

Global Polio Eradication Initiative

# Technical Advisory Group (TAG) on Polio Eradication in Afghanistan

Meeting Report, 17, 18 & 20 March 2021

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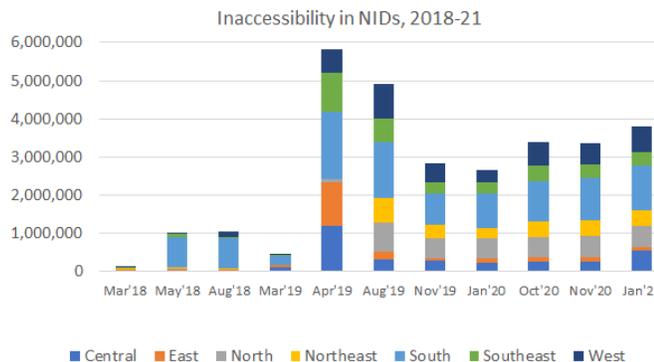
## Acronyms

AFP	Acute Flaccid Paralysis (surveillance)
AGE	Anti-Government Elements
EMRO	(WHO) Regional Office for the Eastern Mediterranean
EPI	Expanded Programme on Immunization
ES	Environmental Surveillance
FLW	Frontline Worker
GPEI	Global Polio Eradication Initiative
H2H	House-to-House (immunization activity)
NEAP	National Emergency Action Plan (for polio eradication)
NEOC	National Emergency Operations Center
NID	National Immunization Days
SNID	Sub-National Immunization Days
OPV	Oral Polio Vaccine
bOPV	bivalent Oral Polio Vaccine
mOPV2	monovalent Oral Polio Vaccine type-2
nOPV2	novel Oral Polio Vaccine type-2
tOPV	trivalent Oral Polio Vaccine
PEI	Polio Eradication Initiative
REOC	Regional Emergency Operations Center
RI	Routine Immunization
ROSA	(UNICEF) Region of South Asia
SIA	Supplementary Immunization Activity
TAG	Technical Advisory Group (for polio eradication)
cVDPV2	circulating Vaccine-Derived Poliovirus type-2
WPV1	Wild Poliovirus type-1

## Introduction

### Context

The Polio Eradication Initiative (PEI) in Afghanistan with sustained inaccessibility since April 2019 oscillating between 5.8 to 2.6 million missed children during NIDs, has weathered an exceptional confluence of additional challenging circumstances, facing co-circulation of both wild poliovirus type-1 (WPV1) and circulating vaccine-derived poliovirus type-2 (cVDPV2) in the context of deteriorating security situation across the country. Continued ban on house-to-house



mass vaccination campaigns by Anti-Government Elements (AGE) have severely limited the programme's capacity to respond to the twin outbreak particularly in areas with comprehensive bans in place. While normal life was disrupted by the COVID-19 pandemic across the world, it also hindered polio eradication interventions and added to the mounting challenges to the programme.

Appreciating the challenges faced by the polio eradication team in Afghanistan, TAG notes resilience in maintaining core programme functions throughout this period. TAG also recognizes political commitment at the highest level despite COVID-19 priorities and appreciates the bold national decision of resuming outbreak response during the tough and uncertain times during pandemic; successfully limiting the potentially explosive outbreak of cVDPV2. The continuing courage of the programme's frontline workers (FLWs) is remarkable and must be applauded. TAG condemns any act of violence against the polio FLWs and offers deepest condolences to the families of the brave heroes who laid down their lives in line of the noble cause of polio eradication.

### Pillars of Afghanistan Polio Programme Resilience

- Rigorous **humanitarian neutrality** and commitment to universal child health
- Strong **One Team approach**
- **Maintaining programme essential functions** – surveillance, transit vaccination
- Achieving and holding **gains in accessible areas**
- Flexible **multipronged approach to access negotiation**
- **Agility using every opportunity** to vaccinate in a dynamic environment
- **Creative solutions** to local vaccination & strengthening EPI

**Key Recommendation:** *In a highly unpredictable operating environment, the programme can build new opportunities for progress on these pillars of resilience. The programme must develop contingency operational plans building on these pillars of resilience as the country enters a phase of increased political and security uncertainty.*

The programme now has an opportunity to renew its efforts - to go beyond levels of programme quality achieved to-date. It must do this if the primary objectives of Afghanistan's National Emergency Action Plan (NEAP) 2021 are to be reached. Afghanistan has interrupted WPV transmission in the past and can do so again. Lack of sustained vaccination access, particularly in the South, remains the biggest hinderance to eradication. But programme quality in *accessible* areas, where a majority of population resides, is equally critical to secure gains made so far, and to make the additional gains necessary to reach the final goal. In accessible areas, all energies must now be focused on raising the programme to a new level of quality and coverage, driving down to an absolute minimum all children missed – *for any reason* – during all Supplementary Immunization Activities (SIA). Resolving inaccessibility continues to be an urgent need. The programme must improvise and deploy innovative contingency strategies which can be shown to effectively reach as many children as possible in the meanwhile. Building a supportive context of high-functioning EPI will be key to reaching and sustaining eradication.

Across the epidemiologic block there is a window of opportunity in the Northern Corridor to stop transmission of both WPV1 and cVDPV2. With new leadership in the Ministry of Health, WHO and Unicef, there is a unique opportunity to strengthen coordination and commitment for polio eradication.

The Afghanistan NEOC sought guidance from the TAG on several technical aspects of the programme with defined questions. TAG, through working groups, deliberated on the questions through extensive discussions and review of available information before the virtual TAG meeting.

The virtual TAG meeting was conducted on 17 and 18 March followed by feedback from the TAG on 20 March. The videoconferences facilitated the participation of representatives from the national and regional governments, NEOC and REOCs, GPEI partners and Observers (e.g., from donor agencies, civil society organizations). Most of the TAG meeting and feedback were attended by HE the Minister of Health. TAG Members participated actively throughout the extended period of pre-TAG and TAG meetings; this is particularly noteworthy in light of the constraint of being spread across 13 time zones.

## Findings and Recommendations

### Programme Leadership

TAG appreciates the high-level commitment of the National Government and welcomes actions being taken to enhance coordination and accountability across the partnership. Although business continuity was impacted by changes in leadership in the Ministry of Health, WHO & UNICEF during 2020, the TAG believes that new leadership across the partnership presents an opportunity to strengthen coordination and commitment for polio eradication. TAG emphasizes the vital role of *One Team* approach in achieving the eradication goals and highlights the critical importance of fully integrating operational and communication strategies and activities.

The single poliovirus epidemiology interlinking Afghanistan and Pakistan continues to require the highest possible degree of strategic coordination. Both programmes should continue to work closely in synchronizing planning and implementation of activities at all levels.

TAG endorses the EOC management review and encourages rapid completion and implementation of findings. This is an invaluable opportunity to build on existing strengths and streamline EOC management processes contributing to better programme efficiency. The outcomes of this review should be used to

develop an operational accountability framework with clear roles and responsibilities of individuals, agencies, Government, and donors/partners. The review should further empower REOCs/PEOCs for optimal functioning with necessary local-level flexibility, adequate human resources, and supportive supervision mechanisms which are primarily field-based.

Programme neutrality remains critical to the programme's success in the current political and security context. TAG strongly endorses the commitment of all partners and stakeholders to the absolute neutrality of the polio programme. Every opportunity for dialogue, at all levels, must be exploited to enable the programme to mount rapid and effective responses to the virus. Efforts should be made to address gaps in essential health services in extremely underserved populations, clearly identified in the Integrated Service Delivery Plan endorsed by H.E. the President of Afghanistan. H.E. Minister of Health should consider convening essential health programmes, donors, and partners to help provide the technical and financial assistance needed to ensure delivery of integrated essential health services in the most deprived populations.

### Key recommendations on programme leadership

- TAG re-emphasises the vital role of the **One-Team approach** in achieving GPEI goals in Afghanistan.
- Afghanistan and Pakistan are part of one epidemiological block – further strengthen and streamline **cross border coordination**.
- **Empower REOCs/PEOCs** by providing flexibility, adequate human resources and field based supportive supervision.
- Conduct planned **management review of EOC** rapidly. Outcomes of this review should guide the programme to develop an **operational accountability framework** with clear roles and responsibility across the partnership.
- TAG strongly endorses the commitment of all partners and stakeholders to the **absolute neutrality** of the polio programme.
- Continue **supporting negotiation at all relevant levels** to be able to respond with agility to every opportunity for improving access and vaccinating all eligible children.
- The **Integrated Services Delivery Plan**, endorsed by H.E. the President, clearly outlines significant gaps in essential health services. H.E. Minister of Health should consider convening essential health programmes, donors, and partners to help provide the technical and financial assistance needed to ensure delivery of integrated essential health services in the most deprived populations.

### NEAP 2021

TAG appreciates the bottom-up approach to developing NEAP 2021, with details of interventions designed for region-specific challenges. TAG observes that the draft NEAP 2021 takes into account the emerging epidemiology, challenges and evidence of progress through clear analysis and welcomes the focus on programme quality, management and accountability with a clear gender focus. TAG urges NEOC to start implementation of NEAP 2021 by early April incorporating the recommendations of TAG made during its meeting in March.

## Key recommendations on NEAP 2021

TAG recommends the following in addition to the interventions in NEAP 2021:

- **Strengthen measurability of NEAP interventions.**
- Ensure link between operational strategies and geographical risk categorisation and community engagement.
- Benchmark realistic targets and timelines for coordinating, implementing and monitoring **South Region Plan** (e.g., EPI/outreach).
- Strengthen accountability for **programme quality at local level** in accessible areas of South/Southeast:
  - Systematise use of key performance indicators to improve intra-campaign management and inter-campaign course correction, including: FLW recruitment, microplan validation, community engagement, EPI/Integrated Services.
- **Map footprint of different interventions in inaccessible areas**, strengthen coordination & monitor reduction in white areas through these interventions.
- **Integrate gender:**
  - Develop specific Gender objectives.
  - Integration of women at all levels of the programme beyond FLW, in a safe and secure environment, in community engagement and in communication.
  - Develop clear national and regional criteria for recruitment of females at all levels of the programme and address challenges related to their recruitment and supervision.
  - Programme should develop partnerships with Women Organizations.
  - Integrate sex disaggregated data for all evidence generated.

## Strategic programme objectives by end Q3 2021

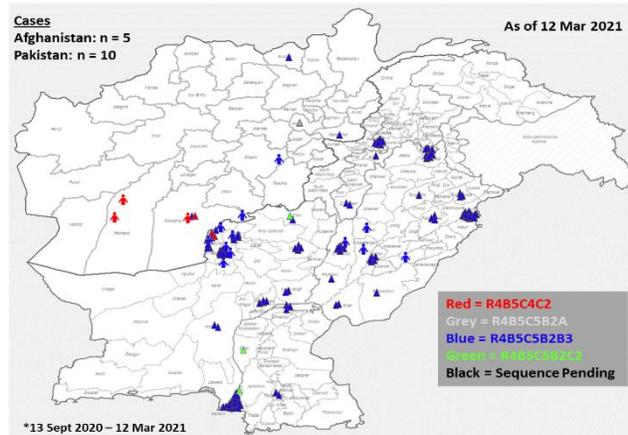
In view of the current epidemiological and programmatic context, TAG recommends following strategic objectives for the programme for next 6 months.

### Strategic Programme objectives by end Q3 - 2021

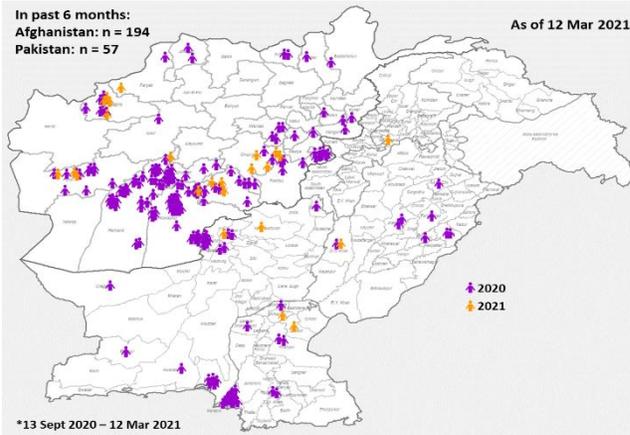
- Stopping cVDPV2 from accessible areas
- Limiting WPV1 transmission to core reservoirs in inaccessible areas
- Maximizing the vaccine footprint in the inaccessible areas
- Revitalize programme management structure

## Epidemiology and Risks

### WPV1 Cases & ES+, AFG & PAK, Past 6 Months\*



### cVDPV2 Cases, AFG & PAK, Past 6 Months\*

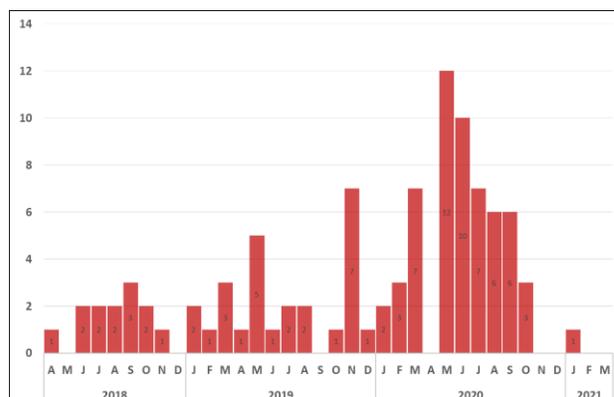


## Epidemiological block continues to confront co-circulation of both WPV1 and cVDPV2

### WPV1

In 2020, 56 WPV1 cases were reported – a dramatic increase over previous years. The progressively deteriorating access situation for polio SIAs since April 2019 has been the primary reason for further geographical spread. The immunity gap is further worsened by sub-optimal SIA quality in accessible areas compounded by the 4-month pause in SIAs throughout the country due to COVID-19, and extremely low routine immunization coverage in some of the most vulnerable communities. The situation was worsened by outbreak of cVDPV2 that competed with WPV1 outbreak response.

### WPV1 Cases, Afghanistan, 2018-21



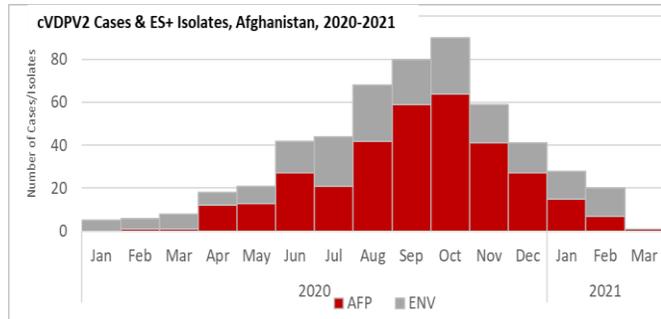
WPV1 cases were reported from 14 provinces, many of which were previously considered polio-free. From July 2020 (i.e., since the last TAG meeting) to date, 23 cases were reported from 8 provinces, with the majority of cases (15, 65%) from the South Region, followed by the Southeast Region with 7 (30%) cases, driven by an outbreak in Khost Province. No polio cases have been reported from the East Region since the last TAG meeting – it has been over one year since a case has been reported from the East Region (from Kunar Province, 5 March 2020 onset date) and environmental surveillance (ES) has isolated WPV1 only two times since July 2020 (both from Nangarhar Province, in July and in October 2020).

There is a marked decrease in WPV1 transmission in the 4<sup>th</sup> quarter of 2020 and 1<sup>st</sup> quarter of 2021. While the resumption of SIAs likely contributed to this reduction in the east, west and north of the country, in

the south, the decline in WPV1 cases and ES-positive samples may be due to naturally induced immunity, and WPV1 transmission seasonality.

## cVDPV2

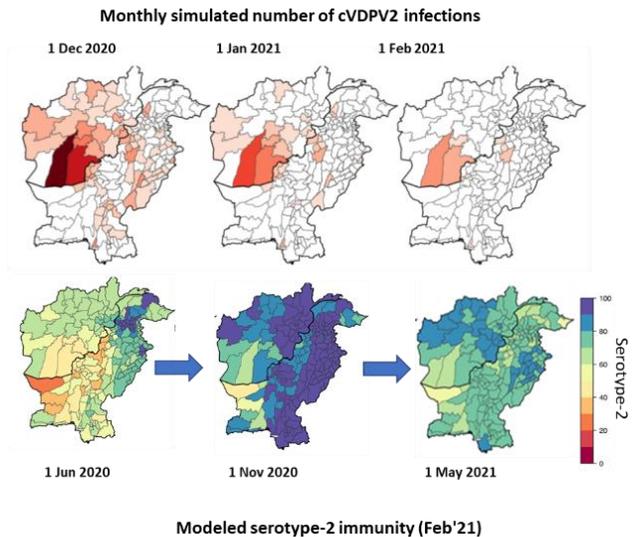
The cVDPV2 outbreak continues and has expanded geographically with recent cases primarily reported from areas with ban on house-to-house vaccination. In 2020, 308 cVDPV2 cases were reported and as of April 1, 2021, 24 cases have been reported in 2021.



The outbreak that began with detections in the East Region in early 2020 spread throughout the country during the year. In response, a number of SIAs with tOPV were conducted starting in July 2020 – essentially covering all accessible areas of the country with tOPV at least twice, resulting in a decrease in cVDPV2 transmission in accessible areas towards end of 2020 and into 2021.

A large cohort susceptible to cVDPV2 poliovirus is the key driver of cVDPV2 transmission in Afghanistan which is compounded by increase in areas with ban on house-to-house vaccination, a weak routine immunization system and pause in vaccination due to COVID-19.

Modeling data suggests that risk of transmission was reduced due to large-scale mOPV2/tOPV rounds in the second half 2020. cVDPV2 transmission will continue into first half of 2021, but significantly fewer cases are expected. cVDPV2 is especially likely to persist in areas with ban on H2H vaccination campaigns.

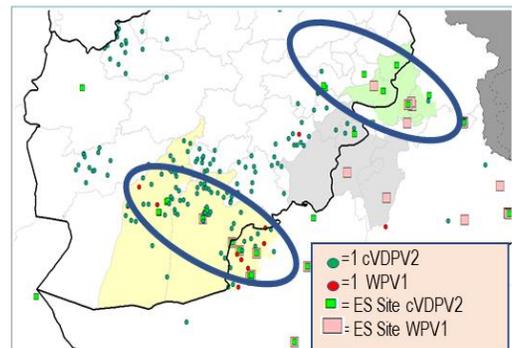


To ensure transmission is stopped in accessible areas and to protect against risk of circulation in inaccessible ones, additional high-quality type-2 SIAs + IPV (through RI) are recommended.

## Opportunity

Across the Northern Corridor of Afghanistan and Pakistan, there has been a substantial reduction in cVDPV2 and WPV1 transmission over the past 6 months. With concerted efforts to deliver high-quality SIAs on both sides of the border, there is an opportunity to shut down transmission of both WPV1 and cVDPV2 across the Northern Corridor. In the Southern Corridor, with persistent transmission of both WPV1 and cVDPV2, there is a need to intensify efforts in both accessible and inaccessible areas as well as enhancing cross-border coordination.

## WPV1 & cVDPV2 (Oct 20-Mar 21)



### TAG Recommendations on WPV1 Strategy 2021

It is likely that WPV1 transmission will persist in an area until >90% of children can be reached consistently. The TAG recommends the following approaches across the different regions of Afghanistan based on epidemiology, transmission history, immunity levels, and access.

- For the **Central, North, and Northeast Regions**, immunity levels are generally higher and there has been limited transmission in these areas. An approach should be taken in these Regions to interrupt transmission and maintain immunity levels through 4 type 1 SIAs and RI strengthening and to rapidly and effectively respond to any WPV1 detections.
- For the **East, Southeast, and West Regions**, given recent transmission patterns, inaccessibility challenges, and a growing immunity gap, additional efforts are required to contain and stop virus transmission. In addition to the approaches above, 2 additional type-1 SIAs should be conducted. Intense efforts should be made to reach children in inaccessible areas of these Regions, including seeking approval of site-to-site or mosque-to-mosque campaigns, implementing multi-antigen campaigns, and expanding OPV delivery at health facilities and through EPI outreach.
- **For the South Region**, WPV1 transmission continues, and the risk of expanding transmission is very high. Additionally, more than 50% of children live in areas inaccessible for SIAs. In addition to the approaches outlined above for accessible and inaccessible areas, the programme should seek to gain access for campaigns through all possible channels and comprehensively implement the integrated services plan to build immunity as much as possible in inaccessible areas.

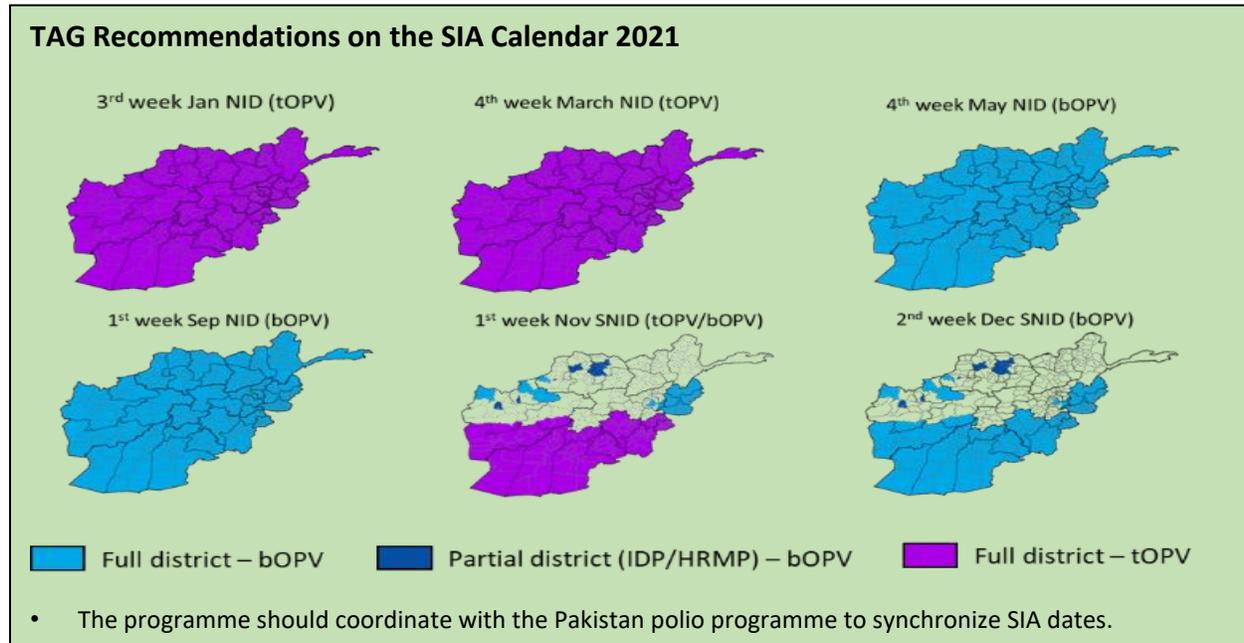
### TAG Recommendations on cVDPV2 Strategy 2021

Similar to WPV1, it is likely that cVDPV2 will persist particularly in inaccessible areas until >90% of children can be reached consistently.

- With the tOPV NID completed in March, the programme should pivot to a containment and response approach.
- If any cVDPV2 is detected outside of the inaccessible areas, 2 type-2 SIAs should be rapidly implemented.
- Additionally, although conditions for large scale nOPV2 use will likely not be present in 2021 in Afghanistan, the programme should prepare to potentially utilize nOPV2 to respond to breakthrough transmission in accessible areas after all nOPV2 readiness criteria have been met.

## SIA Calendar

TAG suggested changes to the SIA plan proposed by the NEOC to further accelerate efforts of stopping transmission of cVDPV2 in 2021. These suggestions include expanding the footprint of tOPV to include the entire country during the March 2021 National Immunization Days (NID), and to include tOPV in districts of the South, Southeast and West regions during the November 2021 SNIDs.



## Case Response

The complexity of co-circulation of WPV1 and cVDPV2 in the context of some areas being accessible to H2H campaigns and some areas being inaccessible to H2H campaigns, requires the programme to be flexible as regards vaccine choice and delivery methodology.

**TAG Recommendations on Case Response in Areas Accessible for H2H SIAs**

If the following is detected in the area:	Use the following vaccine for response:
WPV1	bOPV
cVDPV2	tOPV or nOPV*
WPV1 and cVDPV2	tOPV

\*Prepare for nOPV2 use for responding to breakthrough transmission in accessible areas

**TAG Recommendations on Case Response in Areas Not Accessible for H2H SIAs**

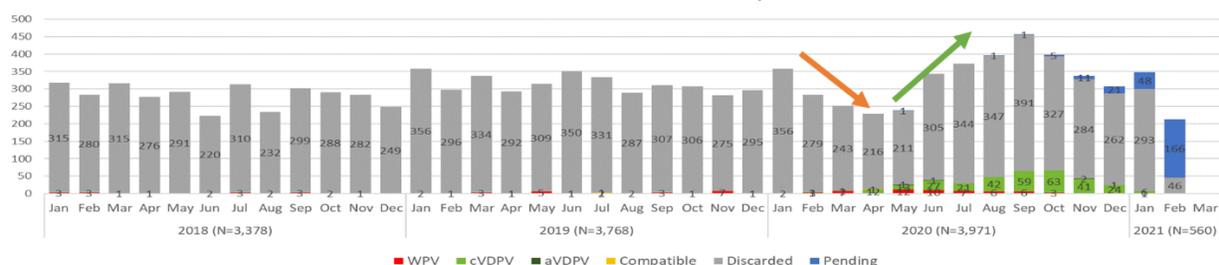
- Rapidly deliver 3 tOPV Short Interval Additional Doses (SIADs) for any area where access is allowed.

## Surveillance

**Question to TAG:** What additional interventions TAG recommends not to miss polio transmission and isolation of orphan viruses?

The polio surveillance system in Afghanistan remains strong for both acute flaccid paralysis (AFP) and environmental surveillance (ES) – not only making a good recovery from the negative impact of COVID-19, but also contributing valuable expertise to combatting COVID-19.

*AFP cases – National level trend, 2018-2021*



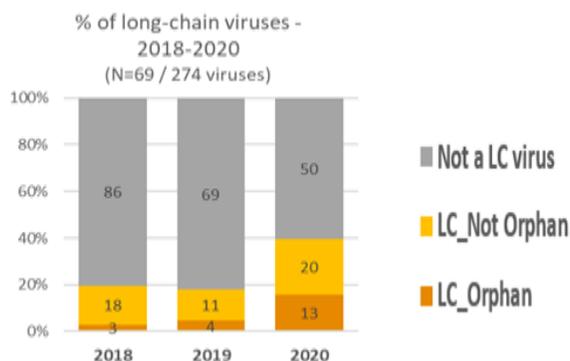
With extensive AFP surveillance network of >40k reporting volunteers, Afghanistan programme continues to meet the main surveillance indicators, including in areas inaccessible to SIAs. The footprint of areas accessible for AFP surveillance continues to be larger than the areas accessible for SIAs; however, there are signs that access issues are adversely affecting AFP surveillance in South region, including delays in case detection and sub-optimal stool adequacy rates.



Source: Tableau, data as of 31-Dec-2020, accessed 02-Feb-2021

**Compatible cases:** One issue that the programme needs to reconcile is the very low number of polio compatible cases, i.e., polio compatible cases are possibly being discarded inappropriately. Polio compatible cases should not be viewed as a threat to programme quality or credibility; rather, the existence of polio compatible cases should be regarded as an opportunity to improve surveillance system.

**Orphan viruses:** Genomic sequencing of a poliovirus isolate with  $\geq 1.5\%$  nucleotide divergence in the VP1-coding region from previously identified poliovirus isolates (i.e., an “orphan” virus), indicates prolonged undetected circulation and gaps in AFP surveillance. There has been an



increase in the overall number and proportion of long-chain viruses<sup>1</sup>, especially with orphan viruses: from 3% in 2018 to 16% in 2020. As of November 2020, 13 orphan viruses (12 from cases, 1 from ES) were reported from 8 provinces – all of which were from areas inaccessible to SIAs in November 2020, as follows: Kandahar (n=5), Uruzgan (n=1), Zabul (n=1), Herat (n=2) and Badghis (n=1).

### **TAG Recommendations on Surveillance**

- Assess and address gaps in the South Region regarding delays in case detection and low stool adequacy.
- Contact sampling: **consider 3 samples per case rather than 5** to optimize efforts and resources.
- Healthy Children stool sampling should not be routinely conducted, in line with global guidance.
- Review ERC and take strengthening measures prior to next meeting.
- Carefully assess polio volunteer workforce; evaluate contribution, document lessons to utilize more efficiently.
- In inaccessible areas:
  - Verification of process and indicators is key.
  - Implement, document and monitor supervision.
  - Innovate modes of surveillance in inaccessible areas.
  - Stratified analysis by type of access for immunisation vs surveillance should be regularly conducted.
- **Environmental surveillance (ES)**
  - Continue exploration of ES expansion based on feasibility and risk; establish ES in Ghazni, as it is the largest city in Southeast.
  - Need to regularly monitor indicators by ES site and take action.
  - Consider reverting back to monthly ES sampling in Kabul, Kandahar and Helmand.
- **Orphan Viruses**
  - Continue to work with Pakistan and Hub in reviewing details and areas where transmission may have been missed in preparation for field reviews.
  - Establish a rapid response unit that will support the additional review and investigation (e.g., the 'A-team' model to investigate flags as used in Pakistan).

**Question to TAG:** Does TAG recommend sero-studies of confirmed polio cases to further determine the immunity level?

Afghanistan has conducted sero-surveys in past, result of sero-survey conducted in 2019 is still pending. Currently there are many areas which are under-immunized and are inaccessible for SIAs.

### **TAG Recommendation on Sero-Studies**

- Sero-studies are not recommended at this time.
  - Many areas still un- and under- immunized – and access for SIA is difficult.
  - Lab testing – CDC has backlog; 2019 sero-survey specimens still waiting for testing.
  - Facility based sero-surveys have limitations on generalizing results.

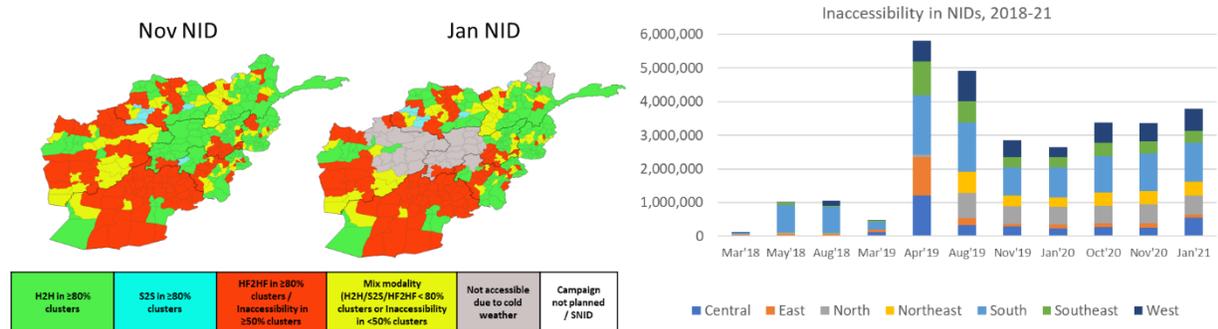
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<sup>1</sup>Long-chain (LC) viruses: ≥1% divergence (Orphan virus: ≥1.5% divergence; non-Orphan virus: 1%-1.4% divergence)

## Vaccination in Critical Areas

### Inaccessibility

As mentioned in previous TAG meetings, inaccessibility remains the **major threat** to interrupting polio transmission in Afghanistan. The TAG acknowledged that the programme is working towards maximizing the vaccination footprint in inaccessible areas through alternate approaches e.g., under the South Region Plan; however, there is urgent need for a more coordinated approach to getting vaccine in inaccessible areas and reducing “white areas.”



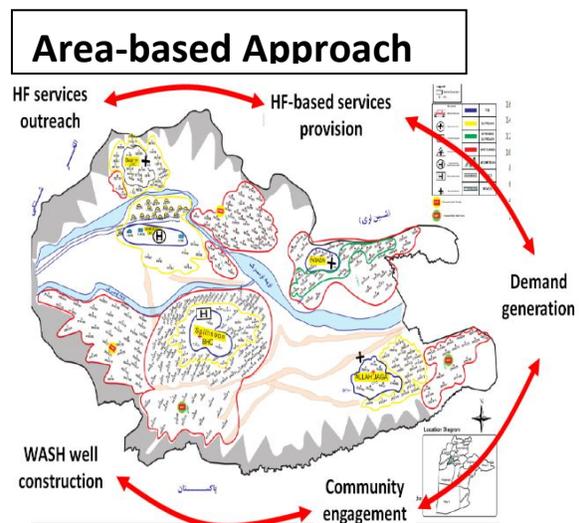
### TAG Recommendations on Access:

- Rigorously maintain **programme neutrality**.
- Develop a **coherent and consistent access negotiation approach** and coordinate its application at all levels to obtain access for various vaccination modalities (H2H/M2M campaigns, outreach, multi-antigen campaigns, PIRI, and mobile health teams).
- Strive for H2H access but **remain flexible** on alternatives (site-to-site, mosque-to-mosque, etc.).

### South Region Plan

*Questions to TAG: Does the TAG endorse the South Region Plan? If yes, what should be the measure of assessing the impact of these interventions?*

The South Region Plan is a much-needed opportunity for stronger coherence and coordination between programme actors and activities in inaccessible areas. **Implementation of the South Region Plan is of highest priority for Afghanistan.**



## TAG Recommendations on South Regional Plan:

The programme should move urgently developing an operational version of the Plan focusing on:

- Developing an **area-based approach** integrating immunization and community development activities in specific target localities.
- Integrating communication strategies with operational activities for combined impact.
- Tracking progress on implementation of activities in detail, including steps to take when implementation is off-track.
- Measuring impact on vaccination and demand for vaccination through area-based methods:
  - **Qualitative data** (focus group discussions, key informants)
  - **Quantitative data** (field or remote household survey)
- Final results of the facility assessments in southern region should be provided to TAG; and shared with Sehatmandi and polio partners so that the findings can inform the Southern Region Plan.

## Routine Immunization (RI)

**Question to TAG:** *In addition to monitoring support provided by PEI, in what other areas can PEI and EPI collaborate to fast-track eradication?*

TAG appreciates MoPH policy to deliver OPV to all children under 5 years at all health facilities, and also acknowledges the work done to improve oversight and monitoring of immunization and PHC services. BPHS-Plus has demonstrated the value of monitoring and accountability towards better service provision.

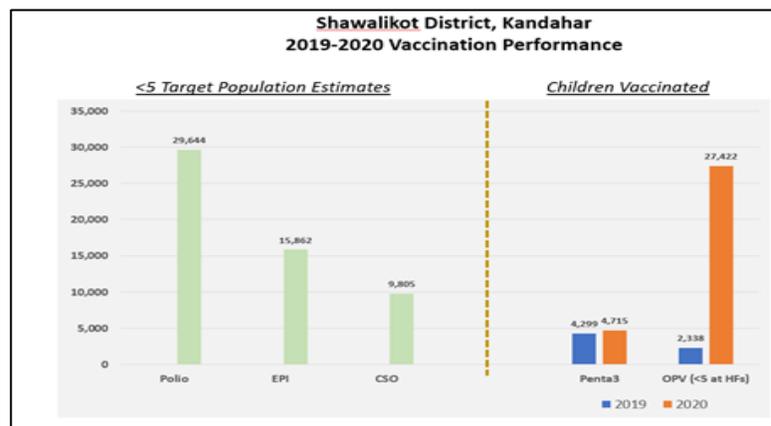
The programme is using zero dose/under-immunized children analyses for addressing the gaps identified;

however, birth dose is not analysed or addressed systematically. There is scope to use technology to better understand population distribution and targets to address the variation in denominators between the RI and polio programmes.

RI is one of the important components of the polio eradication strategy; however, there are severe gaps in RI exactly where polio needs RI the most.

TAG notes following bottlenecks in polio priority areas:

- There are not enough service delivery points: ~40% of all villages are over 5 kilometers from a health facility and in South Region, ~30% of villages are over 10 kilometers from health facility (beyond outreach).



- Sehatmandi mid-term review did not address issues related to tariffs & pay for performance which are insufficient to drive immunization performance and no capital has been allocated for new facilities or renovation.
- Political complexity and conflict affect access and human resources.
- In many areas Anti-Government Elements have not permitted outreach vaccination
- Demand related barriers such as maternal autonomy for movement to distant RI services, opportunity cost of accessing healthcare over distance, and low literacy remain important bottlenecks.

#### **TAG Recommendations on Routine Immunization:**

- MoPH and partners must urgently address structural shortcomings of Sehatmandi:
  - Expand 'footprint' of BPHS service points and improve the quality of existing sites.
  - Increase resources for outreach services and strengthen the monitoring and accountability.
  - Leverage the opportunity of the Gavi FPP process and World Bank engagement.
- Any new investment should be prioritized for **white areas** rather than duplicating.
- MoPH and immunization partners should work towards establishing a common monitoring platform for BPHS and outreach services to improve service delivery oversight and accountability.
- EPI should strategically and meaningfully engage NEOC's SWG in EPI planning and implementation.
- Provincial EOCs should participate in provincial monthly reviews organized with Acasus support.
- For OPV vaccination at EPI centers, denominator from polio programme should be used.
- GPEI partners should support RI microplan review and establishment of outreach services.

## SIA Quality in Accessible Areas

### **Questions to TAG:**

*Does TAG consider refusal to vaccination to be significant factor in sustaining transmission, particularly in south region? Does the communication and community engagement plan efficiently address refusal families at community and doorstep levels? What further steps does TAG recommend to reduce refusals in Kandahar Province and the SE?*

### South Region

TAG reiterates the view that Kandahar is the **central engine of polio transmission**. Missed children are the primary problem, with refusals being a significant problem only where they are clustered, persistent and/or a security risk.

TAG appreciates the recent progress made in Kandahar City, but is concerned about stagnation of quality improvement in surrounding similar areas like Dand, Manzalbagh, etc. Robust evidence of positive impact in target localities should be used to guide expansion in other challenging **accessible** areas, using a neighbourhood-by-neighbourhood approach.

### **Neighbourhood strategy**

Five core functions of effective local engagement - in critical localities, communication and operations teams should be working in an integrated way to achieve coherent effect in:

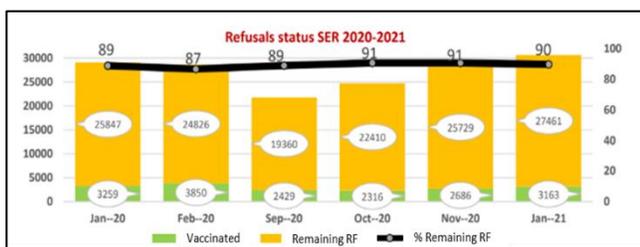
1. Evidence driven community engagement interventions.
2. Local cadres of neighborhood leaders to positively influence households.
3. Trusted FLWs and mobilisers at door
4. Partnerships focused on improving the provision of community level services.
5. Supportive credible and locally appropriate media messaging environment

### **TAG Recommendations on Improving SIA Quality: SOUTH REGION**

- Document effectiveness of engagement strategies in **Kandahar City**.
- Using '**neighbourhood-by-neighbourhood**' strategy based on priority clusters and scale up to other areas.
- Integrate '**operations**' and '**communication**' activities to optimise impact on household decision-making:
  - Differentiated interventions as per understanding of community needs in various geographies.
  - Maximising quality of **FLWs** (selection, training, supervision, payment)
  - Systematically identify **neighbourhood influencers** to create positive pressure on households.
  - Refine **intrahousehold communication** strategy (caregivers/grandmothers/spinsaree/TBA).
  - Building **wider alliances** through integrated/complementary services.
- Generate and share evidence for outcomes of various implemented communication interventions.

## Southeast Region

Security, access, and refusals remain primary challenges in the SE region. Missed children remain persistently high, contributing to localised immunity gaps making the region vulnerable to importations and re-establishment of poliovirus transmission. Khost and Paktika have increasing numbers of refusals unconverted during the campaigns. There are high rates of refusal among the high-risk mobile populations, refugee settlements and internally displaced population groups.



### TAG Recommendations on Improving SIA Quality: [SOUTHEAST REGION](#)

- Ensure the Southeast Region programme is adequately staffed and resourced to carry out these activities at the local/outreach level - **strengthen and empower the REOC**.
- Refusals are a significant challenge and must be addressed, but the **primary goal is to reduce any and all cases of 'still missed children'**.
- Ensure comprehensive **identification and mapping of displaced/cross-border & HRMP communities** in microplans.
- **Identify community leaders** in hardcore refusal areas with whom to initiate community engagement. Develop cross-border coordination to identify key influencers and elders on all sides
- Use **dialogue/FGDs** to determine community concerns and identify solutions for acceptable vaccine delivery (e.g., location based FLW recruitment).
- Assess **availability of other services** available to displaced/refusal communities.
- Engage with provincial government and partners to facilitate **enhanced local service provision** (HFs/health camps, WASH, nutrition).

## East Region

TAG is impressed with the achievements in eastern region with continued high levels of coverage and innovative strategies including effective outreach activities linked to HFs, HRMP settlements, MNCH, education etc.

## West Region/North Region/Northeast Regions

These regions continue to maintain effective programme operations but remain vulnerable to issues of access, HRMPs/IDPs and population exchange with the South Region. Reducing the numbers of missed children, particularly in the "Not Available" category remains the priority for these regions and will require continued and sustained community engagement. There is a need to focus on keeping up operations quality, including efforts to further improve EPI in these areas.

### **TAG Recommendations on Improving SIA Quality: [EAST REGION](#)**

- Continue measures to improve SIA quality.
- **Continue** to prioritise **effective community engagement and outreach activities** and develop clear strategies to ensure continuity of performance.
- Review regional programme resources to ensure **adequate human capacity are available** to maintain essential community engagement activities.

### **TAG Recommendations on Improving SIA Quality: [WEST/NORTH/NORTHEAST REGIONS](#)**

- Ensure programme capacity to sustain operational quality, including local community engagement.
- Ensure continuing improvement of regional EPI services.

## Communication

TAG welcomes the development of an integrated national communications strategy to be incorporated in the NEAP and supports the use of local research initiatives to understand community perceptions of core public health issues including MNCH, RI and polio.

However, TAG emphasises the critical importance of effective evidence-based community engagement strategies to maintain and improve household vaccine uptake. Development of the facility based FMV is a good initiative, but it needs to be balanced with investments in community outreach.

Mass and social media play an important role in creating an enabling information context for PEI, RI and MNCH, but they are no substitute for locally accepted community engagement strategies and investments.

### **TAG Recommendations on Communication:**

- Communication and community engagement interventions must be guided by evidence and monitored through an M&E framework.
- Focus community engagement on neighbourhood strategies (see *SIA Quality – South Region*) to reduce missed children of all kinds in accessible areas and tailor as per the needs of communities.
- Continue to broaden local engagement communication by FLWs and mobilisers to focus on maternal health, child welfare, referrals, and vaccination – not just 'polio and OPV'.
- Integrate communication strategies in operational plans to maximise acceptance of alternate vaccination modalities in inaccessible areas.
- Review capacity needs for effective community engagement, particularly in ER, SER and WR – evaluate impact of facility-based FMV on core programme objectives.
- Maintain mass, social, and local media strategies, measuring impact on community awareness of SIAs, confidence in OPV and attitudes to EPI.

***IN A HIGHLY UNPREDICTABLE OPERATING ENVIRONMENT, THE PROGRAMME CAN BUILD NEW OPPORTUNITIES FOR PROGRESS ON THESE PILLARS OF RESILIENCE:***

- Rigorous **humanitarian neutrality** and commitment to universal child health
- Strong **One Team approach**
- **Maintaining programme essential functions** – surveillance, transit vaccination
- Achieving and holding **gains in accessible areas**
- Flexible **multipronged approach to access negotiation**
- **Agility using every opportunity** to vaccinate in a dynamic environment
- **Creative solutions** to local vaccination & strengthening EPI

## Questions to TAG - March 2021

### 1. Strategic / Overall

- A. The Afghanistan polio programme has successfully resumed polio SIAs with infection prevention and control measures related to COVID-19. The country has completed three rounds of type 2 containing vaccines in the accessible areas. With regard to planning vaccination response, what does TAG advise in the following situations: Having implemented three type 2 containing vaccination campaigns in accessible areas, what should be the response strategy in the following situations:
- i. cVDPV2 detected after the last type 2 vaccine containing SIA?
  - ii. Only one type 2 vaccine containing SIA after the last cVDPV2 detected. Should another opportunity be given?
  - iii. What should be the preferred type of vaccine for response?
  - iv. What should be the response in areas where all, one, two, or three campaigns are missed due to inaccessibility – in case inaccessibility continues, and in case access is gained?
  - v. What should be the response to continued detection of cVDPV2 only in sewage samples?
  - vi. Given dual outbreak, in what situation should the programme use nOPV2?
- B. Should a cVDPV2 case confirmed from inaccessible area (where at least two type 2 vaccine containing case responses could not be implemented) be considered as breakthrough transmission in a given district or province?

### 2. Proposed SIAs Schedule / Outbreak Response 2021, Afghanistan

Month / Date	Scale / Type	Vaccine	Remarks
11 – 15 Jan	NIDs	tOPV	
29 March – 2 Apr	NIDs	bOPV	
24 – 28 May	NIDs	bOPV	
12 - 16 Jul	CR	nOPV2	Epidemiology / nOPV2 availability to guide the scope / vaccine type
06 – 09 Sep	NIDs	bOPV	
01 – 04 Nov	SNIDs	bOPV	
13 – 16 Dec	SNIDs	bOPV	

The country is proposing three bOPV NIDs, one tOPV NID, two bOPV SNIDs and two type 2 containing vaccine case responses to respond to both cVDPV2 and WPV1 outbreaks. This plan will provide four countrywide opportunities with type 1 containing vaccines and two opportunities in high risk areas; and one opportunity countrywide of type 2 containing vaccine plus another opportunity in areas with breakthrough transmission (as per epidemiology of cVDPV2)

- I. Does the TAG endorse this plan?
- II. Should the programme consider using tOPV instead of bOPV (during planned bOPV SIAs) in districts where only one type 2 vaccine containing opportunity has been given after the detection of last cVDPV2 case?

- 3. South Region Plan:** If the situation of access remains the same, the country has developed a plan which include outreach vaccination in three endemic provinces of South (Helmand, Kandahar & Urozgan – starting with Urozgan first) with a target children to reach 70%, enhancement of PTTs within the inaccessible areas and the entry/exit points, roaming teams at the Bazar, Bus stations, mela (local festivals - carnival) points, multi antigen campaigns, improved health facility based vaccination and bringing in more than 350 private health facilities in the vaccination centers

  - I. Does the TAG endorse this plan?
  - II. If yes, how what should be the measure of assessing the impact of these interventions?
- 4.** In spite of the concerted efforts to reduce the number of refusals especially in Kandahar province and South East region, the hardcore refusals still remain a challenge and becoming a security issue for the FLWs. What does TAG recommend as further steps?
- 5.** Despite of the concerted efforts to reduce the number of refusal children especially in Kandahar city, and Khost and Paktika provinces of South East region, the refusal still remains a challenge in these areas. Community engagement and mobilization interventions reaches its limitation towards persistent and harsh resistant families and some influencers. Trying to vaccinate children in these refusals families is becoming a threat for vaccinators.

  - I. Does TAG consider refusal to vaccination to be significant factor in sustaining transmission, particularly in south region?
  - II. Does the communication and community engagement plan efficiently address refusal families at community and doorstep levels?
- 6. Surveillance:** The AFP and environmental surveillance has recovered from the dip in key indicators during first wave of COVID-19 pandemic mainly due to the reengagement and trainings of health care providers and recovering staff, in addition AFP surveillance internal reviews have been completed in the whole country, reports are being compiled for corrective actions.

  - I. What additional interventions TAG recommends not to miss polio transmission and isolation of orphan viruses?
  - II. Does TAG recommend sero-studies of confirmed polio cases to further determine immunity level?
- 7. EPI:** Strengthening EPI, particularly in areas with limited access, will be important to achieving and sustaining eradication in Afghanistan.

In addition to monitoring support provided by PEI, in what other areas can PEI and EPI collaborate to fast-track eradication?



<b>Day 2: 18 March 2021</b>		
10:30 – 11:10	<b>Integrated services plan</b> <ul style="list-style-type: none"> <li>- Activities planned under the plan</li> <li>- Activities implemented</li> <li>- Impact</li> </ul> 20 minutes presentation and 20 minutes discussion	Dr Zaheer
11:10 – 11:50	<b>Strengthening EPI services</b> <ul style="list-style-type: none"> <li>- Interventions in 2020 to improve EPI coverage</li> <li>- EPI strengthening plan in FPP (focus on polio endemic provinces)</li> <li>- Health systems transformation &amp; alignment with polio eradication</li> </ul> 20 minutes presentation and 20 minutes discussion	Dr Nazary
11:50 – 12:30	<b>Communication and social mobilization</b> <ul style="list-style-type: none"> <li>- Impact of comms &amp; SM activities</li> <li>- National &amp; regional plan</li> </ul> 20 minutes presentation and 20 minutes discussion	Dr Rashidi
12:30 – 12:50	<b>Break</b>	
12:50 – 13:20	<b>Discussions with donor partners</b>	
13:20 – 13:50	<b>Way forward</b> <ul style="list-style-type: none"> <li>20 minutes presentation and 20 minutes discussion</li> </ul>	Dr Rashidi
13:50 – 14:00	<b>Closing remarks and adjournment</b>	Chair
<b>Feedback: 20 March 2021</b>		
10:30 – 11:45	<b>Observations &amp; recommendations</b>	Chair
11:45 - 12:00	<b>Remarks from partners</b>	
12:00 – 12:10	<b>Remarks from Regional Offices WHO/UNICEF</b>	Dr Hamid, Dr Paul
12:10 – 12:20	<b>Remarks form HE Minister of Public Health</b>	HE Dr Majrooh
12:20 – 12:30	<b>Closing remarks and adjournment</b>	Chair

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