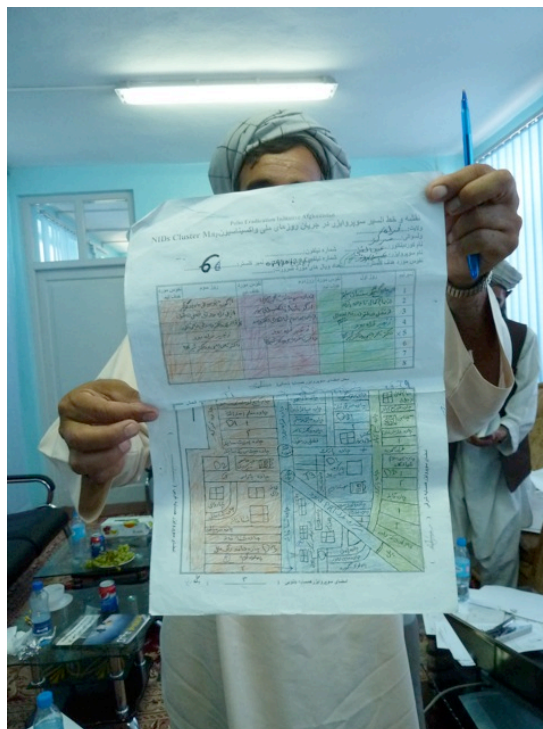


Independent Review of the Afghanistan Polio Eradication Programme

29 June – 5 July 2012



Independent Review Team

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ACKNOWLEDGEMENTS

We thank the Government of Afghanistan for their support throughout this assessment. In particular, **Dr Soraya Dalil**, Her Excellency the Minister of Public Health, **Dr Mohammad Taufiq Mashal**, Director General Preventive Medicine, and **Dr Agha Gul Dost**, the National EPI Manager all provided excellent assistance at the national level. Their colleagues within MOPH and the GCMU, as well as the many dedicated public health officials, workers and volunteers at national, regional, provincial, district, cluster and community level throughout Afghanistan were always welcoming and helpful.

We would also especially like to thank the Governors of the provinces we visited. Their continued commitment to polio eradication is vital to the success of the programme.

Staff from WHO and UNICEF Afghanistan and from NGOs implementing the BPHS, as well as delegates from the ICRC all facilitated our understanding of the challenges and needs of the national polio eradication initiative.

Findings and Recommendations

Independent Review of the Afghan Polio Programme

29 June - 5 July 2012

Following the identification of 80 cases of poliomyelitis in 2011,¹ predominantly in the persistent transmission zone of the Southern Region and Farah province with a smaller number of infections in hitherto polio-free areas, the Independent Monitoring Board (IMB) recommended an external programme review as a matter of urgency. The Government of Afghanistan, in response, promptly requested the WHO through its Eastern Mediterranean Regional Office (EMRO) to convene an independent review team.

THE MISSION

The principal aims of the mission were to investigate the 'root causes' of the upsurge in cases and to make recommendations to strengthen programme performance.

Specifically, the team was asked to conduct district-level analyses of the causes of outbreaks/renewed transmission in 28 key high-risk districts and to provide district-level strategies for programme strengthening. On preliminary review of the TOR, the team agreed that 28 separate district-level analyses was not possible with the time and resources allotted to the mission; instead, the most useful contribution to the programme would be a broad analysis of factors contributing to outbreaks and continuing circulation of the virus, and determination of key strategies likely to produce improved programme outcomes across both transmission and non-transmission zones of Afghanistan.

Three observations based on discussion and field assessment are important to note:

- First, the core objective of any and all programme investments, strategies, action and evaluation, should be to reduce the number of **missed children** in the delivery of oral polio vaccine (OPV). If a strategy cannot demonstrate – first through plausible hypothesis, then through empirical measurement – its capacity to directly reduce the number of missed children, it should be considered of secondary importance for the national polio eradication initiative (PEI).
- Second, the key focus of programme investment – not simply financially, but in terms of data and analysis, programme strategy, operational management and implementation, and campaign evaluation – should be **the District**. The District (via the newly established District EPI Management Teams) is the closest coherent level of programmatic and operational management to the target communities, and should be the primary unit of analysis, action and evaluation. Capacity at this level is particularly important given the diverse challenges faced by specific districts (even clusters) across Afghanistan.
- Third, the 194 WHO Member States at the 65th World Health Assembly, May 2012 and the latest iteration of the Afghanistan national polio eradication plan all describe polio eradication as an **emergency** – action needs to be mounted proportional to this declaration.

¹ This was a 220% increase compared with 2010 (25 cases).

THE APPROACH

Afghanistan is one of three remaining polio-endemic countries.² The Afghanistan polio programme has hosted a series of external and in-country reviews from a diverse group of partners and contributory experts³ culminating in the draft National Emergency Action Plan (NEAP). The twin objectives for the national polio programme are: (i) to halt the outbreak in the Southern Region; and (ii) to prevent re-establishment of viral transmission in polio-free regions of Afghanistan, thereby reducing the risk of cross-border transmission northwards into Central Asia.⁴

The downside of wave after wave of review and revision is that the programme ends up in a permanent condition of innovation. This can be disruptive to the basic objective of the programme – to vaccinate every Afghan child – and to the relatively simple logic of programme activities – verifiably efficient and comprehensive vaccine delivery at the doorstep, to informed and consenting families, supported by a strengthening infrastructure of routine immunisation and wider primary health services.

It is not the intention or approach of this mission to add to the lengthening list of recommendations and strategic innovations. Rather, it is our intention to draw the programme’s focus back to its basic necessary functions, and to suggest how the effectiveness of those functions may be improved by recommending ways in which the *current* national plan (NEAP) can be more effectively put into practice. As such, we focused attention on the transmission zones and met with provincial and district teams from Kandahar, Helmand, Farah and Nangarhar, as well as informants at the national level in Kabul.

ROOT CAUSES OF THE OUTBREAK

The root cause of the 2011 polio outbreak in Afghanistan is simple: an increasing ‘pool’ of susceptible children, especially in the transmission zone (Southern Region) where population immunity has never been above the 80-86% required to disrupt transmission and where OPV coverage has been steadily declining between 2006 and 2011, such that wild poliovirus transmission is sustained.⁵ The principal intermediating causes are variable quality of SIAs conducted by the polio programme, ongoing weakness in routine immunisation, and the unrelieved threat of importation from Pakistan.⁶

FINDINGS AND RECOMMENDATIONS

Recommendations have been aligned with the four causes of continuing viral circulation in Afghanistan as described in the NEAP since this document constitutes a central point of reference for all programme activities. We have also made recommendations for two new thematic areas.

NEAP	Management and Accountability
	Inaccessibility
	Communications & Demand
	Routine Immunisation
New thematic areas	Cross-border threat – <i>a known major risk for progress</i>
	Programme coordination – <i>an under-exploited opportunity to maximise program effectiveness</i>

² The others being Pakistan and Nigeria

³ Taking together the 2009 programme review, the IMB reports from late 2011 to early 2012, the June 2012 Technical Advisory Group (TAG), and the 2012 draft National Emergency Action Plan (NEAP), the programme has had almost 100 recommendations from general management to community communications.

⁴ Taking into account the need to reduce risk of cross-border transmission within the AfPak block and into Central Asia.

⁵ See, O'Reilly KM, Durry E, Ul Islam O, Quddus A, Abid N, Mir TP, Tangermann RH, Aylward RB, Grassly NC. 2012 *The effect of mass immunisation campaigns and new oral poliovirus vaccines on the incidence of poliomyelitis in Pakistan and Afghanistan, 2001-11: a retrospective analysis.*

⁶ This has a bearing on the policy, structure and performance of the Basic Package of Health Services (BPHS) service providers (NGOs), operating throughout Afghanistan. Whilst this is ancillary to the core focus of this mission which was the review the national PEI, the team paid close attention to evidence of BPHS performance and makes recommendations in this direction.

1.0 Management and Accountability & Routine Immunisation⁷

Recommendation 1.1

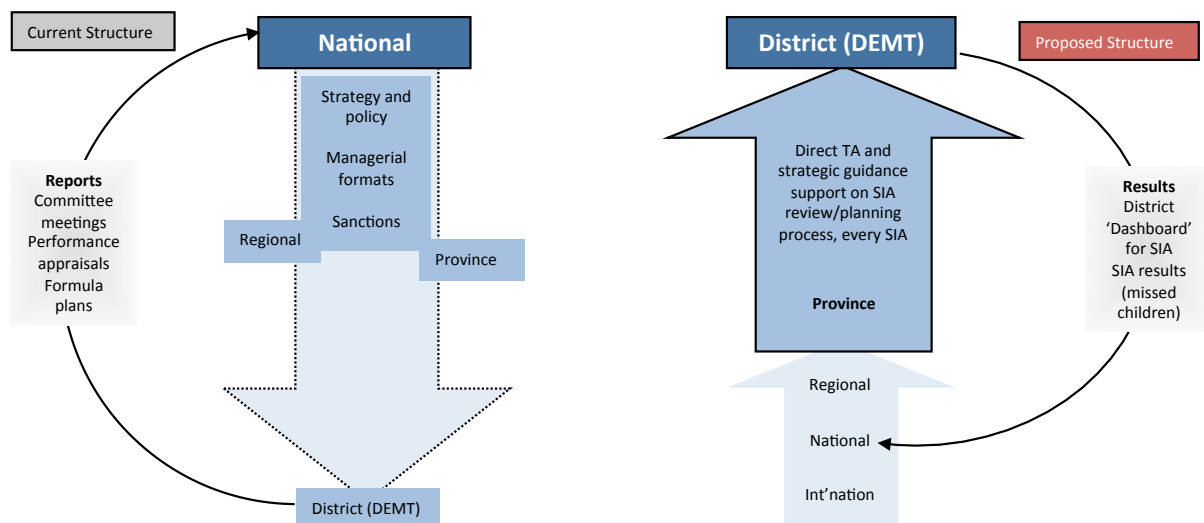
Focus ‘management and accountability’ on operational SIA planning, action and results (reduced missed children), not on internal (bureaucracy-heavy) systems reforms

Focus ‘management and accountability’ as support to District SIA performance (rather than upwards systems reporting), backed by a surge of technical assistance from provincial and national (+/-international) levels, with individuals at provincial/national level assigned to support the same Districts over multiple SIA rounds

RATIONALE

The current programme’s emphasis on ‘management and accountability’ appears to reflect a hierarchical programme structure that favours top-down determination and delivery of strategy and operational procedure to a relatively under-developed District level. NEAP reforms in management and accountability appear to reinforce this, with an emphasis on reform of internal programme managerial systems (performance appraisals, formulaic reporting formats and schedules etc.) flowing upwards and post-campaign sanctions in the form of withheld payment or warning/dismissal of staff flowing downwards (see Illustration 1, below).

Illustration 1: Current and Proposed Programme Hierarchy



Although this illustration is a characterisation of the programme (and not an accurate representation of all functions and relationships), it makes a clear point. Using the analogy of a fruit tree, the current system’s top-down structure is one in which strategy and operational policy drop like fruit onto the District. In many instances such fruit falls onto dry ground – that is, the top-down strategies are inappropriate to and hence operationally redundant in local circumstances, and at the same time Districts simply do not have the capacity to implement. In theory, micro-plans encompass tailored responses to problems faced by individual districts and clusters; in practice, districts lack the managerial and strategic skills required to adapt plans and too often apply untailed national formulations round after round. As such, the proposed structure suggests that the

⁷ These two thematic areas are addressed jointly, recognising that PEI activities and wider development of routine immunisation service delivery are profoundly and necessarily interconnected.

national, regional and provincial levels should operate as roots, nourishing Districts with knowledge, technical expertise, strategy and SIA guidance in an upwards fashion, emphasising the supportive role of the province to help Districts improve their performance through consistently driving up quality round by round. The basic map of each District with area demarcation of clusters should be available and updated regularly.

The team's view is that the conventional programme hierarchy should be more or less entirely reversed. Districts – primarily referring to the 28 high-risk ones – need the confidence, capacity and flexibility to respond to highly localised conditions, and to be able to improve their 'ownership' of PEI. In this sense, the District should be seen as the apex of the programme hierarchy. We note that problems and challenges facing the PEI programme in Afghanistan, whilst related to a few core causes – are localised in specific forms. Hence, planning and strategising programme responses to obstacles must be as localised as possible, at the District but perhaps even more importantly at the sub-District level.

Efficient finance and high-quality technical assistance should flow into these Districts from national, regional and provincial levels *every* SIA. Accountability should flow from District to national level in the form of better analysis of past SIA shortfalls, better planning of future SIAs based on that analysis, and verifiably improving outcomes, primarily in the form of falling numbers of missed children as the result of each round.

DETAILED SUB-RECOMMENDATIONS FOR MOPH / UNICEF / WHO

- The emphasis of a 'management and accountability' strategy should be on results (fewer missed children), focusing on the District as primary unit of analysis, planning, action and evaluation.
- The programme should focus its support on the District, rather than allocating a separate tier of strategy to high-risk clusters, which will dilute the impact of available resources. Such clusters will form a key element of District analysis, planning and SIA strategy, but within an emphasis on District-wide campaign management capacity.

Recommendation 1.2

Understand in more detail the specific local reasons why children miss out on OPV

Strengthen pre and intra-campaign analysis and planning

Create a District 'dashboard' showing analysis of obstacles & strategies in last SIA with new or modified strategies for next SIA

RATIONALE

Currently, causes of sub-optimal performance (missed children) at District and sub-District levels are reported in **generic** terms (e.g. 'inaccessibility, insecurity, non-attendance of vaccinator team, child absent, child sleeping, sick, newborn'). These data are too broad to allow for detailed analysis and identification of specific challenges and the impact of various programme strategies. In addition, context specific data available at a higher level (e.g. security assessments, population movements) are not routinely brought to bear to improve understanding of factors militating against higher coverage in each district and aid planning for the next SIA.

The current programme strategy also focuses heavily on post-campaign review (post-SIA evaluation through house-to-house and market surveys) and action (imposing ex post sanctions including financial penalties and personnel warning/termination). This approach over-emphasises **retrospective accountability**: it is backward looking and reacting to problems that have been inadequately characterised. What the programme needs

now is **prospective accountability**, demonstrating how review of data from the last SIA and data from information sets available at the national level are absorbed into future SIA planning to address local problems and improve OPV delivery in each District. This offers a concrete metric of District performance that should be looked for by higher-level programme management.

Reviewing problems in the last SIA round, and planning for success in the next should be a **single process**. The quality of this joint review/planning process relies on the quality (and range) of available data and the quality of analysis and planning. To strengthen this, Districts (DEMTs) need significantly higher levels of technical support and strategic guidance from (primarily) the provincial level. This requires improved capacity – assigned exclusively to PEI – at the provincial level (with further backing from regional, national and international levels where feasible).⁸

DETAILED SUB-RECOMMENDATIONS FOR MOPH / UNICEF / WHO

- **Key causes of missed children should be broken down** in review process in more (e.g. what specific aspect of insecurity; what probable time length for child not available); sub-factors should be evaluated against numbers of missed children to look for more specific correlations (e.g. lack of correlation between household ‘awareness’ & coverage (as ‘awareness’ is a generic term), but possibly stronger association between awareness and proportion of missed children resulting from ‘Child Not Available’). Tools used during SIAs, particularly tally sheets and intra-campaign monitoring formats may be modified to capture this kind of factual information
- More time and attention should be given to **pre- and intra-campaign performance**
- A **combined review/planning process** should happen after last SIA & before forthcoming SIA (2-3wks prior to next SIA)
- Combined review/planning process should be **held at District** where possible or at Province where not
- Combined **review/planning process should take longer** (4-5 days), with discrete review & planning sessions for each individual district team
- Each review should assess **epidemiological, operational & social data in an integrated fashion to explain numbers of missed children**, and should support the district programme to respond with agility & speed to identified problems & opportunities.
- Support is required to strengthen DEMT capacity to analyse past SIA performance, develop strategy and plan for future SIA (a **combined SIA review/planning process** to be held between rounds at District level).
- Additional support for District-level review/planning implies the need for a **further technical/operational programme personnel ‘surge’, strengthening (primarily) provincial capacity** (in particular supporting the capacity of PPOs):
 - Provincial review/planning personnel should be recruited and assigned to cover specific Districts (a recommended ration of 1 person to 2 HR Districts), consistently over multiple rounds to develop a supportive relationship with DEMT, and become familiar with local conditions and specific programme challenges
 - Provincial review/planning personnel should spend an average 10 days at District between SIAs, providing the DEMT with comments on review/plan (and microplans), and a checklist for SIA preparation and readiness (to be submitted one week before SIA)
- The District SIA review and planning process should produce a **‘District dashboard’** showing in a concise format evidence of analysis of last SIA shortfalls (security, operational/supervision problems, causes of missed children etc), and modifications to District and Cluster strategies for next SIA. This dashboard can be efficiently used as an overall District SIA quality report and checklist that is also usable as an indicator at the national level.
- The DEMT members (DCO, DPO, EPI Manager) should have **overlapping TORs and job specs**, to ensure that the three

⁸ We recognise the reality that that this would, at this point, require upgrading provincial level HR capacity to an extent that may not be possible even in the longer run. It may be that the programme will be able to procure and recruit good people with better capacity at the regional/national level. We suggest that even a surge of TA at regional level has the potential to make a significant difference – so long as they are in direct, sustained contact with Districts providing support to the review/planning process each SIA.

key members are working together towards, and are equally accountable for, improved SIA performance (rather than reporting in 3 separate lines to 3 agencies at higher levels (Govt, WHO, UNICEF)).

Recommendation 1.3

Focus on improving operational quality of vaccinator teams

RATIONALE

Data show that in many instances, the dominant factor inhibiting programmatic success is weakness in the delivery of OPV by vaccinator teams. Most programme partners place a heavy emphasis on better supervision and monitoring as the key to lifting vaccinator team performance. We agree. The question remains, though, *how* to achieve this. We suggest that real-time (as opposed to post-campaign) SIA monitoring be enhanced through more systematic reviews during the campaign (e.g. evening meetings or daily reviews by the district supervisor to troubleshoot problems encountered as they occur). But we also see an opportunity to use community-based monitoring to build community engagement and acceptance of polio vaccination (e.g. toll free numbers to enable *passive* call-in by the public to report when vaccinators fail to attend during SIAs; *active* call-in by designated local contacts enlisted through social mobilisation or through the extensive existing AFP surveillance network to report on vaccinator presence in communities during SIAs; representative tele-surveys where mobile phone ownership is high and network coverage allows⁹).

Better intra-campaign monitoring should focus on reducing the number of missed children with a series of procedures for teams to follow if children are not home or teams cannot access a household (e.g. enlist local midwife or neighbour), immediate follow-up (same day return) built into the daily plan, and a more systematic follow-up strategy for the fourth SIA day. Teams and monitors should also provide more detail on reasons why children were missed. In order to maximise children vaccinated, DEMENTs should also consider setting up temporary vaccination booths (in particular in urban areas or on popular rural road routes) to complement house-to-house.

SIA vaccinators (volunteers) appear to be substantially underpaid, a problem that is relatively worse in some of the more insecure areas of the country (e.g. poppy growing regions employ day labourers at a base wage five times higher than that paid to vaccinators). This may be reflected in rates of team turnover and poor motivation. A salary increase should be considered, along with more detailed and verifiable approach to vaccinator recruitment, selection and training (with emphasis on interpersonal communication training). The financial system remains inflexible and is a constraint to fast-tracking some of the successful innovations that have been introduced in the high-risk areas.

DETAILED SUB-RECOMMENDATIONS FOR MOPH / UNICEF / WHO

- Ensure **intra-SIA evening meetings**, with DEMENT, Cluster Supervisors & intra-campaign monitors; document daily format (problems encountered, strategies to respond, remaining missed children); identify & act on daily SIA shortfalls

⁹ In the Eastern Region, a mobile phone tele-survey was conducted in collaboration with the mobile operator. Ten MoPH workers contacted people from specific districts in the Eastern Region: ~30% of those called participated and over 85% said that a vaccinator visited their home in the last SIA. This was reasonably consistent with other post campaign monitoring. As the most remote sites may not have the network - only 60% of areas have mobile coverage in Southern Region - some alternative arrangement for these areas should be in place.

- DEMA to use AFP network and/or local community **monitoring contacts** (mobile phone) to validate vaccinator team presence in planned area (+/- toll free passive system to enable community to independently report on team presence and performance)
- **Tele-surveys** may be used where it can be assured that mobile ownership and survey responsiveness is representative of the target population especially in high-risk areas
- Maintain **lists of recruited supervisors and vaccinators** and assess teams performance in past SIA to modify teams (dismiss, restructure) in next SIA
- Vaccinator *team* lists should include profile details associated with better performance, e.g. age (e.g. mixed age of 2 vaccinators - 1 older & 1 younger); sex; other demographic characteristics; training; number of SIAs
- Retain 3+1 day SIA timeline (with stronger intra-campaign monitoring as above), but strengthen revisit strategies: both **same-day re-visits as well as systematic re-visit of absent children on day 4**. Where children are absent for longer periods of time, this should be noted, and a response determined by the DEMA, in consultation with cluster supervisor and monitors
- **Interpersonal communication training** to vaccinators should emphasise a 'checklist' of strategies to completely enumerate all eligible children in the household, to gain access to these children, and document time of return of 'Not Available' missed children for more systematic follow-up. We note that a direct, regular training (e.g. on IPC) to vaccinators by District PEI personnel can be more effective than the current cascade approach with loss of quality and impact of training.
- Complement house-to-house strategy with **fixed post vaccination** points in urban areas and on well-used transit routes. Consider the added value of using **private health providers** particularly in high-risk districts where volunteers persistently fail to increase OPV coverage
- Consider **increasing volunteer vaccinator salaries** & resolve the current issues with budgeting & the dispersal of funds (e.g. late payments must cease, advances could be considered in selected cases where outlays for transport are considerable, standardised budget approaches to costing transport need to be revised & based on real local costs, payments for training of district supervisors & subsequent training of vaccinator teams need to be realistically budgeted)

Recommendation 1.4

Evaluate and refine Permanent Polio Team (PPT) strategy

Focus PPT strategy within SIAs as small-scale response in fully inaccessible areas

RATIONALE

The mission team supports the concept of the Permanent Polio Team. Where the level of verifiable insecurity in an area prevents access to any outside actors (for the time being), vaccinators recruited from within that area and working to a longer timeframe than the SIA campaign model may be the best (or only) available option. There is anecdotal evidence from a pilot initiated by Farah province in Khakisafed and Balabaluk that PPTs can improve coverage particularly for younger children and, in fact, may improve estimates of missing children and total estimates of the target population. However, logistical questions remain regarding how the PPT is supervised and supplied. These are being resolved, but we suggest that the first 3-month evaluation should be followed by further evaluations to monitor progress as logistical requirements are put in place.

The team also felt that the PPT works best as a small-scale sub-strategy *within* the wider SIA campaign strategy (rather than as a separate or alternative strategy to be scaled up at some future point). PPTs should be applied

within the general District and Cluster plans within relatively small areas, where their measurable objective is to deliver OPV in areas that have been conclusively demonstrated to be inaccessible to other SIA means.

DETAILED SUB-RECOMMENDATIONS FOR MOPH / UNICEF / WHO

- Evaluate PPT impact (3 months and 6 months); resist scaling up PPTs to wider catchments
- Review logistics requirements of PPTs (supervision, cold chain): in highly insecure areas flexibility of operations is required - it makes sense to properly equip PPTs to continue to vaccinate children without constant need for resupply
- Focus deployment of PPTs on small areas verifiably inaccessible to other SIA efforts

Recommendation 1.5

Prioritise efforts and resources on Polio Eradication (SIAs) in the transmission zone

Continue to focus on combined SIA and routine immunisation strategy via the BPHS in non-transmission zones

RATIONALE

Building routine immunisation is a core health strategy for Afghanistan, and is a key long-term strategy for achieving polio eradication and maintaining a polio-free environment. EPI services, within the Basic Package of Health Services (BPHS), are currently provided under an out-contracted model to a number of BPHS NGOs. Provision of services, as well as basic health facility infrastructure, remains chronically poor in many areas especially in the transmission zone.

The independent team recognises the importance of routine immunisation to the PEI and, indeed, to population health more generally. However, in the transmission zone the priority for the next 18 months must be to focus resources on polio eradication efforts. This does not imply reducing other resources flowing into BPHS and EPI. But it does imply that there should be no blurring of resource allocation between the two strategies.¹⁰ In other regions of the country with significantly fewer OPV campaigns, a more closely combined dual strategy of PEI and EPI should be emphasized to maintain and improve population immunity in order to prevent spread of imported WPV (including emphasis on routine immunisation as a strategy in border areas, see Recommendation 8).¹¹

Nationally, performance of BPHS service providers should be subjected, as a matter of urgency, to independent review and evaluation. Stipulations for service delivery within contract and related action plans should be transparently assessed, including a clear assessment of provision of doses of OPV. More broadly, consideration should be given to the range of quality of performance indicators applied in contracts to BPHS service providers with emphasis on: development of health facility infrastructure (often non-existent or sparse in high-risk districts); delivery of outreach services; and EPI coverage disaggregated by vaccine type and regional/provincial performance, and confirmed through independent scrutiny.

¹⁰ Further noting the potential of EPI and PEI resource demands to undermine one another in, for example, recruiting scarce vaccinators.

¹¹ Most notably, of the 10 cases of poliomyelitis identified in 2010-2011 outside of the southern transmission zone, only 3 isolates were genetically linked to other cases within the region. This suggests that although poliovirus is frequently transported to this region, population immunity is usually sufficiently high to prevent circulation of WPV.

DETAILED SUB-RECOMMENDATIONS FOR MOPH / UNICEF / WHO / BPHS implementers & donors

<ul style="list-style-type: none"> Consider prioritising PEI now, given the ‘emergency’ nature of the current situation, in the Southern Region and Farah province; focus on joint PEI/EPI strategy in non high-risk provinces with better SIA performance 	<p><i>MOPH / WHO / UNICEF BPHS implementers</i></p>
<ul style="list-style-type: none"> Advise against seeing PEI and EPI as sharing resources (acknowledging the inevitable overlap of some functions within the health system as a whole but emphasising that while natural synergies are acceptable, deliberate operational re-tasking between EPI and PEI is for the period of emergency is not. A natural synergy could be to promote <i>opportunistic</i> vaccination of all young children attending fixed health facilities regardless of the reason for attendance and ensure that fixed sites in non-transmission zones vaccinate all children coming from transmission zones) 	<p><i>MOPH - National EPI Program WHO, UNICEF BPHS implementers</i></p>
<ul style="list-style-type: none"> Need to strengthen accountability of BPHS EPI reporting to provincial/national level as well as GCMU (and donors), including (depending on contract) rates of coverage (with independent scrutiny on data), outreach and mobile service provision, and development of health facilities in HRDs 	<p><i>BPHS implementers MOPH – GCMU, National EPI Program BPHS Donors</i></p>
<ul style="list-style-type: none"> Review BPHS contracts re requirements for coverage and facilities development; consider strengthening accountability line between BPHS service providers and provincial MoPH/National EPI Standing Committee 	<p><i>MOPH – GCMU, National EPI Program Donors</i></p>

2.0 Inaccessibility

Recommendation 2

Define ‘insecurity/inaccessibility’ more clearly at District level during SIA review/planning process; use maps to show trends in inaccessible areas over multiple SIAs. While the point of reference for inaccessibility must be the District, the analysis and detailed mapping should take place at the cluster and sub-cluster level

Use analysis to create a District-level inaccessibility strategy for forthcoming SIA including a checklist of strategic options (cancelling or deferring SIA where all checklist options have been exhausted)

RATIONALE

Insecurity, especially in the Southern Region, remains a clear threat to the programme. However, insecurity and resulting reports of inaccessibility during SIA rounds can be used as a blanket reason or ‘smokescreen’ to hide poor SIA work and missed children. We acknowledge that security is a problem but only genuinely affects access in small areas of Afghanistan. The larger problem is management and accountability as noted by the IMB. In the June round in the Southern Region, we estimate that some 80,000 children were missed due to no access and no campaign. In contrast, as many as 250,000 children were missed as a result of lack of delivery of vaccine because of poor planning and poor performance. For too long the programme has used security as a default explanation for why UN staff from the provincial or regional level cannot spend much time in the field supporting districts and clusters and monitoring activities. This must change and can change. While security risks do indeed preclude the travel of international staff, they do not always preclude field movements of (all) Afghan staff. The UN system, particularly the two agencies of WHO and UNICEF, must find ways to make the UNDSS system work for them, to allow UNDSS approved access of Afghan staff members to security high risk areas in ways that mitigate the risks faced by those staff and provide insurance mechanisms in the event of malicious acts. Other programmes have found ways; so must polio.

It is important to distinguish between 'hard insecurity' (areas in which there is active conflict, or presence of weapons such as landmines and other ordnance) and 'soft insecurity' (areas in which AGE and/or community are hostile to the PEI or where vaccinators harbour a perception of threat whether real or assumed). In cases of hard insecurity, some access may be achieved by utilising accurate mine contamination maps or by timing SIAs to capitalise on breaks in fighting. In soft insecurity areas, a wider range of options may be available, including negotiation (either with local AGE or with community, or supporting community themselves to engage with AGE), engagement of local partners (shuras, community and religious leaders etc.), enlisting of private practitioners, and closer support to and supervision of vaccinator teams.

The choice of strategies to confront insecurity and maximise access should be based on clear localised analysis from past SIAs, using a District-level map as a visual tool for planning those strategies and for assessing changes to inaccessible areas before and after each round. A checklist of strategic options for improving access in areas of hard and soft insecurity should be worked through in planning each SIA, and should be used as the basis for re-analysis of 'inaccessibility' after each round.

It should be noted that field staff interviewed in the Southern Region report that vaccinators who regularly cross lines between AGE and government-controlled areas experience a higher level of harassment from government and ISAF personnel than they do from opposition forces in AGE-controlled areas. ISAF and national and local Afghan police should be instructed to facilitate rather than impede campaign delivery.

DETAILED SUB-RECOMMENDATIONS FOR MOPH / UNICEF / WHO

- Strengthen current attempts to **map inaccessibility/insecurity** with overlay of available data from different sources to better understand factors that influence accessibility (ICRC Afghan Mine Action Coordination Centre, UNAMA and ISAF security analysis)
- Where possible **standardise partnership/relationship** with ICRC on local intelligence and strengthen communications with security forces at all levels of the health department - Ministry of Interior/Defence, Police, ISAF and AGE
- Although it is recognised that the polio programme may be most readily accepted in insecure areas when it is understood to be a humanitarian programme distinct from other international or multilateral programmes, there is no convincing argument in favour of investing in a large-scale 'humanitarian' branding exercise. Rather, in a more applied way, the **PEI on the ground should ensure that its 'neutrality'** and the benefit to the Afghan people are consistently and prominently stated. Interlocutors such as the ICRC can facilitate this message.

3.0 Communications and Demand

Recommendation 3

Focus all communications and social mobilisation activities on improving vaccinator performance

Prioritise interpersonal communication support for SIAs at community and vaccinator level with back up from mass media where evidence shows effectiveness. Avoid IEC.

RATIONALE

There has been a notable increase in investment in and action on communication and social mobilisation in the Afghan programme in the last 18 months. This is commendable. However, communication and social mobilisation strategies/activities should be entirely focused on the core programme objective – reducing the

number of missed children during and around SIA campaigns. Any investment that cannot demonstrate its contribution to improved operational performance should be terminated.

It should be recognised that liaison with communities is key to programme effectiveness especially in the high-risk districts for polio transmission. Establishing relationships, understanding local perceptions and priorities, and negotiating specific intervention protocols are pre-requisites for success – in a word, ‘*engagement*’. In this sense, communications and social mobilisation are core strategies, integral to operations to deliver OPV. But they must be based on sound localised analysis showing empirical relation to objective conditions (rather than generic assumptions about what local people think and do), and demonstrating impact that directly improves the operation of PEI. For instance, the limited effectiveness of IEC materials was reported from the governor down to cluster supervisors in the high-risk districts of Farah province yet significant investments have continued there in each round.

DETAILED SUB-RECOMMENDATIONS FOR MOPH / UNICEF / WHO

- Critically assess impact of **IEC** on SIA performance and missed children in HRDs and consider terminating if not effective
- Demonstrate reach of **mass media** outlets in HRDs/Clusters to validate investment in radio/TV
- Measure **impact of mass media** on demand (e.g. proportion of missed children due to ‘sleeping, sick, newborn’)
- Continue to **focus on raising awareness** of SIA dates through mass and local communications and measure impact against proportion of missed children due to ‘child not available’. Awareness of SIAs and PEI remains notably low in the transmission zone, and communications and social mobilisation activities must retain a core focus on awareness.
- Focus SM on 3 key issues:
 - Supporting **vaccinator teams** in reducing missed children at household (esp. sleeping, sick, newborn) before and during SIAs
 - Supporting (directly or indirectly) **communities** in negotiating SIA access with local AGE before and during SIAs
 - Supporting identification of community-level **SIA monitors** including female monitors where feasible (name, phone number etc) to enable real-time and post campaign monitoring
 - Ensure that social mobilisation personnel are able to work for **more extensive periods of time** prior to, during and after each SIA
- Incorporate supportive Islamic statements and verses in all forms of communications (e.g. verses from the Qur’an are especially for HRDs)

4.0 Cross-border Threat

Recommendation 4

Maintain and continue to strengthen border crossing vaccination (Pakistan) and consider inter-province vaccination transit points

RATIONALE

Epidemiological data suggest that a key risk factor for future progress in the polio programme in Afghanistan is continuing viral circulation in Pakistan and cross-border transmission. The mission team was impressed by the strong performance of Afghan vaccination border posts at official points including Torkham and Spinboldak.

However, the threat remains and should continue to be a major focus of programme attention. We recognise that the cross-border strategy will not prevent all cases of potential importation of polio; nonetheless, it presents an opportunity to give additional doses to high-risk groups, including migrants, nomads and mobile children.

DETAILED SUB-RECOMMENDATIONS FOR MOPH / UNICEF / WHO

- **Assess population flow** across authorised & unauthorised crossing points, and the potential value of additional fixed vaccination points
- Ensure data from **independent monitoring** (finger-marking survey) at border crossings are regularly fed back into the programme to validate and maintain high coverage
- Continue to strengthen complementarity between **Afghan and Pakistan NEAPs** on border activities and on opportunistic infection of children crossing borders and presenting to fixed health facilities
- Maintain emphasis on building **routine immunisation at border points** e.g. promoting community support for getting newborns into the routine system
- Consider **additional fixed posts at inter-provincial transit points**

5.0 Programme Coordination

Recommendation 5

Make better use of other sector, agency and programme experience, knowledge and information that is of use to the PEI – coordinate this at the national level and feed to provincial and district levels for improved microplanning

RATIONALE

Sometimes, programmes (in whichever sector) can develop tunnel vision. Other actors may have programmes or strategies of relevance to PEI aims that have been overlooked. For example, the polio programme continually struggles to recruit and supervise adequate vaccinators for SIA campaigns: mine action agencies (like the Mine Action Coordination Centre, Afghanistan) often have excellent experience recruiting, training and supervising staff at community level, often in highly insecure environments. This may also be the case with UN-Habitat's experience with the National Solidarity Programme (NSP). Education programmes often have high credibility at community level even in insecure areas, and provide ready access to primary- and secondary-level children, including girls. Dynamic and fast-moving contours of conflict mean that up-to-date, accurate security information is vital. There are a number of national and international agencies with considerable expertise and information in this field. These efforts are of considerable potential value to polio and there may be many more examples.

PEI in Afghanistan can also benefit from channelling messages through other sectors, through intersectoral engagement with a range of government ministries as well as major sectoral programme interventions by UN and non-government actors.

DETAILED SUB-RECOMMENDATIONS FOR MOPH / UNICEF / WHO / OTHER MINISTRIES

- At national level **map out partner agencies/programmes that have relevance to PEI** (e.g. education for

communications and health education access; MACCA for mapping mined areas; UNAMA/ISAF for localised security analysis and mapping; MACCA and UN Habitat for recruitment of local operational staff; WASH for sanitation and water access data etc)

- Ensure that polio is a true cross cutting concern of all UNICEF and MOPH community education programs

Concluding Observations

The team thanks the many people who supported our work in the midst of pressing programme management priorities. We recognise the distinct challenges posed by conditions in Afghanistan today – continuing conflict and insecurity, strategic shifts towards 2014 with the draw-down of ISAF, and complex, rapid shifts in the structure and orientation of anti-government elements. We recognise the very real risks that the PEI staff face every day in attempting to carry out the programme. And we recognise the critical, longer-term imperative of building a working health system providing vital services equitably across the Afghan population. In this context, we wholeheartedly commend the Afghan polio programme and its domestic and international partners, in the commitment they continue to show and the progress that has been made especially in the last 18 months.

That said, we note that – both globally and nationally – polio is a public health *emergency*. The term ‘emergency’ must elicit a new character in the programme’s response to the virus. If, as evidence suggests, the principal problem in the programme to-date is efficient, effective and verifiable OPV delivery at the doorstep in key high-risk areas, the emergency response must be to focus all efforts on delivery, organised at the district level, supported by a surge of technical support from provincial and even national or international sources. Those best placed to provide strategic direction, operational guidance and management oversight must be brought in and placed in a position to provide that support directly, every SIA round to the DEMA and its corps of vaccinator teams.

While the mission team was impressed with the key strategies of the NEAP, it was concerned to find that some 6-8 weeks after the commencement of the NEAP it was already behind schedule.¹² For instance, a review of performance against the NEAP defined performance indicators, such as recruitment of full DEMA teams in all high risk districts by end June, clearly showed that the new strategy was not being implemented in an emergency mode (none of the Government DEMA leaders were in place in the high risk districts, and only 7 of 13 (really 15) DPOs from WHO had been recruited, as of end June). Any emergency action plan, regardless of the soundness of its underlying strategies, is only of relevance if it translates into actions on the ground. This translation is not occurring promptly at the district level and the support staffing at the provincial, regional and national levels of the programme remains inadequate to meet the needs of the programme - a surge of personnel consisting of national staff (and international staff if required) for 12-18 months and beginning immediately is needed if the programme is to succeed.¹³

¹² Similarly, many of the recommendations of the 2009 independent review that have considerable overlap with the findings of our team have not been actioned. In 2009, it was said that people knew what the issues were but faced a problem in deciding how to address them. Now, while people still know what their broad issues are, they lack the detail that would improve planning. And while they know significantly more about how to go about addressing these (broad) issues, the programme has not yet provided the right kind of support to overcome these barriers and is not adequately checking that things are being done.

¹³ It should also be mentioned that the successes of the strong Indian programme with rigorous mechanism of oversight and checking might not simply be transferable to the Afghan context without appropriate adaptation