WHO-EM/POL/402/E

Summary report on the

Meeting of the Technical Advisory Group on Polio Eradication in Afghanistan

Kabul, Afghanistan
6–7 May 2012

World Health Organization
Regional Office for the Eastern Mediterranean

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Document WHO-EM/POL/402/E/06.12/90

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1. Introduction

The Afghanistan Technical Advisory Group (TAG) on Poliomyelitis Eradication convened its first separate meeting in Kabul on 6–7 May 2012 (previously the TAG met in joint meetings of the Technical Advisory Group for Pakistan and Afghanistan). The objectives of the meeting were to review progress towards interrupting wild poliovirus transmission in Afghanistan and to discuss planned activities and to make recommendations to improve technical and managerial aspects of the programme in Afghanistan. The meeting was attended by members of the TAG, staff of the Ministry of Public Health of Afghanistan, representatives of partners and donor agencies and WHO staff from headquarters, the Regional Office for the Eastern Mediterranean Afghanistan and Pakistan country offices.

Over the past 15 months, Afghanistan has seen a significant increase in polio cases, coupled with a declining immunity profile in the transmission zone of the southern region. In response to this situation, the Government of Afghanistan and partners have developed a draft National Emergency Action Plan for Polio Eradication (NEAP), with the aim of stopping all wild poliovirus transmission in Afghanistan by 2013. The TAG deliberations took into account both epidemiological and programme developments, and the initiatives proposed by the government and partners under the NEAP.

2. Summary of discussions

Current situation

As of 2 May, only 52 cases of polio due to wild poliovirus have been reported with onset in 2012 across the world, and only 4 countries,

Nigeria, Pakistan, Afghanistan and Chad, have reported cases. This is the lowest number of cases and countries for the first four months of the year ever reported by the global polio eradication programme. In contrast, there has been a significant upsurge in wild poliovirus transmission in Afghanistan in 2011–2012.

Afghanistan reported 80 polio cases in 2011, the highest number for over a decade, compared with 25 cases in 2010. More cases have already occurred in 2012 (6) than in the same time period in 2011 (1). All cases reported in 2011 and 2012 to date are due to wild poliovirus type 1 (WPV1). The most recent WPV3 case was reported in April 2010 and the last case due to circulating vaccine-derived poliovirus type 2 (cVDPV2) was from a small outbreak in September 2011.

Transmission in 2011 and 2012 to date displays two patterns.

- Intense transmission in the well characterized endemic transmission zone consisting of the southern region and Farah province of the western region, which together account for nearly 90% of all cases reported in 2011–2012 to date. Genetic data show that this transmission results both from local maintenance of circulation and from regular re-introduction of virus from the shared transmission zones with neighbouring Pakistan. Within the transmission zone, four provinces are the main sources of transmission (in total reporting more than 80% of cases nationally): Helmand, Kandahar, Uruzgan and Farah. In turn, 13 contiguous districts within the first three provinces continue to be the main reservoirs, with an additional 15 districts in close geographical proximity at high risk of regular re-introduction of virus.

- Sporadic cases in other regions as a result of introduction of wild poliovirus. Genetic data show that re-introductions are primarily from reservoirs in Pakistan. There is also evidence of spread from the transmission zone in southern Afghanistan. Outside the transmission zone, the highest risk areas for re-introduction of virus continue to be key districts bordering endemic areas of Pakistan.

Among confirmed polio cases, the median age in 2011 was 24 months (range 12 to 36 months) with a slight preponderance in males over females. Compared with non-polio acute flaccid paralysis (AFP) cases, polio cases were significantly less well immunized; 23 of the 80 cases did not receive any oral poliovaccine (OPV) dose and the median number of total doses for polio cases was 2, reflecting the significant gaps in coverage. Most polio cases were reported from rural areas at some distance (average 17 kilometres) from the nearest health facility. Two cases (one in 2011 and one in 2012) were children from nomadic communities. There were no polio cases in 2011 and 2012 among returnees, despite a sharp increase in returnees between March and October 2011 including during the peak transmission period.

Questions for the TAG

The government and partners in the national programme asked the TAG some specific questions as part of their deliberations. These questions centred on strategies for supplementary immunization, post-campaign assessment methods/approaches, new strategies in the NEAP, and communications.

- The programme plans two national campaigns in the second half of 2012; what should be the number and extent of subnational

immunization day campaigns (SNIDs) to complement the national campaigns?
- What sort of emergency buffer stock of OPV should be held?
- How should short interval additional dose (SIAD) strategies be used in the transmission zone and in response in newly infected or newly accessible areas to quickly boost immunity?
- Is post-campaign monitoring (PCM) of supplementary immunization activities in Afghanistan giving an accurate picture of campaign quality, and what further steps can be taken to strengthen PCM?
- Should lot quality assurance sampling surveys (LQAS) be introduced as a supplement to PCM?
- Should other options, like telephonic surveys, be considered?
- Is there adequate evidence for the expansion of permanent polio teams to additional high risk districts?
- Is the reorganized immunization communication network model and the proposed expansion appropriate?
- Is there a need to better characterize the reasons for children being missed in supplementary immunization activities?

Conclusions

Based on the evidence presented by the programme, the TAG considers that the dramatic upsurge in transmission in 2011–2012 was based on two fundamental developments. The first is a deteriorating immunization profile in children in the southern region, which is the heart of the endemic transmission zone, in particular in the provinces of Kandahar, Helmand and Uruzgan, over the past 18–24 months. This deterioration has led to a significant build-up of susceptible children that has fuelled the widespread transmission in this area, despite the reported improvement in access over the same time period.

The second important development is the intense transmission in the WPV reservoir areas in neighbouring Pakistan, leading to an increased risk of WPV movement and regular re-introductions of virus into polio-free areas of Afghanistan. Cases have occurred following introduction due to the build up of susceptible children over time in these areas.

Data on the quality of both supplementary immunization activities and routine immunization strongly show serious quality issues in the transmission zone, particularly in the key provinces and high risk districts in the southern region. Reported improvements in access have not led to effectively reaching more children, and serious management and operational issues clearly negatively impact the quality of activities in the transmission zone. The TAG emphasizes the conclusion of the draft NEAP that security and access issues alone do not explain poor quality activities in the southern region; while security and access are undoubtedly important, very high numbers of children are being missed in areas with no or very limited access problems, indicating that management, accountability, oversight and operational issues are a major factor in missing children.

In contrast, there is evidence that the quality of supplementary immunization activities has remained good outside this zone. Data from supplementary immunization activity monitoring, the immunization status of non-polio AFP cases and the failure of poliovirus to spread beyond very limited transmission following re-introduction in the remainder of the country all support the conclusion that outside the transmission zone, children are being reached with vaccine and immunity is good.

The key issues therefore remain, as clearly outlined in the draft NEAP, improving the quality of immunization activities and stopping transmission in the transmission zone, and maintaining protection in polio-free areas while this is achieved.

The TAG appreciated progress in development of the NEAP, which is close to release, with its focus on high level oversight from the Office of the President, mechanisms for effective engagement of provincial and district governors, and a solid accountability framework. The plan includes a number of key innovations designed to impact on the quality of immunization activities in the transmission zone, and to ensure that all children are reached and immunized, including the deployment of joint government–partner district EPI management teams, the deployment of permanent polio teams and permanent transit teams to maintain a constant focus on immunizing children particularly from inaccessible areas, the implementation of SIADs to rapidly increase immunity, and the expansion of an immunization communication network. The TAG notes that there is early evidence of the impact of some of these key strategies, including evidence that permanent polio teams may be effectively reaching more zero dose children, especially in areas with security and access issues.

The TAG considers that the proposed NEAP provides a solid framework to ensure that Afghanistan can reach and immunize all children, and become polio-free. The challenge for the Government of Afghanistan and partners is to fully and consistently implement the plan.

The main risk to polio eradication in Afghanistan is stalling or slipping on implementing the NEAP, in particular the risk of failing to rapidly improve coverage in the high risk districts in the

transmission zone by: a) ensuring the basic elements of team selection, training, performance, supervision, and management; b) improving governance and accountability of local authorities for ensuring communities are immunized; c) reaching inaccessible children through negotiation and innovation; and d) creating demand for immunization.

3. Recommendations

The recommendations below should be taken in the context of the strategies and actions detailed in the National Emergency Action Plan with the objective of stopping transmission in the south by 2013, preventing outbreaks in polio-free areas, strengthening the 'backbone' of EPI, and maintaining excellent surveillance ensuring that importations from endemic areas of the country and neighbouring Pakistan are detected early for adequate responses. The recommendations also seek to address the questions to the TAG outlined by the national programme.

Building a national sense of urgency

1. There are only few more months between now and the 2013 goal. Therefore achieving the goal means truly implementing the NEAP as an emergency programme. This is characterized by faster identification and fixing of problems, focused resources in the worst-performing areas, and full accountability of national authorities and partner agencies on their assigned tasks.
2. The finalized NEAP should be launched in the presence of the highest levels of national and provincial authorities, in order to demonstrate commitment and oversight of the governorates.

3. A massive public engagement campaign should be initiated to build on the launch and generate public support, ownership and commitment, especially in the transmission zone.

Enhancing the impact of the NEAP

4. The Government should establish an intersectoral national task force to oversee implementation of the NEAP, reporting directly to the President. The national task force should monitor the implementation of all key elements of the NEAP and provide monthly feedback according to the indicators outlined in the plan.
5. The national task force should ensure a focus on province and district level performance, and ensure that each province and district, especially in the transmission zone, understands “what's different” and how to incorporate new approaches into operations.
6. National authorities and partners should ensure that there is a clear assignment of roles and responsibilities for implementation of the NEAP; the success of the plan depends on each person, authority, and agency at each level understanding assigned roles and responsibilities

Implementing key NEAP strategies

7. The national programme should continue to concentrate and focus efforts on the highest risk districts in the key 4 provinces of the transmission zone. The scaling up of interventions and new innovations should be rolled out prioritizing the 13 highest risk districts (especially those with access problems) and then expanding to the remaining 15 high risk districts.

8. Implementing key elements of the NEAP in the highest risk districts: the following key NEAP elements should be rolled out as rapidly as possible:

- District EPI management teams should be fully recruited, deployed, and trained in the 13 highest risk districts by end June. Deployment completeness and the performance of the teams should be evaluated in July/August to decide on further expansion.
- Permanent polio teams should be rolled out in the 13 highest risk districts (prioritizing high inaccessibility/highest risk areas) as rapidly as possible. Performance should be evaluated in July/ August and based on the results a decision made on further expansion. The TAG urges the government and partners to ensure funding support of the permanent polio teams.
- Transit teams should be continued and evaluated in-depth to ensure maximum impact on immunizing children from inaccessible areas / populations.
- Additional sites for periodic/permanent teams in the transmission zone should be assessed and established especially in shrines, key markets, bus stations, etc.
- The re-visit strategy should be fully implemented, i.e. vaccination teams should go back to houses having absent/unvaccinated children on the same day, and after completion of the campaign days, to attempt to locate and immunize these children.
- The existing process used for in-depth investigation of the social and operational reasons for missed children should be reviewed to ensure it combines all necessary components, and special investigations should be carried out in specific circumstances (e.g. clusters of zero dose AFP cases).

Improving access

9. In addition to the measures to improve oversight and quality in the transmission zone, the TAG endorses the key strategies for accessing children in security compromised areas:

- Negotiation for access through key interlocutors, access negotiators and ICRC.
- Rapidly building immunity when access is achieved through immediate immunization, using the SIAD approach.
- Implementing special strategies including permanent polio teams, transit teams and special teams in other venues, shrines, and key markets, to access children moving into and out of security compromised areas.

Improving information for action

10. Simple templates for monitoring indicators of NEAP implementation should be developed for the President's Office, Minister of Public Health, national team, partners, and provincial and district governors as well as provincial polio eradication teams and district EPI management teams. These should include indicators on preparation, conduct and evaluation of NEAP activities.
11. Post-campaign assessment (monitoring) data and processes should be strengthened by implementing revised global monitoring tools, adopting new independent monitoring forms and methodologies, disaggregating data on reasons for missed children, and refining the special investigation tool to better define operational and social reasons for missing children and to inform corrective actions.
12. Afghanistan's post-campaign monitoring data have been consistent with epidemiology, and the current monitoring

process should continue as the main source of supplementary immunization activity quality assessment. Post-campaign assessment should be supplemented by:

- Selective use of LQAS as a tool to confirm the quality of monitoring
- Telephonic surveys as currently used, provided that response rates are high.

Improving community engagement, knowledge and demand

13. Critical assessment should be conducted of why campaign awareness is higher in polio-free areas and how successful awareness strategies can be applied to the transmission zone
14. A localized mass media campaign should be designed and implemented to ignite social ownership of and commitment for polio eradication
15. The immunization communications network (ICN) should be restructured to achieve at least 90% coverage of all high-risk communication clusters in the southern region and Farah province.
16. All vaccinators (including permanent polio teams) and ICN staff should receive interpersonal communication training by trained facilitators before each campaign, with the indicator of training completeness to be monitored at all levels including the national task force. Audiovisual training tools should be used where appropriate.
17. Efforts to increase the proportion of women working as vaccinators and social mobilizers should be intensified. Innovations that have successfully recruited women in the south and the east should be identified and expanded to additional areas.

Supplementary immunization strategy

The objectives of the supplementary immunization strategy are: a) stopping WPV circulation in the transmission zone; b) maintaining immunity to protect against spread of importations in the non-transmission zones; and c) rapidly responding and stopping transmission if any importation occurs outside transmission zone.

18. Two NIDs should be conducted in the second half of 2012 as per national plans, one using tOPV, and one bOPV.
19. These should be supplemented with 2 SNIDs using bOPV. The extent of the SNIDs will depend on epidemiology and risks, but should include at minimum:

- First SNID: all 28 high risk districts along with high risk areas in the eastern region and in the south east region.
- Second SNID: all 13 highest risk districts (expanded to 28 if epidemiology indicates) along with high risk districts in the eastern region and in the south east region.

20. SNID timings should be flexible to take into account seasonality, time for preparation, and epidemiological developments.
21. Additional rounds should be conducted using the SIAD approach in key persistent transmission areas or recently accessed areas/populations.
22. Mop-ups in response to WPV (as per global recommendations) should be conducted after every virus outside the 4 key provinces of the transmission zone, as an intense activity designed to stop transmission, using the SIAD approach to rapidly boost immunity.
23. A buffer stock of bivalent OPV should be maintained for use in mop-ups. If there are issues in supply of bOPV globally, monovalent buffer stocks, especially mOPV1, should be maintained.

Building the backbone of EPI

24. The following approaches should be taken to link the polio effort to achieving the highest possible levels of EPI coverage in all areas outside the transmission zone:

- Polio micro-plans should be used as a check on routine immunization session plans, both fixed and outreach, to ensure that all communities are covered by routine immunization services
- The polio network should be used to monitor the proportion of routine sessions that are planned versus conducted (as well as key barriers such as vaccine availability)
- The polio social mobilization/communications capacity should be used to promote immunization where access to services is assured to generate stronger community demand and trust

25. In addition to the overall approach outlined above, the following additional steps are recommended in the transmission zone:

- The newly formed district EPI management teams should ensure availability of quarterly plans and cross-check them against polio microplans, and should monitor implementation.
- The permanent polio teams should be used to promote all immunization within the community, and to provide information on planned routine immunization sessions.
- The expanding immunization communications network should be used to promote immunization and generate stronger community demand.

26. A sensitive surveillance system should be ensured through continued focus on quality through regular monitoring of implementation of recommendations of international/national surveillance reviews, continued conduct of rapid assessments and action based on the results, and investigation of all orphan poliovirus detection.

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