

Polio update: Afghanistan

As on 15/07/2015

Context

Afghanistan remains one of the only two polio-endemic countries in the world together with Pakistan, the two countries forming one epidemiological block.

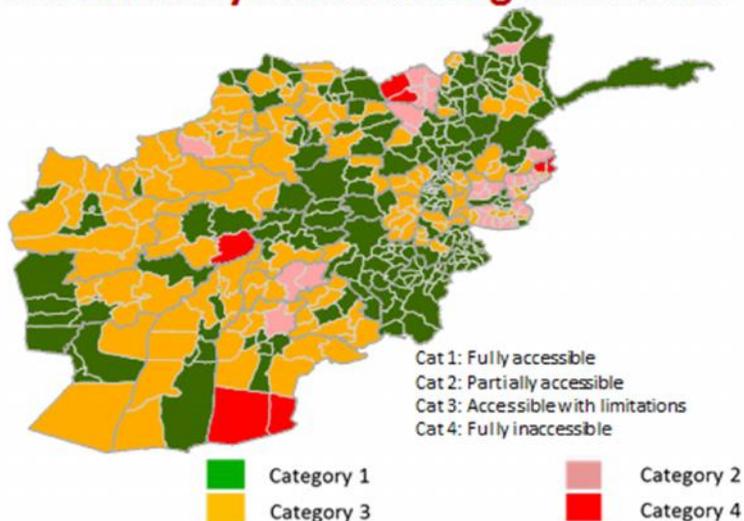
There has been significant progress in polio eradication efforts as evident by epidemiology- (transmission limited to small geographical area and no WPV in environment in 2016), improved population immunity and improved vaccine reach in high risk areas.

Polio eradication is at the top of Afghanistan's health agenda. In 2015/16, the Government of Afghanistan scaled up its efforts to accelerate polio eradication in the country amidst multiple complex challenges, including increasing conflict and insecurity in many parts of the country.

Afghanistan has unique security and access related challenge, making it very difficult to reach all children with vaccine.

- There are pockets under influence of AGE which are inaccessible for vaccination (category 2 and 4 in map below). The number of inaccessible children varies over campaigns and has deteriorated in the last 3 months. In the last NID (May 2016) more than 320,000 children could not be reached with the vaccine, most of these children are from Eastern and Northeastern Region.
- There are other areas including Helmand, Kandahar and Farah province of Southern/Western block, where although it is feasible to conduct vaccination campaign, ensuring quality of these campaigns is challenge (Category 3 in map below). These areas are under AGE influence and present extreme challenges in selection of appropriate vaccinators, monitoring & supervision and implementing accountability.
- It is important to reiterate that 32 of 47 very high risk districts have >50% of their area under control of AGEs.

Accessibility status during recent SIA



When the IMB last met in October 2015, it observed that the Afghanistan programme faced a number of key problems including the stagnant implementation of the NEAP. The programme faced significant gaps in coordination across the partnership at all levels and there was a lack of clarity in the governance structure of the programme. Key recommendations made were (1) establish an Emergency Operations Centre in Afghanistan, (2) non-Governmental Organisations that contribute to polio eradication in Afghanistan should be full members of the new Emergency Operations Centre and (3) review and redesign leadership, accountability and coordination arrangements.

From November 2015, a number of new developments have taken place during the low season for polio transmission to accelerate progress towards stopping transmission.

- Fully functional Emergency Operation Centers (EOCs) at the national and regional levels (3 high risk regions-East, West and South) in late 2015 with the aim to intensify, guide and coordinate efforts of all partners for NEAP implementation under one roof.
- Leadership of core implementing partners has been changed and continued emphasis across the programme has been placed on enhancing governance and coordination at all levels.
- NGOs are now an active part of the EOC structure and are fully engaged in all aspects of the programme.

Two meetings of the Technical Advisory Group have taken place in 2016, with the last meeting taking place from 12-13 June. ***The TAG noted the strong governance and coordination structures that have been established and appreciated the scale of the work being done in the last 6 months. The TAG acknowledged the progress made as evidenced by epidemiology, improvement in population immunity and improvement in quality of SIAs.***

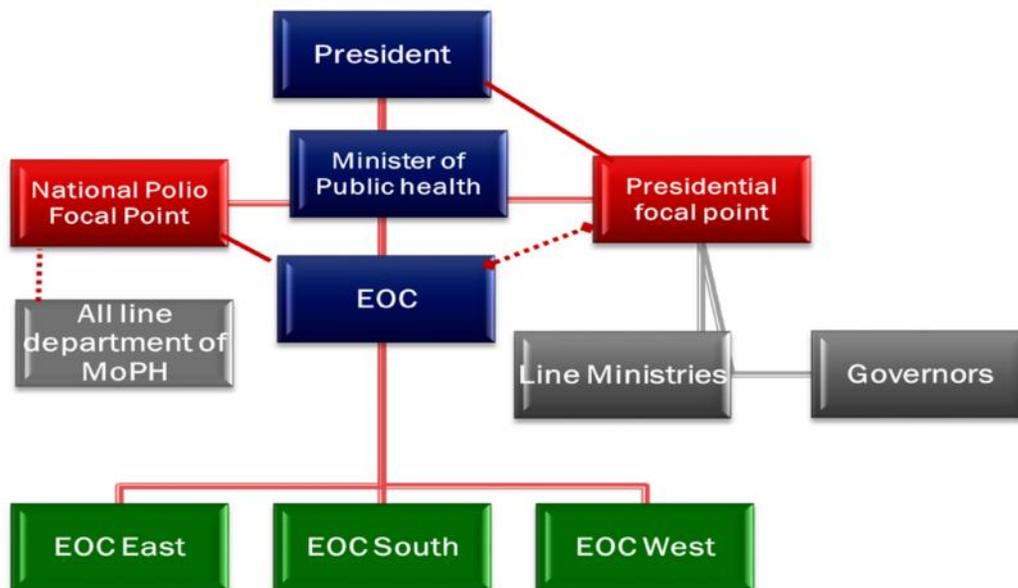
Governance, coordination and program management

Governance and coordination structures have been modified in line with the recommendation from 12th IMB to strengthen programme management and oversight, evidence based decision making, improved situational awareness, early problem detection and a coordinated response by both government and partners through dashboards.

The following steps have been taken to enhance management and oversight:

- EOCs established and made fully operational at National level and in 3 high risk regions (Eastern, Southern and Western). EOC plays central role in program management to ensure coordinated efforts for implementation of NEAP. Additionally Provincial Polio Coordination units are now fully functional in 5 high risk provinces for coordination within province.
- Regular communication channels have been established between the national and regional EOCs to enhance coordination. Members of the national EOC are regularly deployed to support regional EOCs. Monitoring and accountability officers are being deployed to all 47 high risk districts to strengthen linkages between the national EOC and the field level.
- Roles and responsibilities of polio high council, presidential focal point, minister's focal point and EOCs are clearly defined to avoid overlap. As a result of these structures there is strengthened coordination among implementing partners under the leadership of the government, including BPHS implementing NGOs.
- NGOs are fully represented in the EOCs at each level. There are regular meetings with BPHS NGOs to understand their contribution to PEI. BPHS implementing NGOs regularly participate in regional EOC meetings.
- Polio Steering Committee meets every six months and is chaired by H.E the President.
- Regular meetings of the Polio High Council ensures well-coordinated involvement of line ministries and partnerships with relevant departments.
- Governors of high risk provinces are closely involved in the polio program and are reporting to H.E the President and Polio High Council on monthly basis.

GOVERNANCE AND COORDINATION



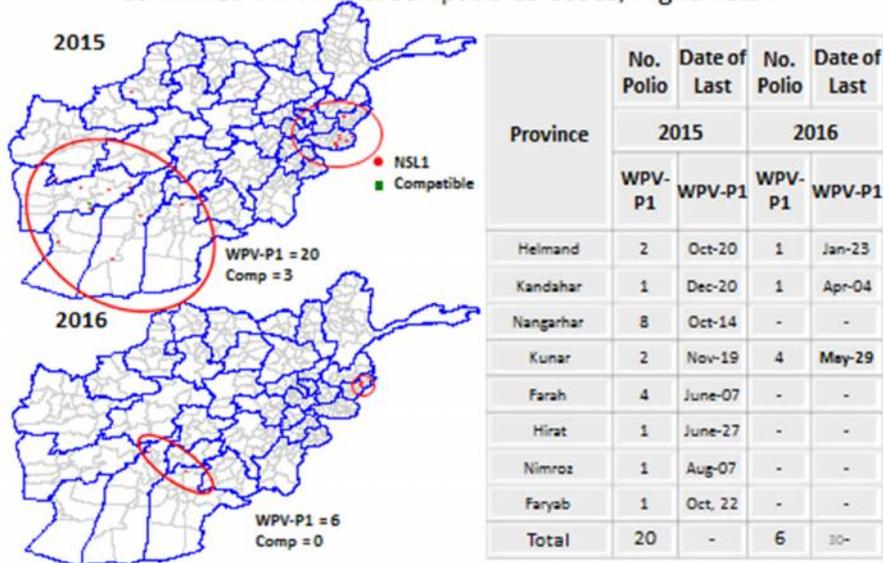
Review of implementation of National Emergency Action plan is undertaken on quarterly basis and EOC task tracker dashboards are modified accordingly.

Epidemiology

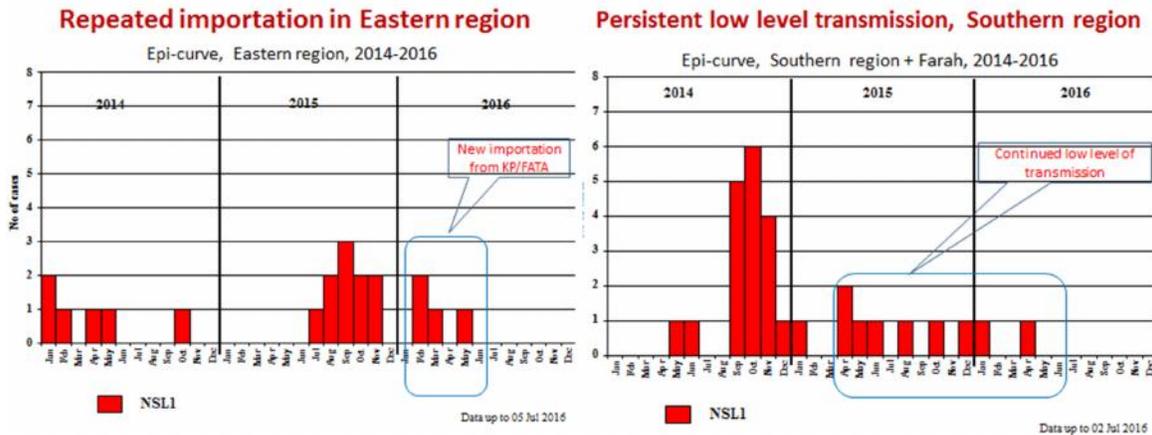
WPV1 transmission is now limited to small geographical area in Kunar province (Eastern region) and northern parts of Helmand and Kandahar province (South region).

Transmission limited to small geographical area

Confirmed WPV-P1 & Compatibles Cases, Afghanistan



- In 2016, there are 6 cases of wild poliovirus from 3 districts, 4 from Kunar (Eastern region), 1 in Kandahar and 1 in Helmand provinces (Southern region).
- 4 of the 6 cases are from Shegal district of Kunar province in a small geographical area (1.5 Km square) which has remained inaccessible for vaccination since 2012 and is at the border with Pakistan (Bajour agency, FATA). Ongoing transmission is limited to this small area which suggests reasonably high population immunity in the surrounding areas. This transmission is genetically linked to the transmission in Khyber/Peshawar.
- The cases from Helmand and Kandahar are linked to transmission detected in the same provinces in 2015 which indicates continuing low level of transmission in northern part of Helmand and Kandahar province.

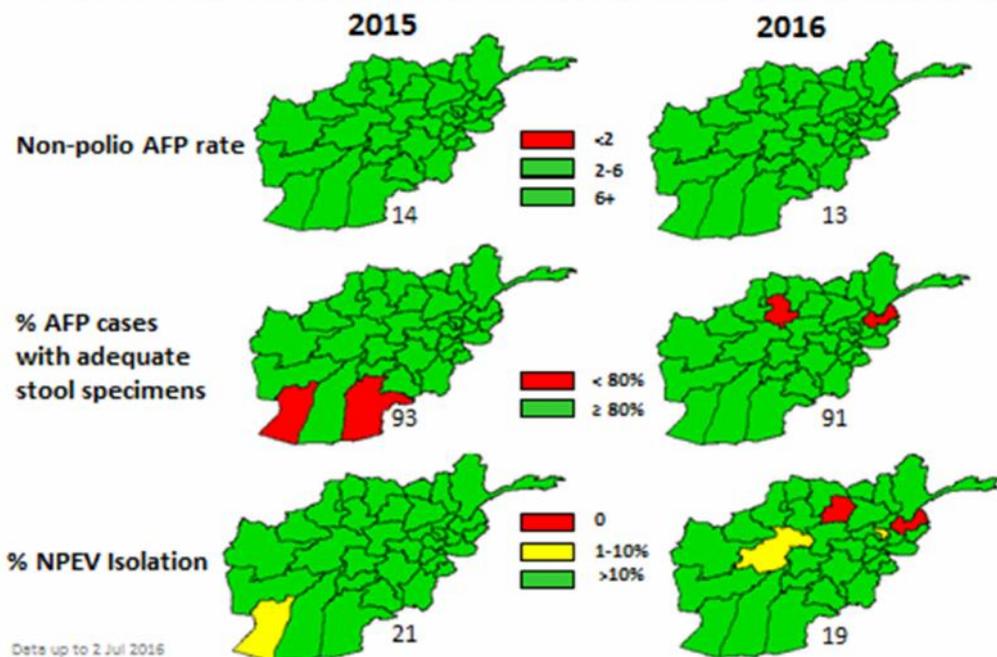


To date in 2016, no positive samples have been isolated from the environment. This is the longest ever period with no WPV in environmental surveillance since July 2014 when first positive isolate was reported.

Surveillance

Afghanistan is maintaining very high levels of surveillance with the NPAFP rate of more than 9, adequate stool rate of more than 80% and NPEV rate more than 10% in all regions and most of the provinces.

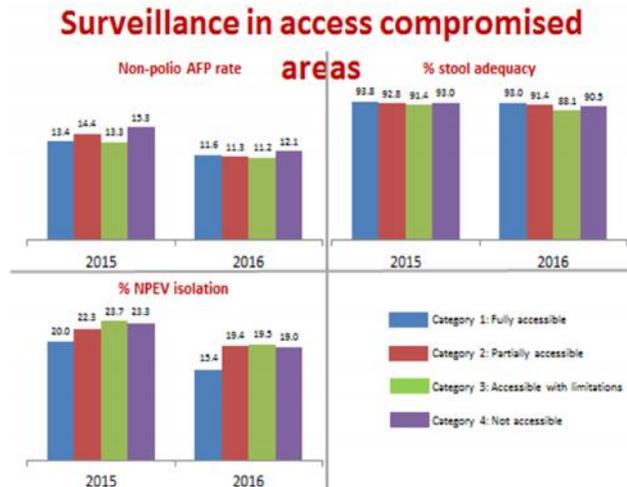
AFP surveillance: quality key indicators



In Afghanistan context, where insecurity is a programmatic challenge, it is important to highlight that sensitivity of surveillance is similar across different access/security categories.

Country also conducts environmental surveillance from 14 sites in 5 high risk provinces and Kabul.

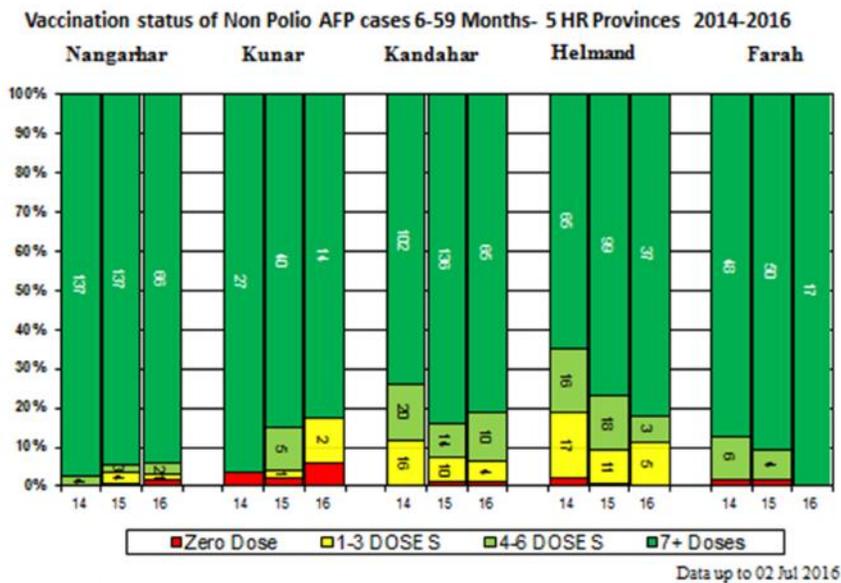
An independent surveillance review conducted in June 2016 concluded that **'circulation of WPV/cVDPV is unlikely to be missed in Afghanistan'**.



Improvements in population immunity and vaccine reach

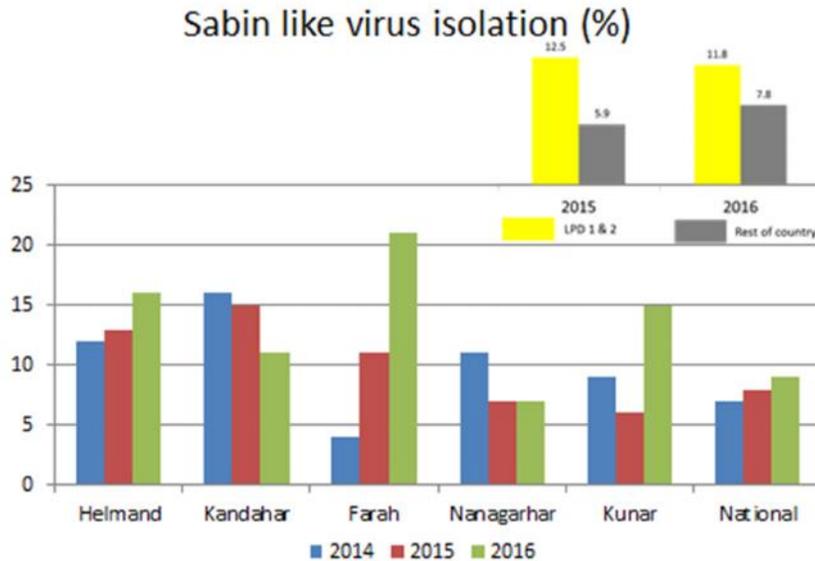
Data on OPV doses in NPAFP cases show improvement in population immunity particularly in the Southern region. Of the 5 high risk provinces, Helmand and Farah show significant increase in population immunity in 2016 as compared to 2015. Despite the improvements, immunity gaps remain a concern in Kandahar and Kunar provinces.

Improvement in population immunity



Analysis of Sabin-like (SL) isolation from stool specimens shows that the reach of vaccine is much higher in 'Very high risk districts' as compared to other areas. As compared to the national level, the SL isolation is also higher in Kandahar, Helmand, Farah and Kunar.

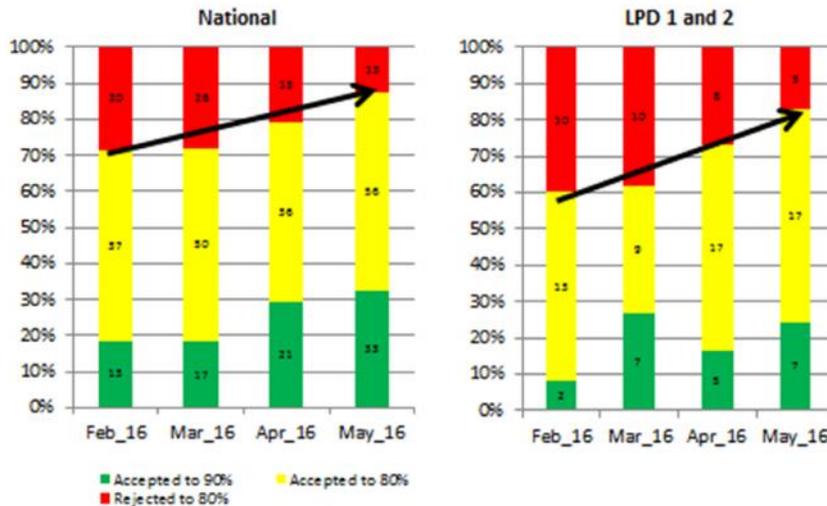
Indirect evidence of vaccine reach



Quality of SIA

LQAS data shows improvements in SIA quality over past 6 months. In the 47 LPDs, the proportion of failed lots has reduced from 40% in the February campaign to 17% in May 2016.

Progressive improvement in SIA quality LQAS results (Q1-Q2, 2016)



Among 5 high risk provinces, there has been significant improvement in Farah, Kunar and Nangarhar. There has not been major impact in Kandahar. LQAS results of Helmand have shown deterioration in past two SIAs.

Program interventions (Implementation of NEAP 2015-2016)

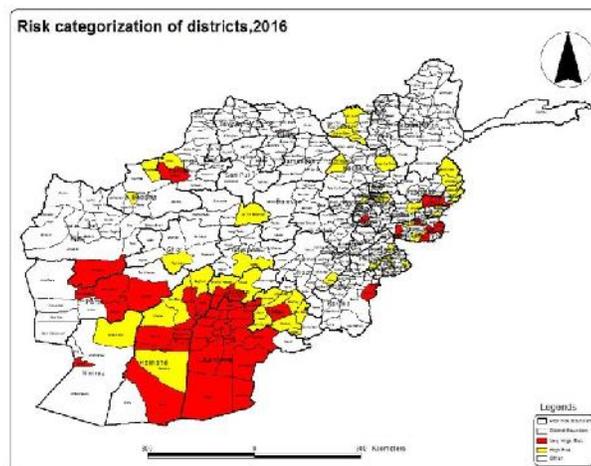
Following the IMB meeting in October 2015, Afghanistan accelerated progress in the implementation of the NEAP together with additional initiatives recommended by the TAG in January 2016.

As outlined in NEAP 2015-16, the program has focused on the 47 prioritized districts and 5 high risk provinces (Helmand, Kandahar, Farah, Nagarhar and Kunar). These initiatives are starting to translate into improvements in the quality of SIAs as seen in LQAS results.

Focus on high risk (prioritization)

An extensive process was undertaken in December 2015 to identify high risk areas within Afghanistan, based on polio virus epidemiology and other factors.

A total of 47 districts were classified as low performing districts (priority 1 and 2) based on epidemiology of WPV transmission, poor routine EPI and SIA coverage, gaps in population immunity and access challenges due to insecurity. These 47 districts are responsible for 84% cases in past 7 years. 5 provinces namely Helmand, Kandahar, Kunar, Nangarhar and Farah are considered high risk provinces.



Looking at the need of uniform intervention across LPD 1 and 2, country program has combined these 2 categories and now uses the term 'Very high risk districts' (VHRD) and 49 LPD 3 are termed as 'High risk districts' (HRD).

Focus of all initiatives, including deployment of additional human resources is on these prioritized areas.

High risk profiling including district specific issue and action plan

For every very high risk district (47 districts), district profiling has been done and integrated district specific plans have been developed on the basis of specific issues in the district, including operations and communications. These plans are updated and tracked after every campaign with the support of the national EOC to ensure that they address the issues identified.

Microplan validation and revision in Very High Risk Districts (47 districts)

Afghanistan initiated the process of field validation and revision of microplans in the 47 very high risk districts to ensure no missed pockets, rationalization of workload and development of integrated microplan with team and supervisor area maps and itineraries.

Microplan validation and revision has been completed in 37 of the 47 very high risk districts, with 7 more districts in process and 3 pending due to insecurity. These updated plans have led to team and supervisor workload rationalization and improved cluster level planning. As a result of this process a total of 276 new villages (with more than 14,000 children) have been identified and included in the updated microplans.

Nationwide implementation of modified revisit strategy

Afghanistan has implemented a modified 5th day re-visit strategy since March 2016 in all 5 high risk provinces; this was expanded to the whole country in the May NID. Teams now implement the campaign for 3 days with same day revisit, have a planning day on day 4 to ensure missed children are re-visited on day 5.

The data shows that an additional 270,000 children are now reached across the country which would otherwise have remain unreached without this strategy.

Revision of FLW training curriculum and strengthened training

The frontline workers training package was revised based on the recommendations of a training needs assessment conducted in 2015. The new integrated package includes both operations and communications and is based on adult learning principles. The package has been rolled out country-wide and is supported by close supervision at all levels.

Quality and attendance of training sessions is tracked and monitored through EOCs.

Field investigation and corrective action on rejected lots and areas with >3 missed children in PCA

Every rejected lot in LQAS and area with >3 missed children through PCA is now investigated in detail by a joint team to understand the root causes for inadequate quality and to ensure the corrective actions are included in the district specific plans to ensure better quality in subsequent campaigns. Also, these areas are recovered to reach unreached children during the campaign.

National and regional EOCs track the failed lots and corrective actions taken.

Strengthened monitoring and pre-post campaign review

The EOCs have placed particular emphasis on strengthening the pre and post campaign review process to take corrective actions ahead of, during and in-between campaigns.

Pre/intra/post campaign dashboards are used in the EOC to closely review all phases of the campaign cycle. Ahead of the campaign, the EOC now reviews the state of preparedness at key intervals (14 days/10days/7days/3days/ 1 day) to take corrective actions. If any area is not fully prepared 3 days prior to the campaign, the campaign is postponed and support from National level is provided for strengthened preparation. (Link to EOC Dashboard: <http://polio-eoc.org/dashboards/19/> user name: guest, password: guest)

After every campaign, review meetings are held at the EOCs, both national and regional level with the involvement of all key stakeholders, including NGOs. District plans and profiles are updated during these post-campaign review meetings based on the results of all data sets.

Data from ICM (intra campaign monitoring) and Administrative Coverage Data is being collected and reach to national EOC on daily basis during the campaign for real time corrective action. Post campaign monitoring has been strengthened- 100% supervisory areas of 47 very high risk districts are monitored in PCA and number of lots selected for LQAS have been expanded from 70 in Feb 2016 to 102 in May. Campaign monitoring data is now getting available to decision makers within 10 days at the end of every campaign.

National monitors to the HR provinces from preparatory phase

For every SIA campaign, the National EOC develops a joint monitoring plan to deploy 'National level monitors' in high risk areas for monitoring and supporting preparatory and implementation phase.

The former SIAs monitoring by national monitors has been transformed to supportive supervision in the preparatory and implementation phase of the campaign.

This process has been strengthened in past 6 months by expanding the number of national monitors, revising SOPs and tools and building capacity.

Additional complementary vaccination strategies

Cross border vaccination

Afghanistan has deployed vaccination teams at 17 border crossing points with Pakistan. Every month, these teams on average vaccinate more than 105,000 children under 10 years of age crossing the border.

Permanent transit teams

In order to reach to the children in inaccessible area, program uses additional strategy in form of permanent transit teams. These teams vaccinate every child moving in/out from the area, more than 6 million children were vaccinated in 2015 and 3 million in 2016. Number of these teams is modified as per the evolving situation and has been increased to 264 (recent addition done in Northeastern and Eastern region) as compared to 163 in January 2016.

Social mobilization

Findings from Harvard KAP study were used for guiding the communication strategy, which includes media and advocacy; social mobilization; household and community engagement including partnerships with religious leaders, medical professionals; development of education and edutainment materials; and training / empowerment of frontline workers. In the past 6 months emphasis has been placed on integration of demand generation activities into all components of the programme including district specific profiling/planning, training and microplanning. The immunization communication network has now been re-adjusted and is poised to be functioning full time to follow up on missed children during and in-between campaigns. The National Islamic Ulema Group is now fully functional and is supporting the engagement of key ulema in the high risk provinces and districts.

Building Partnerships:

During 2016, the program enhanced its focus on building up partnerships with other line ministries, line departments and health departments in the MoPH.

- Action plan with all line ministries including Ministry of Education, Ministry of Rural Rehabilitation, Religious Affairs, Afghanistan Telecommunication Regulation Authority, Afghan Red Crescent Society, and Directorate General of Local Governance have been developed
- Focus of these coordination is mainly on strengthening monitoring process, brining accountability, follow up of missed children and clearing misconception.
- International Islamic Advisory Group Conference was held in Kabul to clear misconception on religious ground. Subsequently, National Islamic Advisory Group was established and conferences are being held at provincial and district level.

Strategies for security compromised/inaccessible areas

The programme uses the following strategies to reach children in inaccessible/security compromised areas:

- Strong emphasis on maintaining programme neutrality
- Negotiations:

- Negotiations at local, regional and national level, through UN and third party channels.
- New channels of communication, with parties having influence in Eastern and North-eastern regions.
- Negotiations for quality of SIAs in areas 'accessible with security challenges'
- Inaccessible areas covered by 3 passages of SIADs as soon as it opens/becomes accessible. One of these campaigns is with IPV-OPV.
- Engagement of community elders and religious leaders.
- Permanent Transit Teams deployed around inaccessible areas
- Polio plus: Coordination with local NGOs to deliver polio vaccine as part of health package and Polio plus services. This has started in Kunar and Kandahar

Reasons for missed children

The Afghanistan programme under the leadership of the EOC, undertakes a very detailed analysis of the reasons for missed children at all levels. The reasons for missed children are categorized below.

- Inability to access children in inaccessible area (due to active fighting or explicit non allowance of vaccination activity)
- Children missed in the area where campaigns are conducted (e.g. children on move, refusals, missed area and poor team performance). Missed children are now being categorized at the cluster level.

Missed children due to access challenges

The number of inaccessible children varies from campaign to campaign, owing to the dynamic security situation on the ground.

- The security and access situation has deteriorated more rapidly in past few months. Around 320,000 children were not reached during the May campaign due to lack of access, most of these inaccessible children are from Eastern and North-eastern regions.
- The situation in the North-eastern region has remained static since late 2015 where program has been missing around 165,000 children.
- The situation in the Eastern region has deteriorated rapidly in April/May 2016, where the number of inaccessible children increased from 26,000 in March NID to 130,000 in May SNID.
- Access in the Southern region remains very fragile. The main challenge in the Southern region (Helmand, Kandahar) and Farah is difficulty in ensuring quality of SIA campaigns. These areas are under AGE influence and presents extreme challenges in selection of appropriate vaccinator, monitoring & supervision and implementing accountability.

Inaccessible children: Aug 2015-May 2016



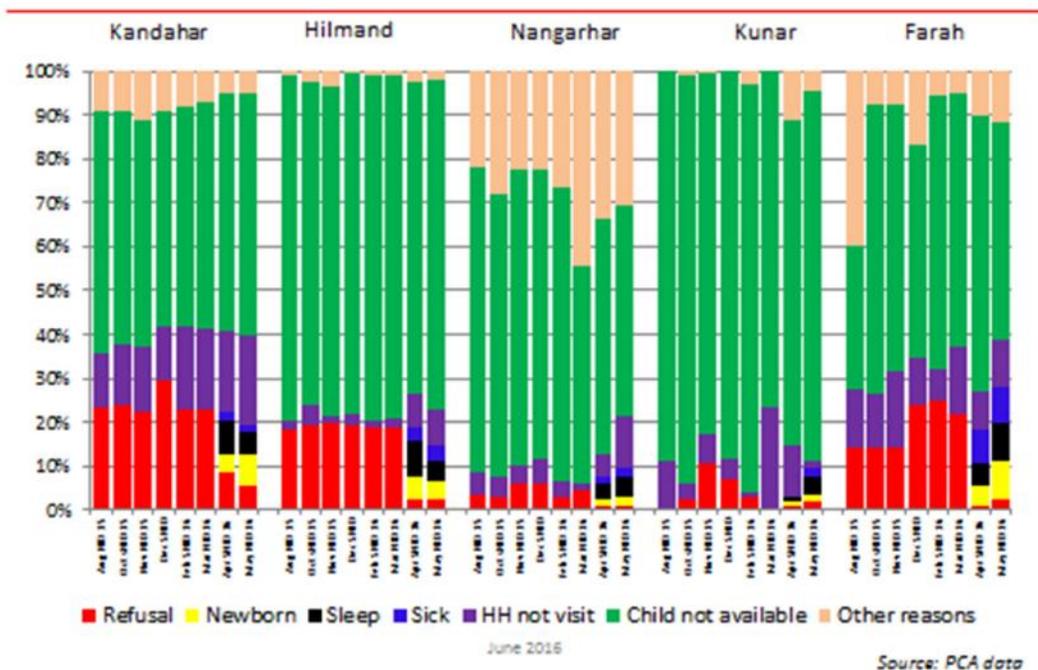
Region	Aug NID	Oct NID	Nov NID	Jan LPD SIA	Feb SNID	Mar NID	Apr SNID	May NID
East	51,327	106,913	57,232	41,744	22,938	25,869	30,555	131,781
North	18,880	0	22,756	0	0	0	0	3,376
NE	6,386	0	173,818	65,584	97,998	146,810	106,281	165,333
South	17,830	15,563	51,105	12,335	7,079	11,684	56,662	22,811
SE	830	1,793	2,020	0	380	0	380	400
West	672	0	0	0	0	0	0	0
Central	0	0	0	0	0	0	0	0
Total	95,925	124,268	306,931	119,663	128,395	184,363	193,878	323,701

Missed children in area with SIAs

The programme continues to use LQAs sampling to understand the quality of campaigns. LQAs has been expanded to all very high risk districts where security permits. There has been significant improvement in quality of activity in VHRDs with number of rejected lots in LQAs reduced from 40% in Feb to 17% in May 2016.

The programme continues to monitor the reasons for missed children at all levels and has recently added additional categories to further understand the social reasons for missed children. As shown below the main reason for missed children is due to child absent. However team missed children due to newborn, sick or sleeping children is also a concern. This analysis is now feeding into the district specific plans and profiling for corrective actions – both operational and communication.

Reason of missed children (Aug 15-May 16)



Challenges

- Volatile security situation resulting in the inability to access children in key regions of the country, particularly the east, south and northeast, leading to a build-up of susceptible children
- Maintaining programme neutrality to ensure vaccination activities reach every child across the country;
- Limitations in supervision and monitoring in three high risk provinces of South/West (Farah, Helmand and Kandahar) resulting in suboptimal campaign quality;
- Full implementation of the accountability framework at all levels remains a challenge;
- Sustaining motivation and commitment of frontline workers and all stakeholders;

Way forward (NEAP 2016-2017)

The National Emergency Action Plan for the period from July 2016 to June 2017 has been updated to further enhance the polio eradication efforts to ensure that Afghanistan achieves the goal of stopping WPV transmission. The NEAP was endorsed by the TAG, during their 12-13 July meeting.

The focus in 2016/17 will be on:

- Development of work-plan for NEAP 2016-17 and its full implementation with quarterly review of progress at National and regional levels.
- Consolidation and strengthening the quality of the new initiatives which are starting to yield results.
- Implementation of an accountability framework at all levels.
- Continued intensified focus on 47 very high risk districts.
- Implementation of strategies for gaining access in inaccessible areas and additional approaches/opportunities for vaccination (category 2 and 4 districts).
- Negotiate for quality campaign activities in areas 'accessible with limitations' (category 3).