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Report on the

Meeting of the Technical Advisory Group for the Eradication of Poliomyelitis in Afghanistan

Kabul, Afghanistan
24–25 January 2016



World Health
Organization

Regional Office for the Eastern Mediterranean

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CONTENTS

ABBREVIATIONS.....	1
EXECUTIVE SUMMARY.....	3
1. INTRODUCTION.....	6
2. SUMMARY OF DISCUSSIONS.....	7
2.1 General conclusions.....	7
2.2 Responses to questions from the country.....	11
3. RECOMMENDATIONS.....	12
Annexes	
1. LIST OF PARTICIPANTS.....	16
2. PLAN FOR NEXT 6 MONTHS TO INTERRUPT POLIOVIRUS TRANSMISSION .	19
3. SUPPLEMENTARY IMMUNIZATION SCHEDULE FOR OPV AND IPV	22
4. INTERVENTIONS IN LOW PERFORMING DISTRICTS.....	23

ABBREVIATIONS

AFP	Acute flaccid paralysis
AEFI	Adverse Event Following Immunization
AHO	Alliance of Health Organizations
ARCS	Afghan Red Crescent Society
BMGF	Bill and Melinda Gates Foundation
bOPV	Bivalent oral polio vaccine
BPHS	Basic package of health services
C4D	Communication for development
CB	Cross border
CDC	Centre for Disease Control and Prevention
CHV	Community health volunteer
CHW	Community health worker
EMRO	Regional Office for the Eastern Mediterranean (WHO)
EOC	Emergency operations centre
EPI	Expanded programme on immunization
ES	Environmental surveillance
FATA	Federally Administered Tribal Areas
FLW	Frontline worker
HQ	Headquarters
HR	Human resource
ICM	Intra-campaign monitor/monitoring
ICN	Immunization Communications Network
IPC	Interpersonal communication
IPV	Inactivated polio vaccine
KfW	Kreditanstalt für Wiederaufbau
KP	Khyber Pakhtunkhwa
LPD	Low performing district
LQAS	Lot quality assurance sampling
M&E	Monitoring and evaluation
MoPH	Ministry of Public Health
NEAP	National emergency action plan
NGO	Nongovernmental organization
NID	National immunization day
NPEV	Non-polio enterovirus
OPV	Oral polio vaccine
PCA	Post-campaign coverage assessment
PEI	Polio Eradication Initiative
PPCU	Provincial polio coordination unit
PPT	Permanent polio team
PTT	Permanent transit team
RI	Routine immunization
ROSA	Regional Office for South Asia (UNICEF)
SIA	Supplementary immunization activity
SM	Social mobilization

sNID	Subnational immunization day
SOP	Standard operating procedure
TAG	Technical Advisory Group
TC	Teleconference
tOPV	Trivalent oral polio vaccine
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VC	Videoconference
WHO	World Health Organization
WPV1	Wild poliovirus type 1

EXECUTIVE SUMMARY

A meeting of the Technical Advisory Group (TAG) on Poliomyelitis Eradication in Afghanistan was held 24–25 January 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 the continuing transmission in Afghanistan and the opportunity to interrupt transmission in the coming low transmission season, the meeting of the Afghanistan TAG was called with two key objectives: to review the progress in polio eradication activities, particularly in implementation of the national emergency action plan (NEAP) 2015–2016 in past 6 months; and to make recommendations to achieve the interruption of transmission by June 2016.

The TAG expresses deep regret regarding the tragedy in Kandahar in which one polio worker lost her life in a horrific attack while working.

The TAG observes that there is significant improvement in programme oversight, management and coordination through establishment of national and regional emergency operations centres (EOCs), and there is a strong partnership between government, United Nations agencies, and other partners.

The TAG notes that Afghanistan and Pakistan, which form one epidemiological block, are the only remaining areas in the world infected with wild poliovirus type 1 (WPV1). There has been significant progress in the past few months as evidenced by the reduced number of cases, especially in the Southern region, but transmission continues particularly, but not exclusively in the Eastern region.

The TAG notes that the deteriorating security situation and increased inaccessibility, particularly in Eastern and Northern regions, are a concern. The country has mechanisms in place to address inaccessibility which need to be continually refined and adjusted – and assessed for impact – to address emerging challenges. TAG continues to urge the programme to maximize engagement with and use of external partners, including in particular nongovernmental organizations implementing the basic package of health services (BPHS).

Despite some progress seen in Helmand, the quality of activity in the Southern region, particularly in Kandahar, remains suboptimal. Interventions for reducing missed children such as microplan validation, the revisit strategy, and the revision and implementation of the training curriculum for frontline workers have not been fully scaled up. The programme should seek to further disaggregate and analyse data on causes of missed children, in particular assessing individually the categories of ‘sleeping’, ‘sick’ and ‘newborn’ children.

There is a mechanism for cross border coordination with Pakistan at national, regional and district levels but it needs to be strengthened, particularly in Eastern corridor.

TAG appreciates that good quality surveillance is maintained in most of areas, however low stool adequacy in two provinces of the Southern region is a concern.

The TAG appreciates the country's achievements and the implementation status report on the recommendations of the previous meeting of the TAG in June 2015. However, the TAG is concerned that implementation of some specific recommendations, particularly related to improvement of the quality of supplementary immunization activities in accessible areas, has been slow.

Key recommendations

- The national EOC should have a systematic weekly teleconference or videoconference with regional EOCs to track progress and provide feedback and support in the implementation of the NEAP.
- Development and implementation of a clear and transparent accountability framework needs to be accelerated.
- Full implementation of the NEAP 2015–16 should be ensured and reviewed through monthly progress reports using the NEAP tracking dashboard. Intervention matrixes for low performing districts, as developed by the country, should be fully implemented. The country should initiate the process of developing the NEAP 2016–17 early enough to ensure that a draft NEAP is presented at the next TAG meeting.
- The TAG recommends fast-tracking thorough field validation and revision of microplans for low performing districts priority 1 and 2 with integrated social components before the end of the first quarter of 2016.
- The revisit strategy should be strengthened and expanded to all five high-risk provinces by the March national immunization day campaign and the entire country before the next TAG meeting.
- The programme should conduct in-depth analysis of missed children due to 'not available' and use the information to modify strategies. Data on children missed should be disaggregated by 'refusals, newborn, sick, and sleeping', with each of the four as a distinct category of analysis to support development of micro-strategies in response.
- The process of revising the training module for frontline workers and rolling it out should be fast-tracked by end of February and with preliminary assessment by end of March.
- Lot quality assurance sampling should be expanded to all priority 1 and 2 low performing districts, where feasible, and those low performing districts where it is not possible to do so should be tracked. Intra-campaign data should be used to identify gaps and for corrective action in preparation for and during the subsequent campaign. For those low performing districts with continuing poor quality, simple district specific action plans should be developed and implemented to improve quality before the next campaign.
- The impact of the community health volunteer initiative should be evaluated against traditional strategies. The pilot in Nangarhar should be fully analysed and another pilot should be undertaken in a low performing district in Southern region (possibly in Kandahar) to learn the lessons, challenges and impact in a different setting. If successful, expand the initiative in a phased manner in prioritized persistently poor performing priority 1 districts for the May national immunization days.

- Current programme activities and plans should be reviewed to maximize the engagement and contribution of external partners, in particular those implementing the BPHS and other in-country nongovernmental organizations.
- The TAG recommends the implementation of area specific plans for the Eastern and Southern regions and for the rest of country by mid February, and reiterates that programme neutrality should not be compromised. Explore feasibility of, and where appropriate make plans for, delivering oral polio vaccine (OPV) combined with other services (e.g. health camps) by the end of February, and measure impact on vaccine uptake.
- Robust preparations should be conducted for supplementary immunization activities with inactivated polio vaccine (IPV), with particular attention paid to having integrated microplans that incorporate social mobilization and fixed site locations, selection and training of vaccinators, social mobilization activities, monitoring, vaccine management, safe injection, surveillance for acute events following immunization and safe disposal of waste.
- Coordination between the Eastern/South-eastern regions of Afghanistan and Khyber Pakhtunkhwa/Federally Administered Tribal Areas in Pakistan should be improved through bi-annual face-to-face meeting and fortnightly teleconferences at regional level.
- Low performing priority 1 and 2 districts of Afghanistan contiguous to Tier 1 and 2 districts in Pakistan should have stronger coordination at sub-district level with information sharing, risk management at micro-level and continued joint analysis of these areas.
- Urgent action needs to be taken to improve surveillance in areas with low stool adequacy. Surveillance data should also be analysed by access status with the outcome shared with the TAG at its next meeting.
- Household and community engagement approaches should be expanded in low performing priority 1 and 2 districts based on local issues. Every district should have an issue-specific monthly communication plan tracked by the EOC, in place by end February.
- More focus should be placed on continuous communication approaches, including the work of the Immunization Communications Network which goes beyond supplementary immunization activities allowing more time for pre- and post-campaign mobilization and missed children tracking and immunization. The monitoring and evaluation platform should be strengthened to focus on measuring results of communications/social mobilization activities and promoting accountability.
- Preparations for the switch to bivalent OPV (bOPV) should be monitored closely and the switch date synchronized with Pakistan.
- The polio legacy plan for Afghanistan should include a strong section on using the experience and infrastructure of polio to strengthen the delivery of basic immunization services.
- A buffer stock of 2.3 million doses of bOPV should be replenished on a quarterly basis to accommodate related to the revision of microplans, the needs of permanent transit teams, newly accessible areas and case response.

1. INTRODUCTION

The meeting of Technical Advisory Group (TAG) on Poliomyelitis Eradication in Afghanistan was held 24–25 January 2016 in Kabul, Afghanistan. The meeting was attended by Dr Stanekzai, Senior Advisor to Minister of Public Health, Dr Kakar, Presidential Polio Focal Point, members of the Afghanistan Polio Eradication Initiative (PEI) team from national and regional levels as well as representatives from the Bill and Melinda Gates Foundation, U.S. Centers for Disease Control and Prevention (CDC), United States Agency for International Development (USAID), the Kreditanstalt für Wiederaufbau and the Government of Canada, the last representing all bilateral partners. The last meeting of the Afghanistan TAG was held on 1–2 June 2015 in Islamabad, Pakistan.

There has been significant progress in polio eradication globally with a decrease in the number of cases from 359 in 2014 to 72 in 2015. Nigeria, one of the three polio endemic countries, was removed from the list of endemic countries in September 2015. Three outbreaks of wild poliovirus type 1 (WPV1), in the Horn of Africa, Middle East and Central Africa, were declared closed in 2015 following outbreak response assessment by an external team of experts.

Afghanistan and Pakistan remain the only two endemic countries in the world. Pakistan has shown tremendous progress with significant reduction in number of WPV1 cases from 306 to 53 whereas Afghanistan had 28 cases in 2014 and 19 cases in 2015. Although there was a significant reduction in number of cases in the Southern region in 2015, transmission spread from the south to the Western and Northern regions and the country witnessed a significant increase in number of cases in the Eastern region.

Afghanistan experiences inherent challenges of inaccessibility and prevailing insecurity, which are further compounded by frequent population movement across the border with Pakistan. Continued spread of transmission across the border poses a strong challenge as the two countries form one epidemiological block with two clearly defined zones, i.e. the Eastern region of Afghanistan with Khyber Pakhtunkhwa/Federally Administered Tribal Areas (FP/FATA) of Pakistan and the Southern region of Afghanistan with the Quetta block of Pakistan. Cross-border transmission in the Eastern region is further aggravated by the number of inaccessible children which has increased 4.5-fold, with a total of 73 000 children unreached in the most recent campaign in December 2015 (from 16 000 in November 2014).

In its 12th meeting in October 2015 the Independent Monitoring Board on Poliomyelitis Eradication (IMB) concluded that “The challenge for Afghanistan’s programme is to clear the fog of doubt and dysfunction that is swirling around it, as it too moves into the last low season. The establishment of a fully functioning emergency operations centre is an essential first step and should happen immediately. Resolving ineffective inter-agency and government-partner working relationships is also a high priority. Polio will not disappear from the country without close and regular strategic planning and implementation with neighbouring Pakistan.”

Since the last IMB meeting the management and coordination of Afghanistan polio programme has gone through major restructuring including establishment of national and regional emergency operations centres. The country has developed the national emergency action plan for polio eradication (NEAP) for July 2015–2016 which, with its detailed work plans, provides the backbone for all polio eradication activities to ensure interruption of transmission by June 2016.

In the context of the continuing transmission in Afghanistan and the opportunity to interrupt transmission in the coming low transmission season, the Afghanistan TAG meeting was called from 24 to 25 January with two key objectives:

- to review the progress in polio eradication activities, particularly in implementation of the NEAP 2015–2016 in the past 6 months; and
- to make recommendations to achieve the interruption of transmission by June 2016.

The meeting was chaired by Dr Jean-Marc Olivé and opened by H.E. Dr Ferozuddin Feroz, Minister of Public Health in presence of the WHO and UNICEF Representatives for Afghanistan. The list of participants is attached in Annex 1.

2. SUMMARY OF DISCUSSIONS

2.1 General conclusions

The TAG expressed deep regret regarding the tragedy in Kandahar in which one polio worker lost her life in a horrific attack 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 commends the leadership and active participation of national, regional and provincial government authorities and partners and participants from global partnership. It regrets the absence of some of partners who could not travel to Afghanistan due to security reasons.

The TAG is pleased to observe a strong partnership between government, UNICEF and WHO in country at national and regional levels. Government and partners are commended for revamping programme management and coordination structures particularly the establishment of national and regional emergency operations centres and the use of the national emergency action plan tracking dashboard to monitor progress. However TAG notes that the agency surge staffing plan, particularly at provincial and regional level is still not fully implemented.

TAG is pleased to note that the country team is in process of developing and implementing an accountability framework.

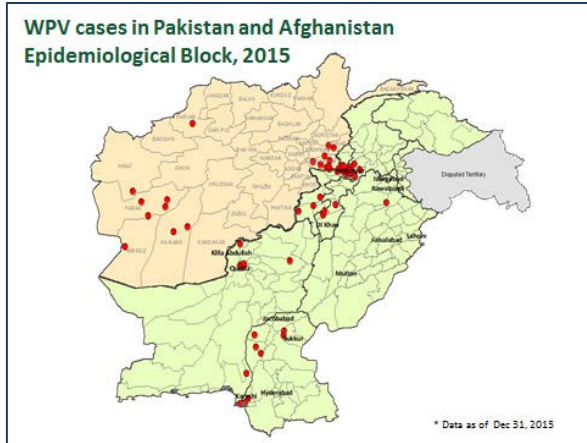


Fig. 1. WPV cases in Pakistan and Afghanistan, 2015

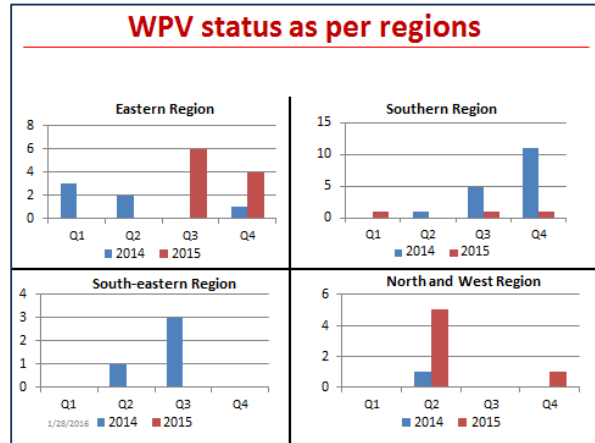


Fig. 2. WPV status per region

The TAG notes that Afghanistan and Pakistan, which form one epidemiological block, are the only remaining areas in the world infected with WPV1. There has been significant progress in past few months however it needs to be further enhanced to ensure transmission is interrupted by the end of this year (Fig. 1). Although progress is seen in the Southern region with reduced number of cases in 2015 compared to 2014, transmission in Afghanistan has continued as evidenced by WPV cases in the east, south, west and north (Fig. 2) as well as in environmental samples.

TAG notes that the deteriorating security situation and increased inaccessibility particularly in the Eastern and Northern regions, is a concern and appreciates the effort of country to develop a systematic approach to reach these children (Fig. 3).

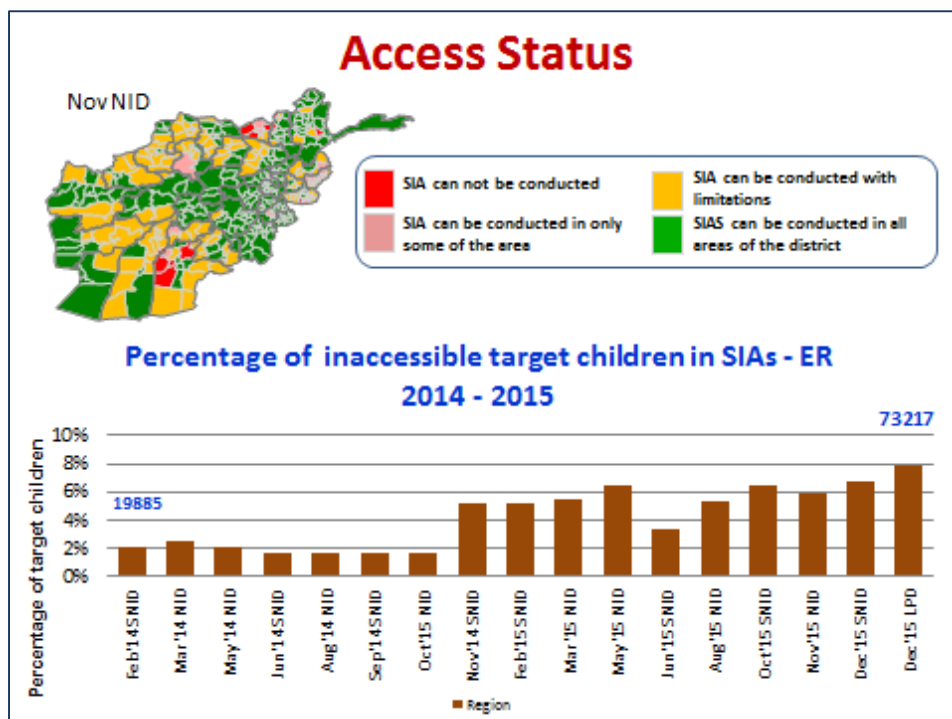


Fig. 3. Access status 2014–2015

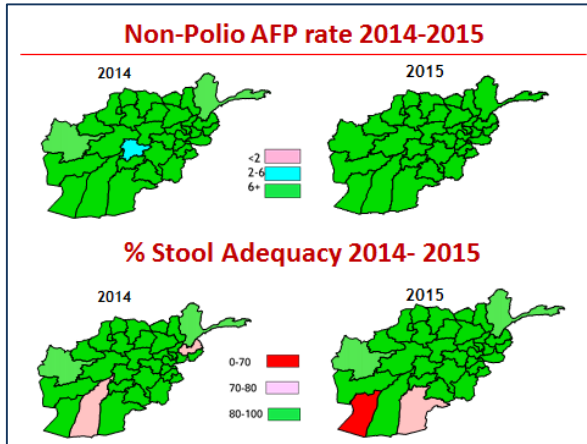


Fig. 4. NP-AFP rate and stool adequacy, 2014–2015

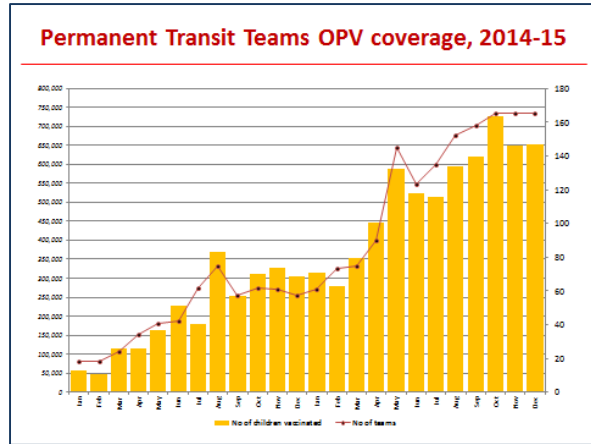


Fig. 5. Permanent transit team performance, 2014–2015

The TAG appreciates that good quality surveillance is maintained in most areas, however low stool adequacy in two provinces of the Southern region is a concern (Fig. 4). The TAG appreciates that the country has clearly identified gaps and outlined appropriate measures to improve surveillance at all levels. The TAG appreciates the strategies such as cross-border teams, permanent transit teams and special nomadic teams as they are helping to reach children on the move. It encourages the country to continue strengthening implementation of these strategies (Fig. 5).

The TAG appreciates the revised criteria for identification of low performing districts and plans for focused and prioritized interventions in these districts. It is encouraging to note that a microplan revision exercise combined with a revisit strategy has shown results where it has been fully implemented (Fig. 6). However, it is of concern that these initiatives have not been scaled up despite recommendations made during the June 2015 TAG meeting.

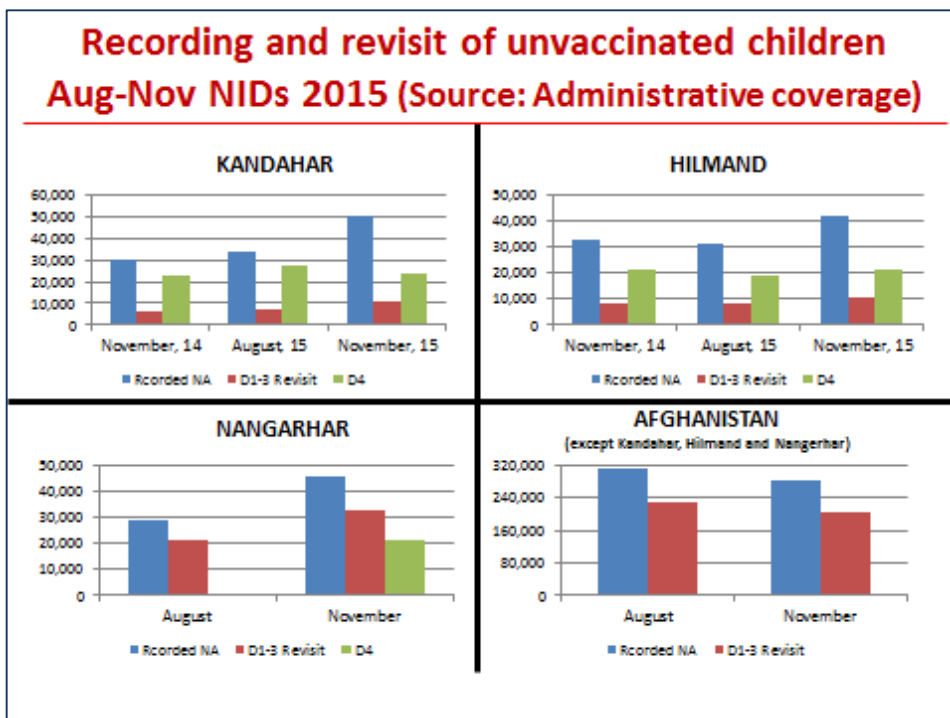


Fig. 6. Revisit strategy 2014–2015

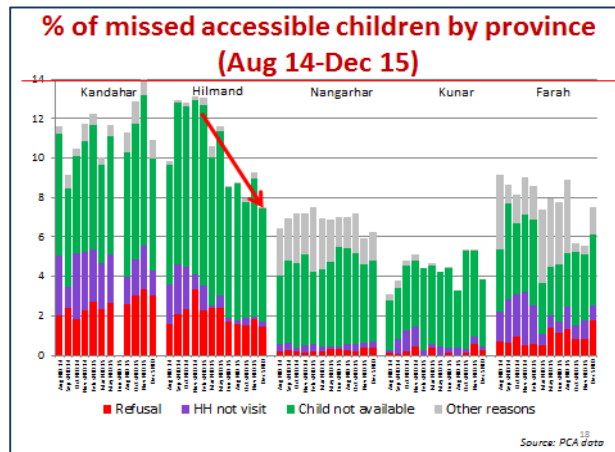


Fig. 7. Percentage of missed accessible children

The TAG appreciates the significant improvement in quality of supplementary immunization activities in Helmand as seen in the reduced number of missed children. However, it expresses concern that high numbers of children are still being missed in accessible areas in Kandahar (Fig. 7).

The TAG appreciates the innovations being tried by the country to reach missed children. However, it suggests that innovations such as the creation of community health volunteers (CHVs) should be fully tested in different situations for impact and challenges prior to further scale-up in appropriate low-performing districts.

The TAG appreciates the efforts being made by the country on reporting oral poliovaccine (OPV) utilization/wastage since the last TAG. The TAG appreciates that supplementary immunization activities for inactivated poliovaccine (IPV) have been conducted and that the country has plans to expand into an additional 28 districts in the first quarter of 2016.

The TAG also notes with concern that nongovernmental organizations are yet to be fully engaged and hopes recent efforts will help to engage them in a more systematic manner.

The TAG appreciates the positive developments in cross border coordination but is concerned about delayed face-to-face at national level and suboptimal meetings in the eastern corridor.

The TAG acknowledges the increased focus on household and community engagement approaches to build further trust as an important and necessary addition to mass media activities. However, more emphasis must now be placed on expanding this work between campaigns and systematically monitoring activities to ensure they are having impact.

The TAG appreciates country achievements and implementation status report on the recommendations of the previous TAG meeting in June 2015. However, the TAG is concerned that implementation of some specific recommendations, particularly related to improvement of the quality of supplementary immunization activities in accessible areas, has been slow.

The TAG therefore makes the following conclusions.

- There is significant improvement in programme oversight, management and coordination supported by a strengthening partnership between government, UN agencies, and other partners.
- The deteriorating security situation in the country and increasing numbers of inaccessible children particularly in the Eastern region is a concern. The country has developed mechanisms to address inaccessibility though these need to be refined to address emerging challenges particularly in the east.
- Despite some progress seen in Helmand, the quality of overall programme activity in the Southern region, particularly in Kandahar, remains suboptimal.
- Interventions for reducing missed children such as microplan revision and validation, the long awaited introduction of a revisit strategy, and training for frontline workers under the newly revised curriculum have not been fully scaled up.
- There is a mechanism for cross border coordination with Pakistan at national level, regional and district levels. However, it needs to be further strengthened particularly in the eastern corridor.

2.2 Responses to questions from the country

Is the 6-month plan presented, appropriate to achieve interruption of polio transmission?

The TAG recognizes the substantial progress made in the programme since the last TAG meeting, but believes that there is still space to strengthen programme fundamentals including improvement in the quality, consistency and analysis of programme data for missed children. This is related to the accuracy and detail of microplans ensuring they are revised before each activity based on analysis of past supplementary immunization activity performance. Operational readiness needs to be sustained and strengthened throughout the low transmission season even though little or no WPV may be seen during this period.

Overall the TAG endorses the plan with the following modifications:

- prioritization of the activities so that they are in sync with the national emergency action plan;
- focus on improvement of AFP surveillance rather than expansion of environmental surveillance – look to increasing the involvement of private health facilities and traditional healers; and
- detailed preparation for IPV supplementary immunization activities particularly social mobilization and vaccinators selection and training.

What should the target age group be for cross border vaccination?

All the cross border vaccinations should target children up to 10 years of age

Is the plan to introduce the CHV approach in the Southern region and phased expansion to poor performing priority 1 districts appropriate?

The TAG endorses the CHV concept and encourages the programme to develop this strategy with some caveats.

- CHV should be viewed as a localized strategy for use only in the poorest performing districts.
- Any new implementation/expansion of the CHV strategy should be based on clear evidence of positive impact in low-performing areas like Kandahar, compared to the existing programme vaccinator model.
- CHV implementation should be based on clear and detailed documentation of cadres eligible to be recruited, their operational role(s), the management structure, and projections for sustainability, including financial sustainability models.

Does the TAG endorse the plan presented for reaching children in inaccessible areas?

- The TAG endorses the broad principles of the plan described and suggests learning from experiences in countries facing access challenges, e.g. Somalia
- The TAG also urges that adequate numbers of locally appropriate surge staff be urgently put in place to ensure implementation.

3. RECOMMENDATIONS

Oversight, coordination and programme management

1. The national EOC should have systematic weekly teleconference or videoconference with regional EOCs to track progress and provide feedback and support in implementation of the NEAP. National EOC members should travel regularly to the regions and provinces to provide support. Provincial polio coordination units should be established in the five high-risk provinces.
2. Government and partners should accelerate development and implementation of a clear and transparent accountability framework including key measurable indicators and a system of tracking timely payment of vaccinators. The country programme should look at the accountability framework of Pakistan and Nigeria and adapt as appropriate by the end of the first quarter of 2016.
3. Understanding the extreme difficulties of recruiting staff in Afghanistan, partners should expedite recruitment as per the surge plan and build the capacity of newly engaged staff by the end of March 2016 to ensure adequate staffing in low performing districts and regional and national levels.
4. Nongovernmental organizations should be systematically engaged in the polio programme, particularly for delivering polio vaccine (in addition to other services as appropriate) in inaccessible and security compromised areas. All the nongovernmental organizations involved in delivering the basic package of health services (BPHS) should be engaged in intra-campaign monitoring as well as be part of regional EOCs and

provincial polio coordination units; progress regarding the engagement of nongovernmental organizations delivering the BPHS should be quantified and monitored.

National emergency action plan

5. The TAG recommends that implementation of NEAP 2015–2016 should be fast-tracked to ensure full implementation by the end of February. The country should review progress made on a monthly basis using the developed NEAP tracking dashboard and take timely corrective action. The programme needs to maintain a high level of vigilance and preparedness for responding to any WPV during low transmission season.
6. To avoid delay, the country should initiate the process of developing NEAP 2016–2017 early enough to ensure that the draft NEAP is presented in next TAG meeting.
7. The intervention matrix for low performing districts as developed by the country should be fully implemented. A mechanism to track these interventions should be developed and shared with TAG members on quarterly basis.

Reaching missed children in accessible areas

8. Explore reasons for persistent poor performance in Kandahar by the end of February to inform revision of microplans, training and other interventions as appropriate.
9. The TAG recommends fast-tracking field validation and the revision of microplans to ensure that microplans for low performing districts priority 1 and 2 are revised on the basis of field validation findings before the end of the first quarter of 2016. These plans should be fully integrated with social components.
10. Systematically strengthen implementation of migrant and mobile population strategy (including internally displaced) for vaccination as well as for surveillance activities. Nomadic vaccination strategy should target children up to 10 years of age.
11. Expand lot quality assurance sampling to all priority 1 and 2 low performing districts where feasible and track the low performing districts where it is not possible to do so.
12. After each campaign, supplementary immunization quality in all low performing priority 1 and 2 districts should be evaluated, and in those low performing districts with continuing poor quality, simple district specific action plans should be developed and implemented to seek to improve quality before the next campaign.
13. Intra-campaign data should be used to identify gaps and corrective action during the campaign.
14. The quality of post-campaign coverage assessment should be reviewed and improved (with special emphasis on Kunar) before the March national immunization days campaign.
15. The revisit strategy is showing results; the strategy should be strengthened and expanded to all five high-risk provinces by the March national immunization campaign and the entire country before the next TAG meeting.
16. The programme should conduct in-depth analysis of missed children due to 'not available' and use the information to modify strategies. Data on children missed should be disaggregated by 'refusals, newborn, sick, and sleeping', using each of the four types as a distinct category of analysis.

17. Based on a previous recommendation, the TAG recommends that the process of revising the training module for frontline workers should be accelerated and it should be rolled out by the end of February.
18. The country should evaluate the impact of the CHV initiative as compared to traditional strategies. The initial pilot in Nangarhar needs to be fully reviewed to determine the impact of CHVs. A further pilot should be done in a low performing district in the Southern region (possibly Kandahar) to learn the lessons, challenges and impact of the approach in a different setting. Equipped with these experiences (if successful), the country should plan to expand this strategy in a phased manner in prioritized persistently poor performing districts for the May national immunization campaigns. The CHV strategy should not be taken as an alternative to strengthening existing campaign approaches including microplanning, training and the revisit strategy. The implementation should be based on clear and detailed documentation of cadres eligible to be recruited, operational roles, management structure and projections for sustainability.

Reaching children in inaccessible areas

19. The TAG recommends the implementation of area specific plans for the Eastern, Southern and Northeast (Kunduz) regions, and for the rest of country, by mid-February and reiterates that programme neutrality should not be compromised. The TAG also reiterates its earlier recommendation of expanding permanent polio teams in areas with access and security challenges.
20. The programme should explore the feasibility of, and where appropriate make plans for, delivering OPV combined with other services (e.g. health camps) by the end of February by engaging nongovernmental organizations, other sectors, line ministries, the private sector and elders.

Supplementary immunization activities

21. The TAG endorses the OPV and IPV supplementary immunization plans presented and recommends that the activities should be fully implemented as per the planned schedule. Strong preparation for IPV supplementary immunization activities should be done with particular attention paid to having integrated microplans (including social mobilization and fixed site locations), selection and training of vaccinators, social mobilization, monitoring including adverse events following immunization, vaccine management and safe disposal of waste.
22. The TAG requests the programme to develop a summary of experience of IPV use to date including lessons learned.

Cross border coordination

23. Coordination should be improved between the east/south-east regions of Afghanistan and KP/FATA in Pakistan through quarterly videoconferences between the Afghanistan and Pakistan national EOCs with bi-annual face-to-face meetings and fortnightly teleconferences at the regional level. National EOCs should monitor this.

24. Low performing priority 1 and 2 districts in Afghanistan contiguous with tier 1 and 2 districts in Pakistan should be treated as a single entity for high focus interventions. They should have stronger coordination at subdistrict level with information sharing, risk management at micro-level, shared communication strategies and continuous joint analysis of these areas.

Surveillance

25. The reasons for delayed stool collection should be analysed and action taken to improve surveillance in areas with low stool adequacy. Surveillance data should also be analysed by access status and outcome shared with TAG in next meeting. Private sector and traditional healers should be systematically involved in the surveillance. The focus should be on improvement of AFP surveillance rather than expansion of environmental surveillance.

Communication

26. Expand household and community engagement approaches in low performing priority 1 and 2 districts based on the local issues. Every district should have an issue-specific monthly communication plan in place by the end of February which is tracked by the EOC.
27. More focus should be placed on continuous communication approaches, including the work of the Immunization Communications Network which goes beyond supplementary immunization activities allowing more time for pre- and post-campaign mobilization and missed children tracking/immunization. The monitoring and evaluation platform should be focused more on measuring results and promoting accountability.

Cold chain, switch and vaccine management

28. The programme should monitor the preparation and implementation of the switch to bivalent OPV (bOPV) and synchronize the switch date with Pakistan.
29. Bi-annual inventory of cold chain for supplementary immunization activities should be conducted and monthly reports submitted on all vaccine stock.
30. The TAG reiterates that a robust routine immunization system is critical to maintaining the progress achieved in eradicating polio, and urges the government and partners implementing the BPHS to ensure high quality provision of immunization services. The polio legacy plan for Afghanistan should include a strong section on using the experience and infrastructure of polio to strengthen the delivery of basic immunization services.
31. Quarterly replenishment of a buffer stock of 2.3 million vials of bOPV should be ensured to accommodate changing needs related to the revision of microplans, the needs of permanent transit teams, numbers of children in newly accessible areas and case response.

Next meeting of the TAG

32. The next meeting of the Afghanistan TAG is proposed to take place in Kabul, Afghanistan, during the week of 29 May 2016.

Annex 1

LIST OF PARTICIPANTS

Members of the Technical Advisory Group

Jean-Marc Olivé, TAG Chairman
Chris Morry, TAG Member
Nasr El Sayed, TAG Member
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Bijan Sadrizadeh, TAG Member
Abdel Majeed Siddiqi, TAG Member
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Annex 2

PLAN FOR NEXT 6 MONTHS TO INTERRUPT POLIOVIRUS TRANSMISSION

Oversight, coordination and management

- Strengthen engagement of political leadership at provincial/district level to enhance program oversight
- Further engage line ministries through office of presidential focal point for polio
- Make EOCs fully functional with dashboards and strong accountability framework by mid February
- Systematically engage NGOs implementing the BPHS in the programme (CHWs, ICMs and EOCs) at provincial/district levels
- Establish polio coordination units in 5 priority provinces by end February

National emergency action plan

- Full implementation of NEAP and close monitoring of progress through EOCs
- Use of NEAP activity tracker dashboard
- Review of NEAP implementation in mid-February and adjustment of action plan accordingly
- Develop NEAP 2016/2017 by May 2016

Supplementary immunization activities

- Implement 6 SIAs synchronized with Pakistan in first half of 2016 and OPV-IPV SIAs in 28 high risk districts (Annex 3)
- Ensure highest quality of activities in all 47 (LPD 1 and 2) high risk districts (Annex 4)
 - Fast-track micro plan revision to complete in all high risk districts by end of Q1 2016
 - Roll out revised training methodology by end-Feb 2016
 - Operationalize updated revisit strategy country-wide (strengthen daily revisit and fifth day revisit) by March NID
 - Day 4 for the planning of revisit
 - Use PCA data to identify and address chronically missed children
 - Streamline flow and use of ICM information using mobile technology for concurrent correction
 - Ensure direct oversight of 19 priority 1 high risk districts by national level monitors
- Introduce CHV approach in one LPD in southern region in February
 - If trial in Kandahar in February is successful, phased expansion in poor performing priority 1 districts in east and south by May NIDs
- Review and improve quality of PCA in Kunar
- Fully implement IPV SIA plan for Q1 of 2016
- Track displaced populations for immunization

Communication

- Strengthen communication HR capacity
- Create a more focused enabling environment to promote trust in vaccination
- Expand radio partnerships focused on high risk districts
- Scale up household and community engagement approaches, including between campaigns
- Standardize ICN structure/activities throughout high risk districts
- Develop monthly district-specific communication action plans
- Improve monitoring of communication approaches
- Equip CHVs and FLWs with IPC training and polio plus materials

Inaccessible areas

- Develop and implement area specific plans for eastern and southern regions, and for the rest of country, by mid February
- Maintain programme neutrality
- Continue negotiations through partners for full access in high risk districts
- Conduct subdistrict-level mapping of access and area specific approaches completed for high risk districts of eastern region by mid-Feb
- Engage NGOs who have access for delivery of vaccine and monitoring of campaign
- Engage local communities and elders in a systematic manner; ensure use of locally appropriate vaccinators
- Explore feasibility of delivering OPV combined with other services (e.g. health camps) by end February
- Review and strengthen permanent vaccination points by end February
- Maintain preparedness to conduct SIAs (including IPV SIAs) when any area becomes accessible

Cross-border coordination

- Hold quarterly VC between Afghanistan – Pakistan national EOCs with bi-annual face-to-face meeting
- Conduct fortnightly TC at regional level with regular exchange of information
- Share information on cross-border population movements to ensure coordinated vaccination
- Synchronize communication approaches between Afghanistan–Pakistan at border sites
- Produce and analyse data as per epidemiological blocks and contiguous LPD 1 and 2 and tier 1 and 2 districts from February 2016

Vaccine management

- Ensure vaccine availability for all planned SIAs, complimentary immunization activities (CB, PTTs, PPTs) and sufficient buffer stock to address case responses
- Functionalize systematic delivery of vaccine utilization reports from the provinces

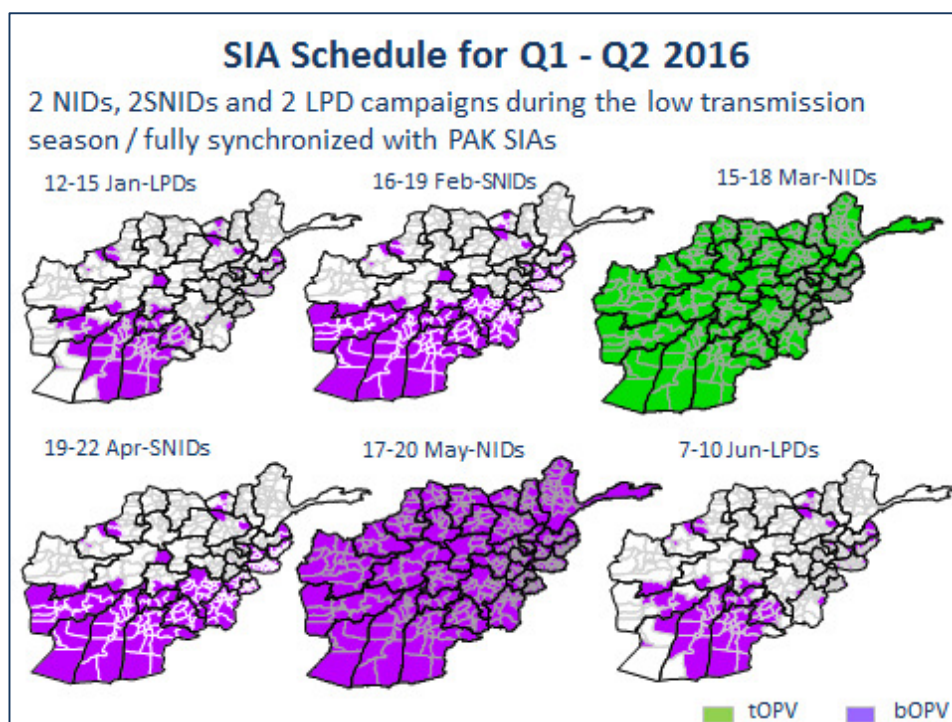
- Strengthen capacity of provincial and district-level SIA service providers to ensure SOPs for vaccine and cold chain management during SIAs are followed
- Update cold chain equipment requirement for SIAs bi-annually

Surveillance

- Explore expansion of environmental sampling sites and if feasible expand by end of Q1 2016
- Track quality of surveillance in inaccessible and security compromised areas through disaggregated data analysis and disaggregate analysis of surveillance data by district
- Conduct reason analysis of low stool rate in Kandahar and Nimroz and take corrective action
- Conduct surveillance review in Q2 of 2016
- Track displaced populations for surveillance

Annex 3

SUPPLEMENTARY IMMUNIZATION SCHEDULE FOR OPV AND IPV



Plan of IPV SIAs - Q1 2016

PHASE	Districts	Dates	Target Population	Doses required
Phase 1	Nangarhar-Achin, Lalpura, Momandara Farah (Balabaluk, Gulistan) Herat (Shindand)	6-13 Feb 2016	180,243	212,686
Phase 2	Nangarhar-(Batikot, Dehbala, Kot); Kandahar (10 districts),	28 th Feb to 5 th Mar 2016	261,443	308,503
Phase 3	Helmand (Kajaki, Nawa-e Barakzaly, Nawzad, Sangin, Washer, Lashkargah, Nadali/Marja, Nahre Siraj, Musaqala)	27 th Mar to 2 nd April 2016	371,298	438,132
Total			812,984	959,321

■ IPV Phase 1
■ IPV Phase 2
■ IPV Phase 3

Annex 4**INTERVENTIONS IN LOW PERFORMING DISTRICTS**

LPD category	Specific SIAs	Increased resources	Monitoring
LPD 1	LPD SIAs	<ul style="list-style-type: none"> • 1 DPO (possibly one PPO) and 1 DCO • Decreased Vaccinator to supervisor ratio • M and A officers 	<ul style="list-style-type: none"> • LQAS in each campaign • National level monitors • Increased post campaign monitors • Close tracking of preparation and activity
LPD 2	LPD SIAs	<ul style="list-style-type: none"> • 1 DPO and 1 DCO • Decreased Vaccinator to supervisor ratio • M&A officers 	<ul style="list-style-type: none"> • LQAS in each campaign • Increased post campaign monitors • Close tracking of preparation and activity
LPD 3	LPD SIAs	<ul style="list-style-type: none"> • Fill existing vacancies, if any • M&A officers to be considered 	<ul style="list-style-type: none"> • PCA and ICM to be continued. • 25% of LPD 3 target for LQAS in each campaign on rotation



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