

Summary report on the

Technical Advisory Group meeting on poliomyelitis eradication for Afghanistan

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Islamabad, Pakistan
1–2 June 2015



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. Introduction

The meeting of the Technical Advisory Group on Polio Eradication (TAG) in Afghanistan was held on 1–2 June 2015 in Islamabad, Pakistan. the meeting was chaired by Dr Jean-Marc Olivé, assisted by TAG members, and was attended by Dr Hedayatullah Stanikzai, Senior Adviser to the Minister of Public Health, Afghanistan, members of the Afghanistan Polio Eradication Initiative team, international partners and donors.

The objective of the meeting was to review progress towards interrupting wild poliovirus transmission in Afghanistan and to make recommendations to improve technical and managerial aspects of the programme in order to achieve interruption of poliovirus transmission in the country.

This meeting of the TAG was held at the close of the low transmission season and on the cusp of the administrative ramp-up of the programme. Afghanistan has detected three cases of wild poliovirus type 1 in 2015 and detected 28 in 2014. These 28 cases represented a doubling of the number detected in 2013, and mirrored an even larger outbreak in the epidemiological block shared with Pakistan. On the global stage, the urgency for this epidemiological block to rapidly interrupt wild poliovirus circulation is great as the only other endemic country, Nigeria, has not reported a case since July 2014. Due to the epidemiological situation in 2014, the Emergency Committee of the International Health Regulations reviewed the global poliovirus situation in the past month and concluded that Afghanistan should be added to the list of countries exporting virus.

Furthermore, the International Monitoring Board noted in its 11th report (May 2015) that, “For some time now, the Afghanistan

programme has failed to make meaningful progress ... is failing to get to grips with the same programmatic problems that it has suffered for years". The TAG took this context into consideration as it reviewed the current status of the programme and formulated recommendations for finishing the job in the country.

Up to 2 June 2015, 3 cases due to wild poliovirus type 1 have been reported, 2 from Farah province and 1 from Helmand province, indicating a shared zone of transmission between these parts of the Western Region and the Southern Region. Two of the cases were reported from Gulistan district in Farah province and the other 1 from Reg district in Helmand province. All of these cases were related to earlier cases in Kandahar. Nearly 90% of polio cases reported in 2014 were in children under 3 years of age, of which 25% had less than 3 doses of oral polio vaccine (OPV). The last case of polio due to circulating vaccine-derived poliovirus2 (cVDPV2) was reported in Kandahar province in March 2013. However, the country must remain vigilant as there is evidence of cVDPV2 circulating in Pakistan.

Historically, there are three geographic areas of concern for polio transmission in Afghanistan: the Southern, Southeastern and Eastern Regions. The Southern Region is an area where endemic wild virus has long circulated. Genetic analysis of the two most recent viruses from Gulistan, Farah province in the Western Region, shows that they are closely related to the virus detected in Kandahar. This pocket of underimmunized children in the Western Region related to virus in the Southern Region demonstrates the ease with which the virus can spread and the need for quality eradication activity with a microscopic focus throughout the country.

Data from the March national immunization days in 2015 show that over 500 000 children under five years of age have remained unvaccinated across the entire country. While the programme has gained information as to why these children have remained unvaccinated, it has yet to fully elaborate on how it will address the causes of persistently missed children, and thus reduce their numbers to a minimum. The on-again, off-again ability to vaccinate in Helmand remains a problem. A recent threat to polio vaccination in the Southern Region was the measles adverse event following an immunization incident in Kandahar province. The two deaths in this incident created a political environment which is currently limiting the ability of the programme to vaccinate.

In 2015 the Eastern Region has remained polio free despite the insecurity of the area. In the past, cases had close links to viruses circulating across the border, indicating a shared cross-border zone of transmission in this part of the country. Fortunately, importations into the Eastern Region in 2014 did not result in extensive outbreaks or expanded circulation. However, the complex nature of security in the region and the resulting programmatic gaps in vaccination leave it susceptible to renewed importation.

The cross-border zone is not a one way street and, despite Pakistan having many more cases, the TAG notes that Pakistan experienced importation of three viruses from Afghanistan in late 2014. The fifth meeting of the Emergency Committee of the International Health Regulations noted that the isolates from one of the cases “was related to a strain that had circulated only in Afghanistan for a period of more than one year, thus demonstrating the strongest evidence of exportation into Pakistan of a strain of poliovirus that has established transmission in Afghanistan.” The other two virus strains circulated in border areas of

Afghanistan following recent exportation from Pakistan (September 2014) and bolster the case for a single epidemiological block. As a result of this analysis the Emergency Committee of the International Health Regulations recommended to the Director-General that Afghanistan be included in the list of ‘States currently exporting wild poliovirus.’

2. Conclusions

On reviewing the data presented by the programme, the TAG concluded that Afghanistan has very recently begun to adjust the programme after a period of relatively limited progress. Nevertheless, the country has not been given the same international attention as Pakistan and Nigeria, so urgent action should be taken to ensure the final push beginning in the autumn of 2015.

The TAG commends the overall commitment of the new Government of Afghanistan to eradicate polio in 2015. It is also encouraged by the nomination of a senior adviser. The TAG recognizes and applauds the government on its commitment to neutrality of the polio programme. However, it notes that these positive developments are recent and that programme oversight has been impacted by the long political transition. This transition has led to the need for the government to create a new coordination mechanism that is not yet fully articulated and a National Emergency Action Plan that is insufficiently detailed to drive the work planning from June 2015.

The TAG notes that the programme has kept most of Afghanistan polio free, and that for the last eight months cases have been restricted to the Southern Region and the epidemiologically-related province of Farah. However, endemic circulation continues in the South and Farah, which poses a risk to the South Eastern and Eastern Regions.

Noting the agreement at the fifth meeting of the Emergency Committee of the International Health Regulations that Pakistan and Afghanistan formed a single epidemiological block, the TAG urges the international community, and the Global Polio Eradication Initiative in particular, to elevate the attention and resources focused on Afghanistan to bring them in line with those focused on Pakistan.

The TAG commends the Afghanistan programme on following up on most of the 2014 recommendations. However, it notes with some concern that the national emergency action plan has not been fully elaborated, and so is not being used to drive activities in the country. It also notes that the impact of the revisit strategy for missed children has yet to be uniformly implemented or fully assessed. The TAG would also like to point out that the previous request for six-monthly reports on routine immunization to the TAG has not been fulfilled, nor has it been followed up on.

The TAG would like to recognize the complexity of the access situation across the country and praise the constant efforts required at local levels to obtain and sustain access. The TAG notes that these efforts come at no small personal cost to many of the local negotiators and appreciates them for their commitment. The TAG appreciates the progress made by the programme in analysing the reasons for missed children, but notes that, unfortunately, the campaign quality continues to underwhelm. It notes that “Not available” continues to be the major reason for children not being vaccinated, and recognizes that there can be a number of reasons for this from the quality of vaccinator interaction with care givers at the door to a form of soft refusal. The TAG notes with some concern, particularly as it pertains to the highest risk areas, that the second major reason for nonvaccination of children is outright “Refusal”.

With enthusiasm, the TAG would like to recognize the innovative use of geographic information system (GIS) information in the mapping survey of Nahrissaraj, Helmand province. This has resulted in the identification of four villages not included in microplans and is a great example of the level of microscopic detail that will be required of the programme in going forward to reach its ultimate goal of polio eradication.

The TAG notes that media plans have been developed, including TV and radio public service announcements, BBC and VOA radio, and bulk SMSs, along with plans to revise information, education and communication materials. The programme is starting to review the structure and role of the Immunization Communication Network to optimize its impact on reduction of missed children and to increase female mobilizers. The TAG acknowledges the recently available data collected through the knowledge, attitudes and practices survey. These data confirm overall high awareness levels in the selected low performing districts but also very low levels of knowledge and risk perception. Both the post-campaign assessment and the knowledge, attitudes and practices survey confirm stagnation in changing attitudes around missed children, including refusals, especially those due to “sleeping, sick and newborn”. The TAG recommends that the programme quickly develop a clear communication and mobilization strategy focused on reducing the rates of missed children during supplementary immunization activities.

Finally, the TAG notes that the quality of the campaigns in the east has not shown adequate improvement to stop transmission of the virus and prevent reinfection although the programme in the southeast is to be congratulated for managing and containing the large influx of displaced persons from the Federally Administered Tribal Areas.

There is a need to accelerate improvement in Supplementary Immunization Activities in those areas and reach more children if the country is to succeed in eliminating polio in 2015.

3. Recommendations

Oversight and commitment

1. There should be dedicated support for the Senior Adviser for polio to fully implement his role. The Ministry of Health and the Global Polio Eradication Initiative partners are recommended to identify and appoint needed support by the end of June. The programme should have an articulated coordination mechanism under one roof where: the Senior Adviser should be convening weekly implementing partner meetings and monthly polio partner meetings by the end of June and there is regional/provincial oversight and coordination linked to national coordination by regular direct feedback from the central level during joint meetings.
2. The primary immediate objective of the government and partners management team should be to ensure full preparedness for a major push from August/September 2015. This push should be based on the fully-articulated national emergency action plan (see below) and, importantly its workplan. The execution of the workplan should be coordinated through an agreed mechanism led by the Senior Adviser.
3. The international partners should support this effort by ensuring that needed human and other resources are appropriately deployed and up to strength before the major push beginning in August/September.

National emergency action plan

4. All efforts should be made to complete the national emergency action plan with its associated detailed workplan by the end of June. Based on experience in other countries, the preparation of the national emergency action plan should include regional consultations as well as, but not limited to:
 - a. a well-defined governance and coordination mechanism that allows it to take timely (and sometimes difficult) action as required.
 - b. a detailed workplan concentrating on key priority issues and activities for the next six months. The workplan should have measurable goals and objectives with appropriate indicators and a detailed monitoring mechanism.

One epidemiological block

Recognising that Afghanistan and Pakistan form a single epidemiological block, the TAG notes that cross border coordination is now more critical than ever. To effectively manage cross border coordination, the TAG recommends the following.

5. The recommendations from the 3 June cross border meeting should be fully and urgently implemented.
6. There should be a focus on mechanisms that allow effective local communication between the bordering provinces.
7. This communication should occur without having to vet minor decisions through the respective central levels.
8. Plans should also be developed to track the movement of populations and exchange information on the final destination of those populations moving across the border to effectively mount a vaccination response in their final destination.

Missed children

The TAG notes that there are two main reasons for children being missed during vaccination activities: some reside in inaccessible areas, often due to insecurity but also due to weather, and children are missed due to the failure of the programme to reach them.

9. The programme should have plans in place for quick, short interval campaigns in those areas which are inaccessible. Thus when these areas become accessible an immediate and rapid response can be mounted.
10. These plans should be prioritized and the biggest risk identified (usually the largest number of unreached children) so that appropriate and systematic action can be taken whenever it is possible.
11. The effects of inaccessibility should be mitigated by transit posts for vaccination placed immediately outside the inaccessible areas, and all children passing in or out should receive vaccine.
12. When possible, permanent polio teams should be set up within the inaccessible areas.
13. The programme should explore other ways to vaccinate and identify best practice strategies for gaining access to these inaccessible children, perhaps by sharing experiences between different regions of the country on how they could carry this out.
14. For those children missed in accessible areas, by the end of July all the low-performing districts should review their microplans and analyse the effectiveness of their market and transit teams with the objective of better distributing them to increase coverage.
15. Further analysis needs to be done on the strategies for the conversion of soft refusal, with further emphasis on training the points of contact in converting these refusals, implementing the revisit strategy throughout the country and actively tracking

missed children with revised intracampaign monitoring guidelines and an improved checklist.

Get the most out of strategies

16. In the low-performing districts, microplans should be revised based on the experience in Nahre Seraj, which combined GIS with other information sources to generate an up-to-date plan, and to continue to monitor the accuracy of these microplans in preparation for subsequent supplementary immunization activities.
17. Data from the permanent polio teams and the transit teams should be disaggregated so as to identify how to get the greatest impact from these interventions.
18. An evaluation of the revisit strategies needs to be conducted to understand their true impact and modify activities accordingly for rapid and full implementation.

Communications

19. The TAG recommends the development of a clear, consolidated, communication strategy in support of the efforts to reduce missed children; this should be prepared in close coordination with all partners and in consultation with the regional teams.
20. This consolidated strategy should be shared with the TAG by the end of June 2015 and the roll-out of new initiatives (mass media, training, restructuring) should be completed by the end of August.
21. For social mobilization, the communication strategy should include a clearly developed plan which delineates the work of the Immunization Communication Network and how that interacts with the role of community health workers. This plan should articulate the expected role in reducing missed children by category, with clear indicators for measuring this impact.

22. In a reiteration of the 2014 TAG recommendation, it is recommended that the programme expedite the development and roll-out of a revised training curriculum for all front-line workers (vaccinators and mobilizers) to improve the quality of activities and reduce the number of missed children. Data from the recent knowledge, attitudes and practices study should be incorporated into the training materials and curriculum. This should be prioritized and rolled out in the low performing districts by the end of August, 2015.

Supplementary immunization activities

23. The TAG endorses the planned supplementary immunization activities schedule June–December 2015 with the following modifications.
- a. At least one national immunization day round should use the trivalent oral polio vaccine (tOPV) instead of the currently planned bivalent vaccine (bOPV).
 - b. Flexibility must be maintained for rapid response rounds in the event that inaccessible areas become accessible, or in response to cases or risks. To effectively do this the TAG recommends a buffer of vaccine be available at central level
24. The TAG also endorses planned inactivated polio vaccine/oral polio vaccine activities June–December 2015 but stresses that flexibility must be maintained for rapid response in the event that inaccessible areas become accessible, or in response to cases or risks in 2015.

Vaccine management

25. Afghanistan should continue to report usage and stock at all storage levels in line with global standard operating procedures.

26. Standard operating procedures from the global guidelines should be incorporated in the 2015–2016 National Emergency Action Plan.
27. The programme should track vaccines to enable optimal management.
28. Systems- and capacity-development should be introduced and supported by the Polio Eradication Initiative partnership to ensure reliable monthly reporting from the provinces to a national Expanded Programme on Immunization.
29. Stock balance reports should be introduced for requesting additional vaccines.
30. A national vaccine management committee should be activated to oversee all vaccine management and cold chain issues.
31. The programme should finalize first priority, inactivated polio vaccine, supplementary immunization activity plans for 2016 in line with the Eradication and Outbreak Management Group guidelines, and submit them immediately for review and approval.

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