afghanistan. It commended the Government of Afghanistan and partners for strengthening programme management and

coordination structures, and noted the improved involvement of nongovernmental organizations in delivering the basic package of health services (BPHS). Coordination between Afghanistan and Pakistan in polio eradication efforts has also improved, with regular interaction at all levels.

The TAG expresses serious concern at the recent deterioration of the security and access situation in Afghanistan, particularly in the north-eastern and eastern regions. Challenges in ensuring the quality of campaigns due to insecurity in the southern region remain a concern. The strategies used by the country for gaining access and improving quality are appropriate.

Communication is integrated across all key components of the programme and there is now a cohesive, solid and integrated communication strategy in place. The standard operating procedures for implementation of the full-time immunization communication network are robust.

Key recommendations

- Country team should sustain and further strengthen the existing structure of the emergency operations centres and fully implement the accountability framework before the end of August 2016.
- The TAG endorses the NEAP 2016–2017 as presented, with some suggested changes, and recommends its full implementation in a coordinated manner through the emergency operations centres.
- Programme neutrality should be maintained by all parties and new approaches to reach inaccessible children should be fully implemented.
- Strong surveillance should be maintained, particularly in areas with recent deterioration in security/access, and recommendations from the June 2016 surveillance review should be implemented.
- The national programme should develop a generic response plan for any outbreak in inaccessible areas and for outbreaks in areas contiguous with Pakistan, there should be joint analysis, planning, response, monitoring and reporting.
- The quality of activity in fully accessible areas of very high-risk districts should be sustained and further improved by consolidating new initiatives. Failed lots in LQAS from very high-risk districts should be tracked over the rounds at national level, and lots failing repeatedly should be further investigated and interventions modified to ensure improvement of quality.
- Solutions should be explored to improve monitoring capacity in category 3 (accessible with limitations) areas.
- The community health volunteer pilot in Spin Boldak should be completed, covering the whole district, and presented in the next TAG meeting.
- Focus on very high-risk districts should be maintained. At the same time, the programme should not lose sight of the 49 high-risk and non-high-risk districts and continue improving quality in these areas.

- Full-time deployment of the immunization communication network in all 47 very high-risk districts should be operationalized by the end of August, and its impact should be assessed in terms of reduction of missed children following the August campaign and onwards.
- Emphasis should be given to engaging local-level influencers and caregivers to address identified issues, including sustained engagement of religious leaders in the very high-risk districts rather than at the national level.
- The Ministry of Public Health and BPHS nongovernmental organizations should make concerted efforts to improve routine immunization in high-risk areas where low coverage is identified.
- Cross-border coordination with Pakistan should continue. Contiguous very high-risk districts of Afghanistan and tier 1 and 2 districts of Pakistan should be seen as one unit for analysis, interventions and reporting.
- A contingency plan should be developed for the possible return of refugee populations.

1. INTRODUCTION

The TAG meeting on poliomyelitis eradication in Afghanistan was held on 12–13 July 2016 in Kabul, Afghanistan. The meeting was chaired by Dr Jean-Marc Olivé and opened by H.E. Dr Feroz Ferozuddin, Minister of Public Health in the presence of the WHO and UNICEF representatives in Afghanistan. The meeting was attended by Dr Hedayatullah Stanekzai, Senior Advisor to the Minister of Public Health, representatives from the Office of the Presidential Polio Focal Point, members of the Afghanistan Polio Eradication Initiative (PEI) team from national and regional levels, as well as representatives from the Grants and Service Contracts Management Unit, Bill & Melinda Gates Foundation, Centers for Disease Control and Prevention (CDC), International Committee of the Red Cross (ICRC), United States Agency for International Development (USAID), Japan International Cooperation Agency (JICA), Rotary International and the Canadian Embassy, the last representing all bilateral partners. This list of participants is attached as Annex 1. The previous TAG meeting was held on 24–25 January 2016 in Kabul, Afghanistan.

Afghanistan and Pakistan are the only two remaining polio-endemic countries in the world and form one common epidemiological block for poliovirus transmission with frequent population movement across the border. Both countries have shown progress corroborated by a decrease in the number of cases and infected districts, with 19 cases in 13 districts reported to date in 2016, compared with 35 cases in 20 districts during the same time period in 2015.

Afghanistan has reported six polio cases to date in 2016: four from a small cluster of villages in Kunar province of the eastern region and one case each from Kandahar and Helmand provinces of the southern region. The current transmission in the eastern region is genetically linked to Khyber/Peshawar in Pakistan and has remained limited to a small area of 1.5 km^2, whereas the cases in the southern region are linked to transmission detected in the same provinces in 2015 indicating low-level local circulation. No WPV has been reported through environmental surveillance in 2016, which is the longest ever period in Afghanistan without WPV in environmental sampling; the last WPV was isolated from Jalalabad in December 2015.

Afghanistan continues to maintain very high sensitivity of surveillance, with key indicators surpassing the global targets in all regions. In addition, environmental surveillance is conducted at 14 sites throughout the country focusing on high-risk areas. Therefore, as concluded by the recent external acute flaccid paralysis (AFP) surveillance review, circulation of WPV/circulating vaccine-derived poliovirus (cVDPV) is unlikely to be missed in Afghanistan.

There is strong commitment from the Government and the Office of the President to the polio programme. The national and three regional emergency operations centres established in late 2015, supported by provincial polio coordination units in the five high-risk provinces, are displaying strong leadership and coordination across the partnership between Government, UNICEF, WHO, Bill & Melinda Gates Foundation, other partners and BPHS nongovernmental

organizations. The country has implemented the NEAP 2015–2016 in a coordinated manner through the emergency operations centres.

The intensive supplementary immunization activities schedule for 2016 has been implemented as planned and there is evidence of significant improvement in population immunity, particularly in the high-risk provinces of Helmand and Kandahar, according to the vaccination status of non-polio AFP cases. Monitoring data (LQAS) show improvement in the quality of implementation of supplementary immunization activities, with the proportion of failed lots decreasing from 40% in the February subnational immunization day to 17% in the May national immunization day in the 47 very high-risk districts. The improvement can be attributed to various interventions that the country has initiated and intensified, with primary focus in the 47 very high-risk districts, including:

- deployment of more human resources and enhanced monitoring and supervision;
- development of district profiles and district-specific action plans which are reviewed and revised after every supplementary immunization activity;
- field validation and revision of microplans;
- revision and roll out of front-line workers training curriculum;
- modification and expansion of the revisit strategy;
- implementation of systematic post-campaign reviews after every supplementary immunization activity at national and regional levels;
- detailed field investigation of all failed lots in LQAS to identify core issues and develop action plans to improve quality.

Along with overall improvement in campaign quality and reach to children, there is increased focus on expanding community and household engagement at various levels aiming to increase demand and trust in vaccination within Afghan communities. These include ulama conferences with the support of the Islamic Advisory Group for Polio Eradication, as well as expansion and intensification of the immunization communication network.

The security and access situation in Afghanistan has continued to deteriorate and during the May national immunization day over 320 000 children were not reached due to bans on campaign activities, mostly in the north-eastern and eastern regions. Access in the southern region remains fragile, impacting the efforts to ensure high-quality campaigns. While alternative strategies are being implemented to maximize the programme’s reach, negotiations are ongoing at various levels aiming to improve access. For the programme to be able to reach all children in Afghanistan, maintaining programme neutrality is essential.

Cross-border coordination with Pakistan has been further strengthened over the past 6 months. Regular face-to-face meetings and video/teleconference calls are taking place between respective national, regional and provincial teams of both countries. The campaign schedules have been synchronized, the switch dates were coordinated, and the target age group at cross-

border points, as well as reporting tools and communication materials, were harmonized. Data on population movement, cross-notification of AFP cases and detailed investigations of all new polio cases are regularly shared.

As outlined in the updated NEAP for 2016–2017, Afghanistan aims to stop polio transmission by the end of 2016. However, the country is well aware of the prevailing risks that may stand in the way of achieving this target. The inability to gain access to all children or to improve campaign quality in high-risk areas can undermine efforts and achievements made. Any loss of neutrality would heavily compromise activities on the ground. However, if the programme is able to continue consolidating on the key interventions started since the January 2016 TAG meeting, and which are showing impact, the target to stop transmission within the current year seems attainable.

The progress of implementation of the NEAP 2015–2016 has been reviewed and a new NEAP 2016–2017, with a detailed work plan and accountability framework, is being finalized. In this context, and with the aim of interrupting transmission before the end of 2016, the Afghanistan TAG meeting had two key objectives:

- to review the progress in polio eradication activities since the last TAG meeting, particularly the implementation of the NEAP 2015–2016;
- to review and provide comments on the newly drafted NEAP 2016–2017 and make recommendations to achieve the interruption of transmission by December 2016.

A schedule for supplementary immunization activities is attached as Annex 2. The vaccine plan for supplementary immunization is included as Annex 3. A map and list of very high-risk and high-risk districts are attached as Annexes 4 and 5, respectively.

2. SUMMARY OF DISCUSSIONS

General conclusions

The TAG expresses deep regret regarding the tragedies in which polio workers have lost their lives or been injured while working. The TAG acknowledges the extremely challenging situation in Afghanistan, and appreciates the hard work done by all involved in the programme. The TAG also notes the recent deterioration in accessibility, which is a major challenge to stopping polio transmission in Afghanistan. The TAG appreciates the programme for maintaining neutrality. The TAG appreciates the fact that the meeting is once again taking place in Kabul and, in particular, the participation of colleagues from the provinces and regions.

The TAG commends the leadership and active participation of national, regional and provincial government authorities and partners, and participation from global partners. However, the TAG reiterated the utility of having representation from the Pakistan programme in the

upcoming TAG meeting. The TAG acknowledges the scale of the work being done in Afghanistan, and appreciates the progress made, as well as the excellent quality of presentations.

The TAG Chair appreciated the opportunity to conduct a joint field visit to the high-risk province of Kandahar, and also commended the team for the good work being done there despite challenging circumstances.

Oversight, coordination and programme management

The government and partners are commended for strengthening programme management and coordination structures, particularly the national and regional emergency operations centres, Polio High Council and involvement of line ministries and provincial governors.

The TAG observes a strong partnership between government, UNICEF, WHO and other partners at national and regional levels. The TAG notes improved involvement of BPHS nongovernmental organizations in polio eradication efforts, but notes also that further alignment, particularly in the area of EPI provision, is both desirable and possible. The TAG is pleased to note that the country team is in process of developing and implementing an accountability framework; however, this process has been slow.

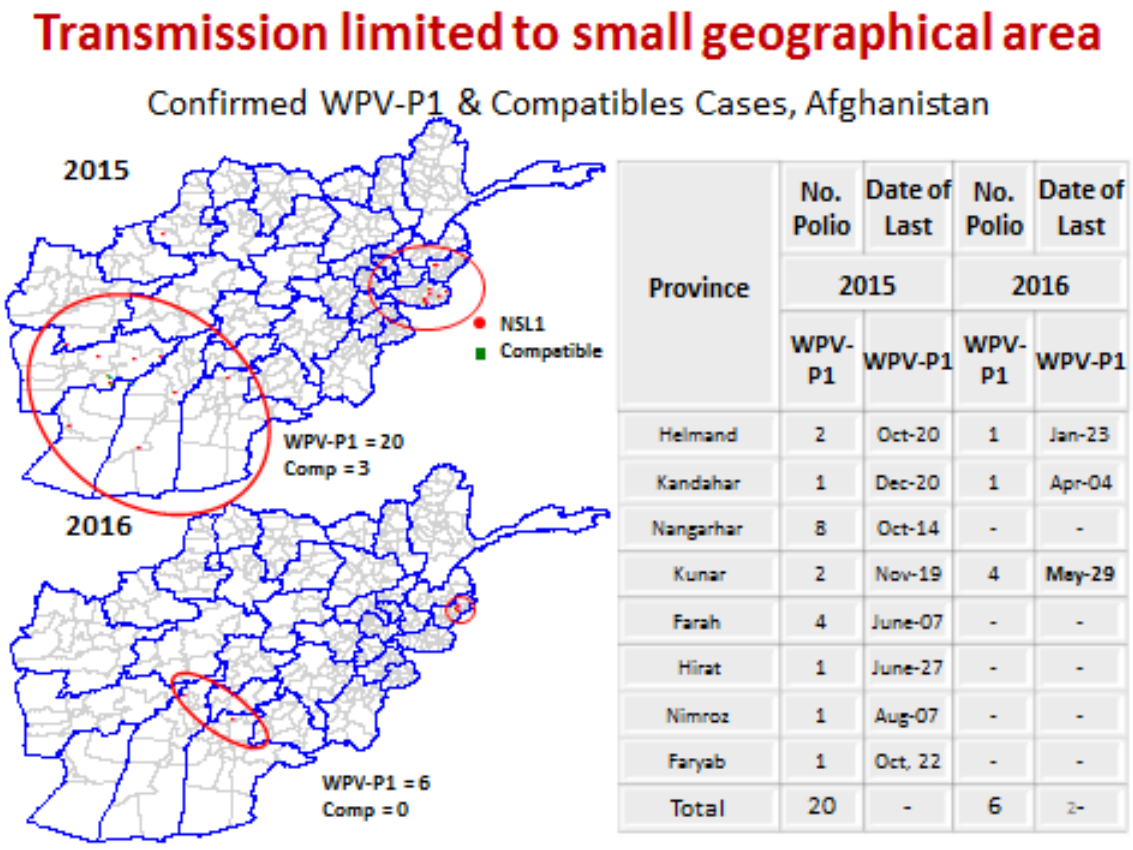
Implementation status of NEAP 2015–2016

The TAG appreciates the significant progress seen in the Afghanistan polio eradication programme as evidenced by epidemiology, improvement in population immunity and improvement in quality of supplementary immunization activities.

The TAG appreciates the progress on implementation of the NEAP 2015–2016, including many new initiatives, such as campaign dashboards, campaign review meetings, deployment of national monitors, use of data for corrective action and deployment of monitoring and accountability officers to high-risk areas. The TAG notes in particular the exceptional progress made in developing the programme dashboard, and encourages the country team to maximize its utilization in guiding real-time monitoring of district and subdistrict campaign quality. The TAG appreciates the country team for the development of a robust NEAP for 2016–2017 based on the lessons learned over the past 6 months and recommendations from the TAG and other key stakeholders. However, there is a need for further fine-tuning in some areas.

Implementation status of TAG recommendations

The TAG appreciates the implementation of the recommendations made during the last meeting in January 2016. Although all recommendations have been responded to, it notes that 10 of 31 recommendations are not yet fully implemented.



Province	No. Polio	Date of Last	No. Polio	Date of Last
	2015		2016	
	WPV-P1	WPV-P1	WPV-P1	WPV-P1
Helmand	2	Oct-20	1	Jan-23
Kandahar	1	Dec-20	1	Apr-04
Nangarhar	8	Oct-14	-	-
Kunar	2	Nov-19	4	May-29
Farah	4	June-07	-	-
Hirat	1	June-27	-	-
Nimroz	1	Aug-07	-	-
Faryab	1	Oct, 22	-	-
Total	20	-	6	2-

Fig. 1. WPV transmission in 2015 and Q1–Q2 in 2016

The TAG is strongly supportive of initiatives to enhance quality of front-line workers and the rigorous assessment of their improvement. The TAG hopes that key elements of the community health volunteer model may be incorporated in ongoing programme implementation.

Epidemiology

There has been significant progress towards the target of stopping transmission of WPV. Transmission is now limited to a small geographical area in Kunar province in the east (one district) and the northern parts of Helmand and Kandahar in the south (two districts) (Fig. 1).

The transmission in the east illustrates the importance of common reservoir transmission between the eastern region and Khyber Pakhtunkhwa/Federally Administered Tribal Areas in Pakistan; however, the country has been able to limit transmission to a small geographic area. The TAG expresses concern that there is still continuous low level transmission in the northern part of the southern region (Fig. 2). The TAG notes that no WPV was detected in environmental samples in 2016, showing reduced virus load in the country.

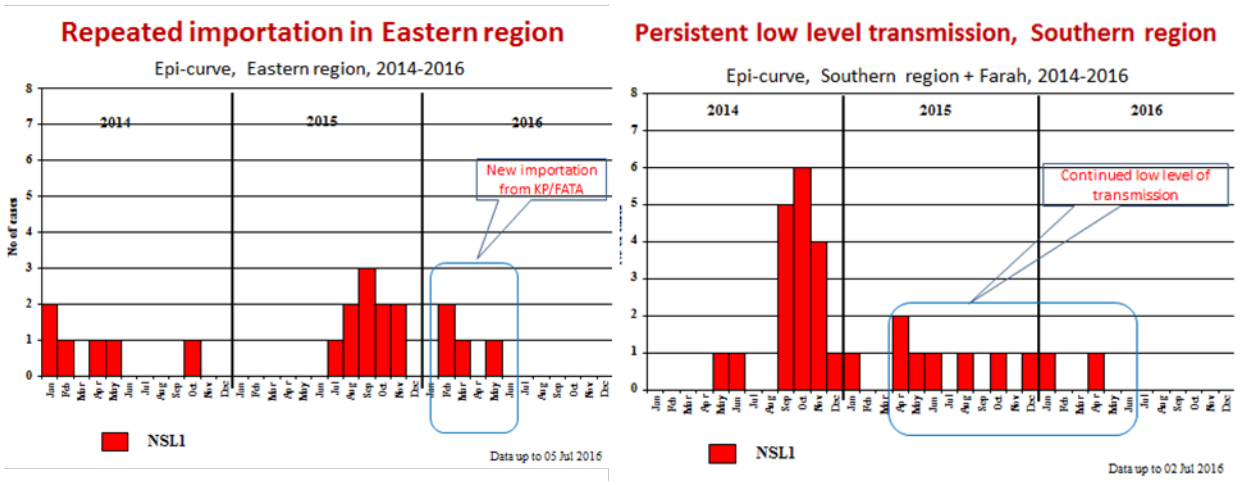


Fig. 2. Repeated importation in the eastern region and continuous low-level transmission in the southern region, 2014–2016

Immunization and population immunity

The TAG observes there is evidence of improved vaccination status in non-polio AFP cases, particularly in Helmand and Farah provinces. Despite the progress made, the proportion of under-immunized children still remains high in Helmand and Kandahar provinces and has increased in Kunar province. The TAG also notes that Sabin-like virus isolation from Helmand, Kandahar, Farah and Kunar is higher than the national level, showing improved vaccine reach into these high-risk provinces (Fig. 3).

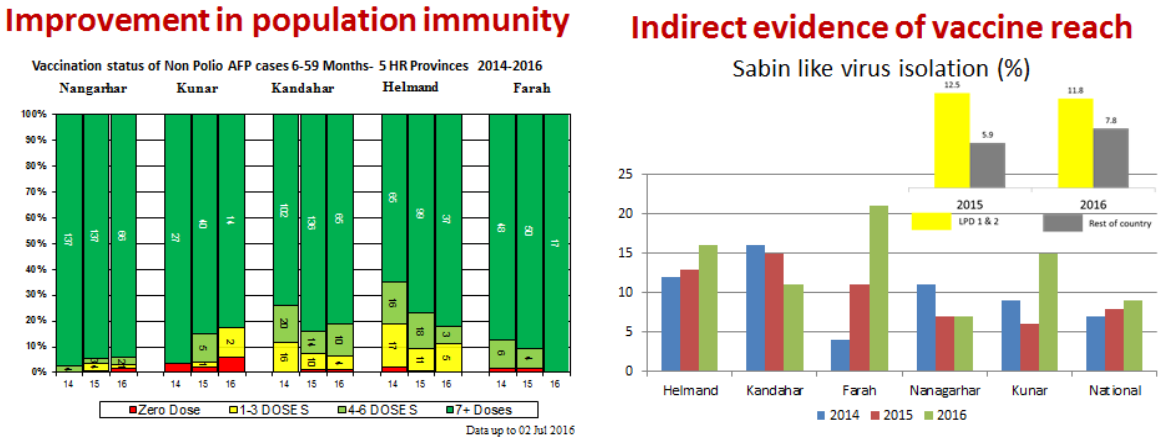


Fig. 3. Population immunity and indirect evidence of vaccine reach in high-risk provinces, 2014–2016

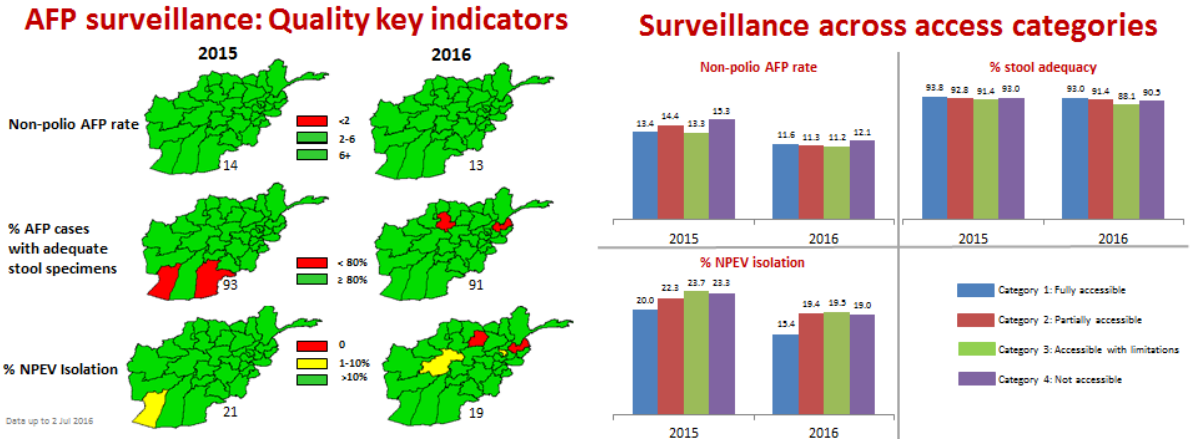


Fig. 4. Surveillance indicators by province and across access categories, 2015–2016

Surveillance

Afghanistan has a strong and highly sensitive surveillance system in place, despite the challenges due to insecurity. The TAG endorses the conclusion made by the recently conducted external AFP surveillance review that "Circulation of WPV/cVDPV is unlikely to be missed in Afghanistan". The TAG notes that the sensitivity of surveillance is comparable across different access/security categories (Fig. 4).

The TAG notes that, currently, samples are shipped to the regional reference laboratory in Pakistan only by road through the Torkham border, presenting a risk in case of closure of the border.

Improvement in quality of supplementary immunization activities

The quality of campaign activities has improved as reflected in LQAS data. The proportion of lots rejected at less than 80% has reduced from over 40% in the February campaign to 17% in the May campaign in very high-risk districts (previously named as low performing districts 1 and 2) (Fig. 5). However, the programme should remain focused on further improving quality (as 17% of lots from very high-risk districts are still being rejected), as well as reducing the proportion of missed children due to no team visiting households during supplementary immunization activities.

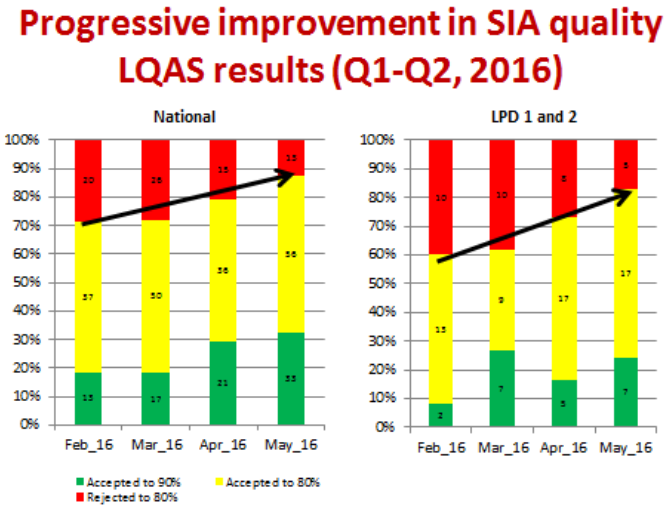


Fig. 5. Improved campaign quality as per decreased proportion of failed LQAS lots at national level and in very high-risk districts

Since the January 2016 TAG meeting, the country has started seven major new initiatives to improve the quality of campaigns and to reduce the number of children missed. These initiatives, with very strong focus on the 47 very high-risk districts, include: microplan field validation and revision; revision and roll out of the front-line workers training module; a modified revisit strategy; district profiles and district-specific plans; investigation of failed LQAS lots and instances of more than three missed children in post-campaign monitoring; deployment of monitoring and accountability officers; and pre- and post-campaign meetings with consistent involvement of national-level monitors to high-risk provinces. The TAG also appreciated the integration of operations with communication across all key components of the programme.

The TAG notes that microplan field validation in 37 very high-risk districts has revealed 276 pockets of missed children, and expresses concern that similar pockets might exist in the remaining 10 very high-risk districts and those not classified as very-high-risk.

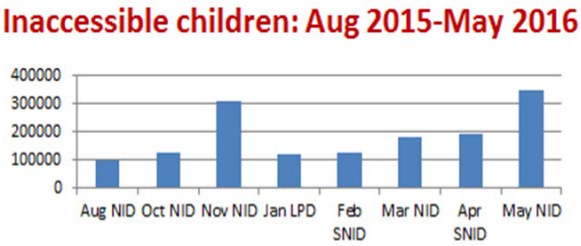
The TAG appreciates the implementation of inactivated polio vaccine (IPV) plus oral polio vaccine (OPV) supplementary immunization activities in most of the high-risk areas as per the plan; however, the TAG expressed concern that these were not implemented in Kandahar due to a ban on campaign activities using IPV.

Currently, 17% of front-line workers are being paid through a direct disbursement mechanism and the country plans to expand this in a phase-wise manner, wherever feasible. However, the TAG notes that there are limitations due to on-the-ground realities.

Access and security

The TAG expresses serious concern about the recent deterioration of the security and access situation in Afghanistan, particularly in the north-eastern and eastern regions, which are contributing to a build-up of a large cohort (at least 320 000) of susceptible and vulnerable children (Fig. 6).

Access in the southern region remains fragile. In addition, the selection of appropriate front-line workers, monitoring and supervision of activities and the implementation of the accountability framework remain a challenge in these areas, undermining efforts to improve quality (Fig. 7).



Region	Aug NID	Oct NID	Nov NID	Jan LPD SIA	Feb SNID	Mar NID	Apr SNID	May NID
East	51,327	106,913	57,232	41,744	22,938	25,869	30555	131,781
North	18880	0	22756	0	0	0	0	3376
NE	6,386	0	173,818	65,584	97,998	146,810	106281	165,333
South	17,830	15,563	51,105	12,335	7,079	11,684	56,662	22,811
SE	830	1,793	2,020	0	380	0	380	400
West	672	0	0	0	0	0	0	0
Central	0	0	0	0	0	0	0	0
Total	95,925	124,268	306,931	119,663	128,395	184,363	193,878	323,701

Fig. 6. Inaccessible children by region, Aug 2015–May 2016

The strategies used by the country in inaccessible areas are appropriate, particularly the expansion of permanent vaccination points around inaccessible areas; strategic use of IPV+OPV vaccination at nearby health facilities; use of polio plus services; negotiations by the United Nations and other neutral parties for gaining access and improving quality; and use of short-interval additional doses in newly accessible areas.

The TAG observed that inaccessible areas are also underserved areas and there is high demand for other services, particularly health services (an area in which BPHS nongovernmental organizations and the Ministry of Public Health play a key role).

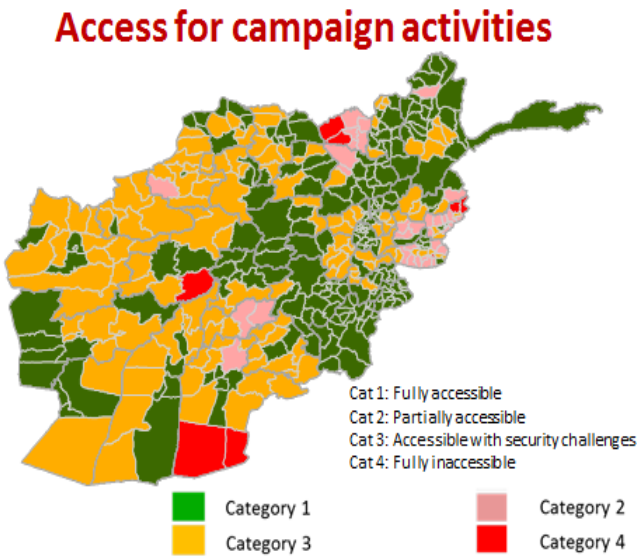


Fig. 7. Access for campaign activities during May 2016 national immunization day

Communication

The TAG acknowledges the sharpened focus on communication and social mobilization. There is now a cohesive, solid and integrated communication strategy in place to build demand for immunization. The standard operating procedures for the implementation of the full-time immunization communication network are solid and must be rapidly operationalized, underpinned by a strong accountability framework.

The TAG appreciates the efforts to ensure that communication approaches – differentiating between strategies to enhance household OPV acceptance during supplementary immunization activities from wider community and national programme awareness and support – are fully integrated with operations, including microplanning, training and district-specific plans.

Cross-border coordination

There has been significant improvement in the coordination between Afghanistan and Pakistan on polio eradication efforts, with regular videoconferences and face-to-face meetings between emergency operations centres at national and local level.

Conclusions by the TAG

- Significant improvement in coordination and programme management with strong partnership between Government, UNICEF and WHO, and involvement of BPHS nongovernmental organizations.
- Significant progress in polio eradication in Afghanistan. Transmission is now limited to very small geographical areas and no positive environmental samples have been found in 2016.
- Improvement in population immunity and vaccine reach as seen in LQAS results, Sabin-like virus isolation and OPV doses in non-polio AFP cases. Despite the progress made, the proportion of under-immunized children still remains high in Helmand and Kandahar provinces and has increased in Kunar province.
- The programme has implemented a number of new initiatives focusing on the 47 very high-risk districts to improve the quality of supplementary immunization activities, which are showing signs of programme improvement.
- The deteriorating security and access situation in the country, particularly in the north-eastern and eastern regions is concerning. Access in the southern region remains very fragile and with security challenges. This has an adverse impact on the quality of campaigns.
- The country has plans in place to address inaccessibility and quality, although these need to be fully operationalized.
- Surveillance sensitivity is maintained at a high level.
- Epidemiology of Pakistan will continue to impact Afghanistan, and vice versa.

3. RECOMMENDATIONS

Oversight, coordination and programme management

1. The country team should sustain and further strengthen the existing structure of the emergency operations centres by:
   - consolidating task team modality at the national level;
   - conducting weekly videoconferences between national and regional emergency operations centres;
   - monthly tracking of NEAP implementation status.
2. Engagement of provincial governors and line ministries should be continued and further strengthened while maintaining programme neutrality.
3. Engagement of monitoring and accountability officers in the 36 remaining very high-risk districts should be fast tracked.
4. Accountability framework should be finalized and fully implemented before the end of August 2016.

NEAP 2016–2017

5. The TAG endorses the NEAP 2016–2017 as presented, with the following suggested major changes:
   - TAG endorses OPV supplementary immunization plan, but suggests one additional supplementary immunization activity in the second half of 2016 and expanding the scope of the January 2017 round;
   - TAG endorses the IPV plan and suggests that selected high-risk areas of Kabul city be included;
   - targets for very high-risk districts should include “more than 90% of LQAS lots accepted at 80%” and “missed children less than 5%”;
   - further expansion of the direct disbursement mechanism should be explored where feasible;
   - plan should identify and focus on clusters of missed children and refusals, and should ensure communication and operational plans are aligned to address local issues at cluster level;
   - for routine immunization and transition, EPI has to take charge and PEI should support EPI strengthening where feasible.
6. NEAP 2016–2017 should be finalized by the end of July, including a work plan with clear indicators and an accountability framework.
7. Government and partners should fully implement the NEAP 2016–2017 in a coordinated manner through the emergency operations centres.
8. Global partners should provide full support in implementation of the NEAP 2016–2017.

Inaccessible areas

9. Programme neutrality should be maintained by all parties.
10. New approaches to reach inaccessible children should be fully implemented, including:
    - new forums for negotiation in the eastern and north-eastern regions;
    - expanding polio plus services around inaccessible areas, where appropriate, and further exploring expansion of other services in insecure areas with Ministry of Public Health, as well as other stakeholders;
    - providing IPV+OPV at health facilities around inaccessible areas;
    - sustained engagement with local influencers.
11. The national programme should develop a contingency plan in case inaccessibility persists and/or increases.
12. The country team should track accessibility at cluster level over rounds and intervene as per above strategy.
13. Further involvement of the International Federation of the Red Cross and Red Crescent Societies in access-challenged areas should be fast tracked and followed up.
14. Areas inaccessible for more than two supplementary immunization activities should be treated as high-risk areas.

Surveillance

15. Strong surveillance should be maintained, particularly in areas with recent deterioration in security/access.
16. The country team should implement recommendations from the June 2016 surveillance review.
17. Existing environmental surveillance sites should be reviewed for their appropriateness.
18. As a contingency, alternate mode/route of specimen shipment to the regional reference laboratory should be explored.

Outbreak response

19. The national programme should develop a generic response plan for any outbreak in inaccessible areas.
20. For outbreaks in areas contiguous with Pakistan, there should be joint analysis, planning, response, monitoring and reporting.

Reducing missed children

21. Quality of activity in fully accessible areas of very high-risk districts should be sustained and further improved by consolidation of new initiatives, such as investigation and intervention in areas with poor performance at cluster level, district-specific plans, fifth-day revisit strategy and microplan validation.
22. Failed lots in LQAS from very high-risk districts should be tracked over the rounds at national level, and lots failing repeatedly should be further investigated and interventions modified to ensure improvement of quality.
23. Where feasible, the country should expand the direct disbursement mechanism modality for payment of vaccinators and use information from the mechanism for tracking turnover in vaccinators.
24. Factors affecting quality of supplementary immunization activities, such as selection and supervision of front-line workers, should be raised and resolved with the party/authority having influence in the area.
25. Solutions to improve monitoring capacity in category 3 (accessible with limitations) areas should be explored.
26. The community health volunteer pilot in Spin Boldak should be completed, covering whole district, and presented at the next TAG meeting.
27. Focus on very high-risk districts should be maintained. At the same time, the programme should not lose sight of the 49 high-risk and non-high-risk districts and continue improving quality in these areas.
28. The eastern region, which has experienced big challenges recently, has non-high-risk districts bordering very high-risk districts; thus in very high-risk districts campaigns, appropriate contiguous districts should be included.

29. Detailed analysis of children missed due to being “not available” should be conducted, particularly in Kandahar. A sample should be surveyed to identify the real reasons, and an intervention plan developed.

Communications

30. Full-time deployment of the immunization communication network should rapidly operationalized in all 47 very high-risk districts by the end of August 2016, while ensuring deployment based on merit and enhanced accountability mechanisms through third party monitoring.
31. The impact of immunization communication network on reduction of missed children should be assessed following the August 2016 campaign and onwards.
32. Quality of communications planning within district-specific plans should be strengthened, prioritizing interventions that enhance household OPV acceptance and reduction in missed children, including a detailed analysis of the clustering of chronically missed children at cluster level.
33. Where communications strategy seeks to build wider community support for PEI as a means to improve household OPV uptake, emphasis should be given to engaging local-level influencers and caregivers to address identified issues, including sustained engagement of religious leaders in the very high-risk districts rather than at the national level.

Routine immunization

34. PEI staff should continue to support monitoring of EPI and provide feedback.
35. PEI should regularly share information on routine immunization coverage from AFP surveillance data.
36. Ministry of Public Health and BPHS nongovernmental organizations should make concerted efforts to improve routine immunization in high-risk areas where low routine immunization coverage is identified.

Cross-border coordination

37. Cross-border coordination with Pakistan should continue. Contiguous very high-risk districts of Afghanistan and tier 1 and 2 districts of Pakistan should be seen as one unit for analysis, interventions and reporting.
38. A contingency plan for possible return of refugee populations should be developed.

Next meeting of the TAG

39. The next meeting of the Afghanistan TAG is proposed to take place in Kabul, Afghanistan, during February 2017.

Annex 1

LIST OF PARTICIPANTS

TECHNICAL ADVISORY GROUP MEMBERS
Jean-Marc Olivé, TAG Chairman
Chris Morry, TAG Member
Nasr El Sayed, TAG Member
Sebastian Taylor, TAG Member
Abdul Majeed Siddiqi, TAG Member

TECHNICAL ADVISERS
Reza Hossaini, UNICEF/HQ
Christopher Maher, WHO/EMRO
Arshad Quddus, WHO/HQ
Philip Smith, WHO/EMRO
Joanna Nikulin, WHO/EMRO

GOVERNMENT OF AFGHANISTAN
H. E. Dr Ferozuddin Feroz, Minister of Public Health
Hedayatullah Stanekzai, Senior Advisor to Minister
Najibullah Safi, DG Preventive Medicine
Sadar Parwiz, National EPI Manager
Maiwand Ahmadzai, EOC Director
Mir Sayed Islam, Head of GCMU
Aga Gul Dost
Kamel Frozanfar
Gula Khan Ayub
Mohammad Hanif Niazi
Asadullah Taqdeer
Wrishmeen Sabawoon
Pir Mohammad Paya
Mirwais Bkhshi
M Sadiq Mossadiq
Ataullah Saeedzai

UNICEF AND WHO REPRESENTATIVES
Adele Khudr, UNICEF
Richard Peeperkorn, WHO

PARTNER REPRESENTATIVES
Waqar Ajmal, Bill & Melinda Gates Foundation/USA
Asmatullah Arab, Bill & Melinda Gates Foundation/Afghanistan
Mohammad Ishaq Niazmand, Rotary International/Afghanistan
Abdul Naser Ikram, USAID/Afghanistan

Ahmad Mudassir Rasuli, JICA
Ahmad Parwiz Habibzai, ICRC
Nasir Ebrahimkhail, Canadian Embassy
Ajmal Pardis, CDC/Afghanistan
Abdul Qahar Momand, CDC/Afghanistan

REGIONAL PEI TEAMS (MINISTRY OF PUBLIC HEALTH, UNICEF AND WHO)
Southern region
M Sarwar Ferozi, Ministry of Public Health/Kandahar
Haji Nazar Mohammad, Ministry of Public Health/Kandahar
Abdul Ahad Hazem, Ministry of Public Health/Helmand
Shah Wali Popal, UNICEF
Mohammed Soghaier, WHO
M Awad Omar, WHO
Najeebullah Zafarzai, WHO
Tahsil Khan, WHO

Eastern region
Najibullah Kamawal, Ministry of Public Health/Nangarhar
Ihsanullah Fazli, Ministry of Public Health/Kunar
Ishaq Khan, Ministry of Public Health/Kunar
Ali Gul, Ministry of Public Health/Nangarhar
Panchanan Achari, UNICEF
Mohammad Akram Hussain, WHO
Assegid Kebede, WHO

Western region
Abdul Jabbar Shayeq, Ministry of Public Health/Farah
Abdul Wahid, Ministry of Public Health/Farah
Asif Kabir, Ministry of Public Health/Herat
Ahmad Shah Ahmedi, UNICEF
Khushhal Khan Zaman, WHO
Esmael Saddiqi, WHO

Northern region
Sailani Wardak, WHO
Wasiqullah Rezaee, WHO

North-eastern region
Saad Mukhtar, Ministry of Public Health/Kunduz
A Ahad Hakimi, Ministry of Public Health/Kunduz
Abdul Nazar Ahmadi, WHO

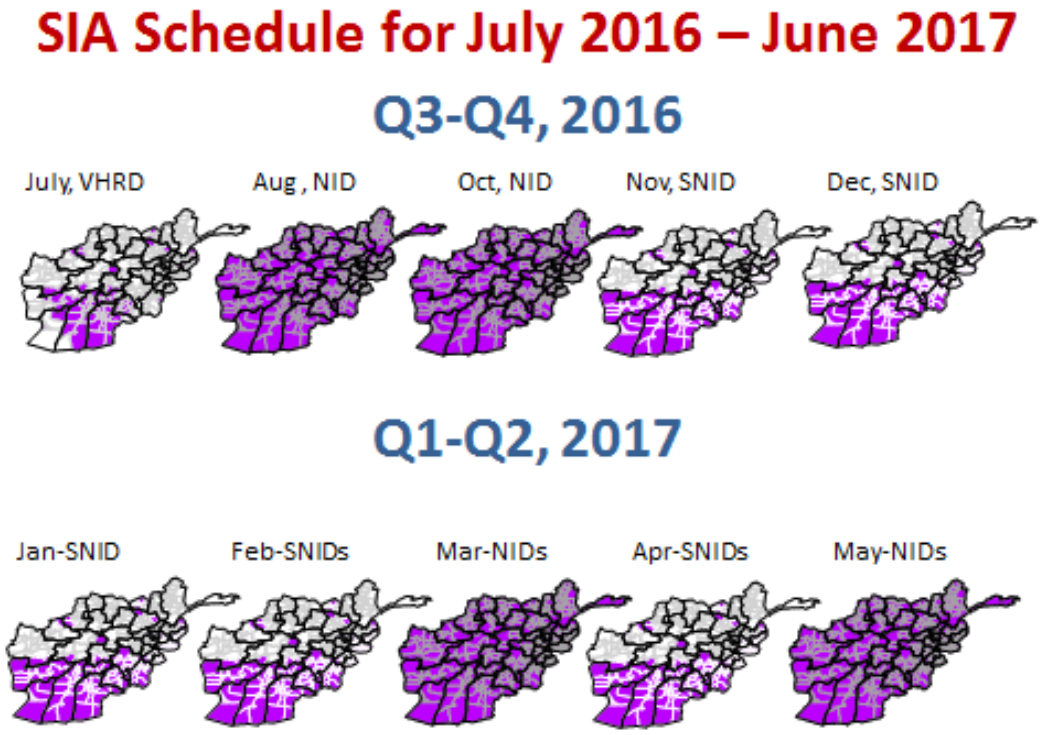
Badakhshan
Zahir Fazil, UNICEF

Central region
R Ghafoory, WHO

UNICEF AND WHO SECRETARIAT
Melissa Corkum, UNICEF
Hemant Shukla, WHO
Laurence Chabirand, UNICEF
Mandeep Rathee, WHO
Shamsher Khan, UNICEF
Hassan Khan, WHO
Javed Iqbal, WHO
Samiullah Miraj, WHO
Dennis Chimenya, UNICEF
Sini Ramo, WHO
Dorn Townsend, UNICEF
Thuy Ha Bui, UNICEF
Habib Rohullah, WHO
Ali Zahed, WHO
Walter Alexis Bruzzoni, UNICEF
Mohammad Ayubi, WHO
Shoresh Mustafa Kalanzani, UNICEF
Hamid Momand, WHO
Rabia Saata, UNICEF

Annex 2

SUPPLEMENTARY IMMUNIZATION SCHEDULE FOR OPV



Annex 3

IPV + OPV SUPPLEMENTARY IMMUNIZATION PLAN

The country proposes to use IPV in supplementary immunization campaigns in two types of high-risk area:

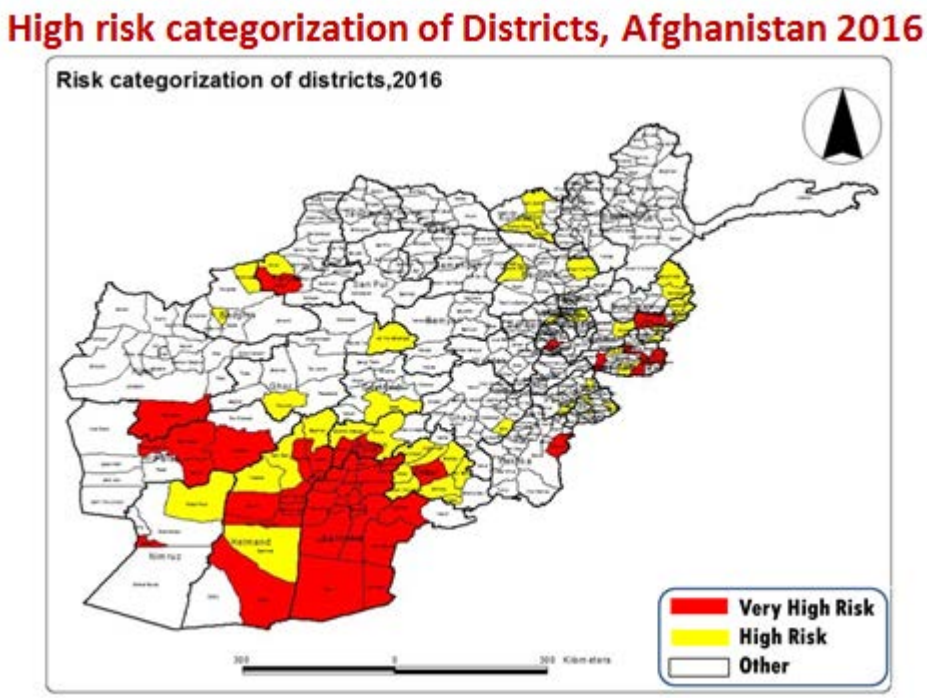
- areas which missed at least three consecutive vaccination opportunities in 2016 due to insecurity/ inaccessibility;
- very high-risk districts that did not have an IPV+OPV supplementary immunization opportunity in 2015–2016.

Table 1. List of districts, target population and rationale for use

Province	District	Rationale	Target	Dose	Timeline
Nangarhar	Behsud, Jalalabad	Very high-risk districts, no IPV in 2015–2016	164 283	197 139	Q1, 2017
Faryab	Qaysar		43 783	52 540	
Nimroz	Zaranj		46 976	56 371	
Uruzgan	Dehrawud, Tirinkot		71 871	86 245	
Zabul	Qalat		27 579	33 094	
Paktika	Bermel		18 129	21 755	
Helmand	Lashkargah, Musaqalah, Nad-e-Ali, Nahr-e-Saraj		254 797	305 757	
Kandahar	Kandahar		107 442	128 930	
Kabul	Kabul		74 000	88 800	
Subtotal			**808 859**	**970 631**	
Nangarhar	Pachieragam, Kot, Achin	Areas which missed at least 3 consecutive vaccination opportunities in 2016 due to insecurity/ inaccessibility	11 867	14 240	Immediately on gaining access
Laghman	Mehtarlam, Alingar		21 573	25 888	
Kunar	Watapur, Marawara, Dara-e-Pech, Chapadara, Nari		17 814	21 377	
Kunduz	Kunduz, Emamsaheb, Qala-e-Zal, Chardarah, Aliabad, Khanabad, Dasht-e-Archi		152 336	182 803	
Nuristan	Kamdesh		590	708	
Uruzgan	Chora		1 769	2 123	
Helmand	Nad-e-Ali		1 694	2 033	
Kandahar	Zheray, Shahwalikot, Maywand, Reg, Shorabak		15 399	18 479	
Paktia	Gardez		376	451	
Ghor	Pasaband		23 885	28 662	
Subtotal			**247 304**	**296 765**	
Total			**1 056 163**	**1 267 396**	

Annex 4

MAP OF VERY HIGH-RISK AND HIGH-RISK DISTRICTS



Annex 5

LIST OF VERY HIGH-RISK AND HIGH-RISK DISTRICTS

Very high risk districts	
Province	**District**
Farah	Bakwa
Farah	Balabuluk
Farah	Khak-e-Safed
Hilmand	Lashkargah
Hilmand	Nad-e-Ali
Hilmand	Nahr-e-Saraj
Hilmand	Reg
Hilmand	Sangin
Kandahar	Kandahar
Kandahar	Maywand
Kandahar	Panjwayi
Kandahar	Shahwalikot
Kandahar	Spinboldak
Kandahar	Zheray
Nangarhar	Achin
Nangarhar	Batikot
Nangarhar	Lalpur
Nangarhar	Muhmand Dara
Uruzgan	Dehrawud
Farah	Gulestan
Faryab	Qaysar
Hilmand	Kajaki
Hilmand	Musaqalah
Hilmand	Nawa-e-Barakzaiy
Hirat	Shindand
Kabul	Kabul
Kandahar	Arghandab
Kandahar	Arghestan
Kandahar	Daman
Kandahar	Ghorak
Kandahar	Khakrez
Kandahar	Miyanshin
Kandahar	Nesh
Kandahar	Reg
Kandahar	Shorabak
Kunar	Chapadara
Kunar	Dara-e-Pech
Kunar	Marawara
Kunar	Watapur
Nangarhar	Behsud
Nangarhar	Jalalabad
Nangarhar	Sherzad
Nangarhar	Shinwar
Nimroz	Zaranj
Paktika	Bermel
Uruzgan	Tirinkot
Zabul	Qalat

High risk districts	
Province	**District**
Badghis	Ghormach
Badghis	Muqur
Baghlan	Baghlan-e-Jadid
Baghlan	Khost Wa Fereng
Daykundi	Gizab
Faryab	Almar
Ghazni	Giro
Ghor	Lal Wa Sarjangal
Ghor	Taywarah
Hilmand	Baghran
Hilmand	Garmser
Hilmand	Nawzad
Hilmand	Washer
Kapisa	Mahmud-e- Raqi
Kapisa	Nejrab
Khost	Mandozayi
Khost	Musakhel
Khost	Terezayi
Kunar	Asadabad
Kunar	Barkunar
Kunar	Dangam
Kunar	Ghaziabad
Kunar	Khaskunar
Kunar	Narang
Kunar	Nari
Kunduz	Aliabad
Kunduz	Chardarah
Kunduz	Emamsaheb
Kunduz	Kunduz
Laghman	Alingar
Nangarhar	Dehbala
Nangarhar	Kot
Nangarhar	Surkhrod
Nimroz	Khashrod
Nuristan	Barg-e- Matal
Nuristan	Kamdesh
Paktya	Chamkani
Paktya	Zadran
Parwan	Charikar
Uruzgan	Chora
Uruzgan	Shahid-e-Hassas
Zabul	Arghandab
Zabul	Atghar
Zabul	Daychopan
Zabul	Mizan
Zabul	Nawbahar
Zabul	Shahjoy
Zabul	Shinkay
Zabul	Tarnak Wa Jaldak

World Health Organization
Regional Office for the Eastern Mediterranean
P.O. Box 7608, Nasr City 11371
Cairo, Egypt
www.emro.who.int