

Report on the

# Meeting of the Technical Advisory Group on Polio Eradication in Afghanistan

Kabul, Afghanistan  
4–5 April 2017

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## ABBREVIATIONS

AFP	Acute flaccid paralysis
ARCS	Afghan Red Crescent Society
BMGF	Bill and Melinda Gates Foundation
BPHS	Basic package of health services
DDM	Direct disbursement mechanism
EMRO	Eastern Mediterranean Regional Office (WHO)
EOC	Emergency operations centre
EPI	Expanded programme on immunization
ES	Environmental surveillance
FLW	Front-line worker
HQ	Headquarters
HRD	High-risk district
HRMP	High-risk mobile population
ICN	Immunization Communications Network
ICRC	International Committee of the Red Cross
IFRC	International Federation of the Red Cross and Red Crescent Societies
IOM	International Organization for Migration
IPV	Inactivated polio vaccine
LQAS	Lot quality assurance sampling
MoPH	Ministry of Public Health
NCC	National Certification Committee
NEAP	National emergency action plan for polio eradication
NEOC	National Emergency Operations Centre
NGO	Nongovernmental organization
NIDs	National immunization days
NPAFP	Non-polio acute flaccid paralysis
NPEV	Non-polio enterovirus
OCHA	Office for the Coordination of Humanitarian Affairs
OPV	Oral polio vaccine
PCM	Post-campaign monitoring
PEI	Polio Eradication Initiative
ROSA	Regional Office for South Asia (UNICEF)
RRL	Regional reference laboratory for polio
SIA	Supplementary immunization activity
SL	Sabin-like
SNIDs	Subnational immunization days
SOP	Standard operating procedure
TAG	Technical Advisory Group
TC	Teleconference
tOPV	Trivalent oral polio vaccine
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VC	Videoconference

VDPV2	Vaccine-derived poliovirus type 2
VHRD	Very high-risk district
WHO	World Health Organization
WPV1	Wild poliovirus type 1
BPHS	Basic package of health services
DDM	Direct disbursement mechanism
EMRO	Eastern Mediterranean Regional Office (WHO)
EOC	Emergency operations centre
EPI	Expanded Programme on Immunization

## EXECUTIVE SUMMARY

The meeting of the Afghanistan Technical Advisory Group (TAG) on polio eradication was held 4–5 April 2017 in Kabul, Afghanistan, chaired by Dr Jean-Marc Olivé and opened by H.E. Dr Ferozuddin Feroz, Minister of Public Health. The objectives of the meeting were:

- to review progress in polio eradication in Afghanistan, focusing on common reservoirs, since the last TAG held in July 2016;
- to review progress against the National Emergency Action Plan for Polio Eradication (NEAP) 2016–2017 and make recommendations to achieve its objectives.

The TAG expresses deep regret regarding the tragedies that continue to affect the population, including polio workers, and acknowledges the extremely challenging context in Afghanistan despite which tremendous progress has been made since the last meeting.

There is strong political commitment and partnership between the government, UNICEF, WHO and other partners. Collaboration within the common reservoir shared by Afghanistan and Pakistan remains a priority for both countries. The participation of Pakistan National Emergency Operation Centre representatives in the Afghanistan TAG meeting will facilitate joint risk analysis and outbreak response, as well as coordinated strategies for reaching high-risk mobile populations.

Most of the recommendations made during the July 2016 TAG meeting have been fully implemented and the TAG appreciates the steady progress in implementation of the NEAP 2016–2017 resulting in reduced number of infected districts, reduced virus load in the country, and improved vaccine reach.

The country has been able to interrupt the transmission of 2015 in the south and east and new transmission in 2016/2017 has been temporally and geographically restricted. However, recent epidemiological evidence illustrates the vulnerability of pockets of unreached children and the role of population movement for poliovirus transmission across the common reservoir.

The capacity of the programme to respond to outbreaks is commendable and the TAG notes that adequate preparedness is in place to respond to vaccine-derived poliovirus type 2 transmission. However, joint monitoring and reporting of outbreak response with Pakistan in bordering areas is not yet taking place.

The TAG recognizes that the country continues to have sensitive surveillance and appreciates the creative solution implemented by Afghanistan and Pakistan programmes to ensure uninterrupted stool sample shipment to the regional reference laboratory during the recent border closure.

Quality of campaign activities in accessible areas has improved as evidenced by reduction of failed lot quality assurance sampling (LQAS) lots and reduced proportion of missed children in post-campaign monitoring. However, the proportion of lots passed at 80% has remained static over 18 months at around 4.5–5 in every 10 lots. Future improvement in

quality of campaigns should be reflected in increased proportion of lots passed at 90% and commensurate reduction in both failed lots and lots >80%.

Despite these improvements in campaign quality, the outbreaks of 2016 underline how essential it is to identify and immunize all remaining clusters of missed children particularly in the southern region.

The expansion of the full-time immunization communications network (ICN) into the very high-risk districts gives the programme further insight into reasons for missed children, including clustering of chronic refusals.

Even though the security situation has deteriorated, access has improved demonstrating the appropriateness of the plan implemented by the country to address inaccessibility. Initiatives of remote and third party monitoring, PCM/LQAS validation, and triangulation of data give further confidence in the programme's reach in access-compromised areas.

The country has various strategies in place to identify and vaccinate HRMP groups and the coordination with the Office of the United Nations High Commissioner for Refugees, International Organization for Migration and United Nations Office for the Coordination of Humanitarian Affairs is appreciated.

#### *Key recommendations*

- Continue engagement of political leadership at all levels; strengthen the new Emergency Operations Centre (EOC) in the southeastern region and the regional structures in the regions without EOCs by July 2017.
- Fully implement the new SOP of Polio Eradication Initiative support to the Expanded Programme on Immunization; hold Basic Package of Services nongovernmental organizations accountable for involvement in polio eradication activities and in improvement of routine immunization coverage.
- Continue implementing accountability framework at all levels with focus on strengthening further at district and front-line worker levels.
- Continue focusing on very high-risk districts, identifying areas with possible immunity gaps similar to Bermel and taking all necessary preventive measures.
- Compile information on high-risk mobile populations at the national level; standardize detailed analysis of data to establish a country-wide overview of high-risk mobile populations and their movements by June 2017. Coordinate closely between regions, provinces and districts within Afghanistan, and with the Pakistan programme on joint mapping and full implementation of the HRMP strategy.
- Review the current NEAP in June 2017 with subsequent extension to include the second half of 2017, and develop a new NEAP for the calendar year 2018 in December 2017.
- Proceed with consolidation of ICN social mobilizer and vaccinator as a 2-person team structure, starting with one district each in the south and in the east to understand possible challenges. Ensure documentation of ICN vaccinator consolidation strategy (including terms of reference, ICN and vaccinator roles, process for consolidation of coverage data (register and tally sheets), team-based single line of oversight,



supervision and accountability), and robust evaluation of impact in pilot districts to ensure efficacy of the new 2-person structure.

- Intensify efforts to engage more female front-line workers.
- Review and modify the transit strategy implemented during campaigns to ensure reaching children on the move.
- Resolve the remaining issues of campaign quality due to security challenges in Helmand and Kandahar provinces.
- Expand environmental surveillance in a phase-wise manner, coordinating with the regional reference laboratory on the sample load.
- Explore different approaches/strategies as alternatives to full-time social mobilizers in areas where the ICN network is not feasible and assess the impact.



## 1. INTRODUCTION

The meeting of the Afghanistan Technical Advisory Group (TAG) on polio eradication was held 4–5 April 2017 in Kabul, Afghanistan, chaired by Dr Jean-Marc Olivé and opened by H.E. Dr Ferozuddin Feroz, Minister of Public Health, in the presence of the WHO and UNICEF representatives for Afghanistan. It was attended by Dr Stanekzai, Senior Advisor to the Minister of Public Health, Dr Mojadidi, the Presidential Focal Point for Polio, members of the Afghanistan Polio Eradication Initiative (PEI) team from national and regional levels, as well as representatives from the Afghan Red Crescent Society, Bill & Melinda Gates Foundation, International Committee of the Red Cross, Rotary International, USAID and the Canadian Embassy, the last representing all bilateral partners. Pakistan EOC Coordinator and polio team leads from UNICEF and WHO also participated. The previous Afghanistan TAG meeting was held 12–13 July 2016 in Kabul, Afghanistan.

Afghanistan, Pakistan and Nigeria are the three remaining polio endemic countries in the world. Afghanistan and Pakistan form one common reservoir for poliovirus transmission and the collaboration between both programmes is getting stronger at all levels while steady progress is made towards stopping transmission.

The Afghanistan national polio eradication programme continues to make significant progress through the consistent and well-tracked implementation of the National Emergency Action Plan for Polio Eradication (NEAP) 2016–2017, guided by strong government leadership and close coordination between partners. The national and the four regional Emergency Operations Centres (EOCs) continue to play a key role in implementation of activities and in coordination within the country and across borders within common reservoirs.

During 2016 Afghanistan reported 13 polio cases of which 11 originated from two outbreaks and two cases represented persisting low-level endemic transmission. The transmission was limited to geographically small areas in the eastern and south-eastern regions and the northern part of the southern region. Both outbreaks were temporally limited to less than 5 months. Out of the 13 cases reported, seven were from the Bermel district of Paktika province in the south-eastern region and four from Shigal Wa Sheltan district of Kunar province from the eastern region. Both districts, in addition to geographically bordering with Pakistan, have populations with strong cultural, economic and tribal ties across the border resulting in frequent informal population movements. All the cases originated from severely access-compromised areas, in Bermel district from within a displaced population group originating from Waziristan and in Shigal from an area inaccessible for the past four years. The transmission in Bermel was genetically linked to South Waziristan and the transmission in Shigal to Khyber. The other two cases of 2016, with onset in January and April, were detected in the northern part of the southern region, one each from Helmand and Kandahar provinces, and linked to 2015 transmission in their respective areas.

In 2017, the previously persisting continued low-level local circulation in the southern region and both the outbreaks in eastern and south-eastern regions seem to have ceased. However, three further cases have occurred during the first quarter of 2017, one each from Kandahar, Helmand, and Kunduz provinces. The closest genetic linkages for all three are of

different lineages from across the common reservoir. Whereas the Kunduz and Helmand cases are from access-compromised areas, the case in Kandahar originates from an area known for clustered refusals as well as strong links to the Quetta-Kandahar corridor. To date, none have resulted in secondary cases.

One vaccine-derived poliovirus type 2 (VDPV2) was detected in September 2016 from Bermel district of Paktika province which, in absence of evidence of local circulation, was classified as ambiguous VDPV2. During the same month one acute flaccid paralysis (AFP) case with Sabin-like type 2 (SL2) poliovirus was detected in Kandahar. The extensive search conducted for post-switch use of trivalent oral polio vaccine (tOPV) resulted in finding of one single partially used tOPV vial in a health facility nearby the residence of the child.

During 2016 all samples from the 15 environmental surveillance (ES) sample collection sites remained negative for wild poliovirus (WPV) and VDPV2 for 11 months, the last WPV1 positive sample having been from Jalalabad in December 2015. This was the longest ever period without detection of WPV since the start of ES sampling in Afghanistan. In December 2016 and January 2017 however, a total of four samples tested positive for WPV1. These samples were collected from sites in Kandahar and Helmand provinces in the south and Nangarhar province in the east. As per genetic sequencing, the virus detected in Kandahar was linked to the polio case detected in Kandahar during the same month and for the other three the closest relatives were independent lineages from across the common Afghanistan/Pakistan reservoir.

Afghanistan continues to maintain a highly sensitive surveillance system, with key indicators surpassing global targets in all regions. The AFP surveillance network continues its strategic expansion and during 2016 all 14 ES sample collection sites were reviewed for their appropriateness. The existing sites were found to remain relevant, and three additional sites were identified, one each in Kandahar, Nangarhar, and Khost provinces, and operationalised in December 2016 and January 2017.

Continued improvement in population immunity is evidenced by temporal and geographic limitation of outbreaks, improved vaccination status of non-polio acute flaccid paralysis (NPAFP) cases, and a relatively higher SL isolation in very high-risk districts (VHRDs) and high-risk districts (HRDs) where an intensive schedule of supplementary immunization activities (SIAs) is being implemented. Lot quality assurance sampling (LQAS) data continues to show improvement in the quality of SIA implementation, with proportion of failed lots decreasing from 26% in February 2016 subnational immunization days (SNIDs) to 7% in February 2017 SNIDs. This improvement can be attributed to the various interventions the country had started in 2016 and continues to consolidate and intensify with primary focus in the VHRDs.

Along with improved campaign quality and increased reach to children, there has been strong focus on expanding community and household engagement at various levels following the country's comprehensive and evidence-based communication strategy. Where feasible, a full-time immunization communications network (ICN) has been established in VHRDs which has provided better data on reasons for missed children and the clustering of chronic refusals, and strategies to address them.

While the security situation in Afghanistan has continued to deteriorate, access to children has improved particularly in north-eastern and eastern regions. The programme has systematically implemented various strategies aimed at sustained dialogue with communities and relevant authorities at all levels. In addition, the programme has introduced strategies such as remote monitoring and engagement of a third party to monitor the programme's reach in areas where normal programme monitoring access is compromised. Programme neutrality has been an essential factor in gaining access through dialogue and mutual trust.

The epidemiology of 2016–2017 clearly demonstrates that mobile populations combined with pockets of under-immunized children play a key role in sustaining poliovirus transmission within the common reservoir. Four main categories of high-risk mobile populations (HRMP) have been identified for each of which specific interventions are being implemented.

1. Long distance travellers within reservoir areas
2. Straddling populations at the border areas
3. Nomadic populations within and beyond Afghanistan
4. Returnees

A joint risk assessment on HRMP has been initiated across the common reservoir and the coordination between the two programmes continues to be further strengthened. Regular face-to-face meetings and VC/TC calls are taking place at national and subnational levels. The campaign schedules continue to be synchronized and cross-notification of AFP cases as well as information-sharing of polio cases is taking place. During the closure of the Torkham border, two teams collaborated seamlessly to minimize the interruption of stool sample shipment from Afghanistan to the regional reference laboratory (RRL) in Islamabad.

As outlined in the NEAP for 2016–2017, Afghanistan had aimed to stop polio transmission by the end of 2016. However, the country seems to be on the right track and as the programme continues to consolidate the key interventions started in 2016 and which are showing impact, stopping transmission within the current year is attainable. In this context the Afghanistan TAG meeting was held on 4–5 April with two key objectives:

- Review the progress in polio eradication in Afghanistan, focusing on common reservoirs, since the last TAG held in July 2016.
- Review the progress against the NEAP 2016–2017 and make recommendations to achieve its objectives.

## **2. OBSERVATIONS, CONCLUSIONS AND RECOMMENDATIONS**

### **2.1 Observations and conclusions**

#### *General conclusions*

The TAG expresses deep regret regarding the recent tragic incident in Kabul, unrelated to polio, in which five polio workers lost their lives while working. It acknowledges the extremely challenging situation in Afghanistan and commends the tremendous progress made since the last meeting in Kabul.

The progress made in addressing inaccessibility is appreciated by the TAG, particularly gains in access in northeastern and eastern regions; focus on HRMP; methods of remote and third-party monitoring; triangulation of available data; validation of PCM/LQAS data; and expansion of the AFP surveillance network and ES.

TAG appreciates the participation of the national, regional and provincial government, the in-country partners, and Global PEI partners in the TAG meeting. The initiative of inviting the Pakistan NEOC representatives to participate in the Afghanistan TAG meeting to further facilitate the common reservoir approach is very much welcomed.

#### *Oversight, coordination and programme management*

There is a strong political commitment at the highest level of the government of Afghanistan led by H.E. President, H.E. CEO and H.E. Health Minister. The TAG observes a continued strong partnership between the government, UNICEF, WHO and other partners at national and regional levels and appreciates continued strong support of all donor partners.

The national and regional EOCs are functioning in well-coordinated manner and a new EOC was established in the southeastern region. The recently completed NEOC building will further facilitate collaboration by having all partners working under one roof. However, TAG also notes the need for improved coordination in the regions without a regional EOC.

The country is implementing an accountability framework and has demonstrated taking action on basis of performance. However, the implementation of the accountability framework at district and front-line worker levels needs further strengthening.

The coordination between Afghanistan and Pakistan at national and regional levels has improved with regular VC and face-to-face meetings taking place. TAG notes that there is need to further strengthen the collaboration and coordination in the context of joint risk analysis, high-risk mobile populations, planned and actually synchronized SIA activities and joint outbreak response.

#### *Status of recommendation from the last TAG meeting*

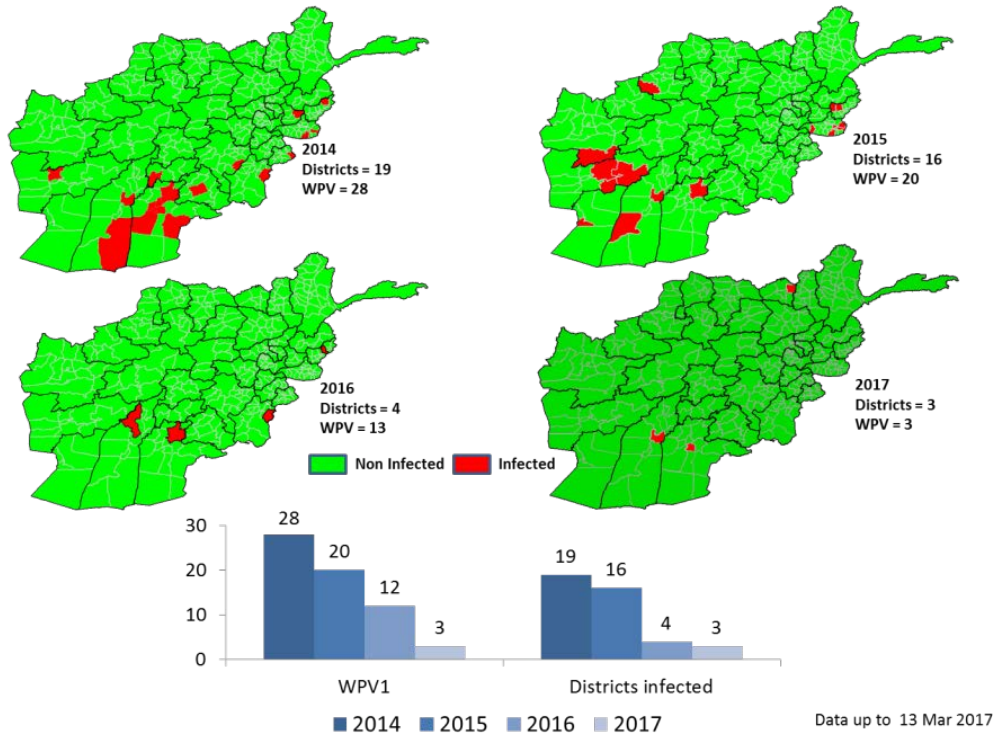
Most of the recommendations made during the July 2016 TAG meeting have been fully implemented. Although all recommendations have been addressed, nine out of the 38 recommendations are not yet fully implemented, notably recommendations related to polio plus, involvement of IFRC, joint case response planning and reporting as well as expansion of the direct disbursement mechanism (DDM).

#### *Implementation of the NEAP*

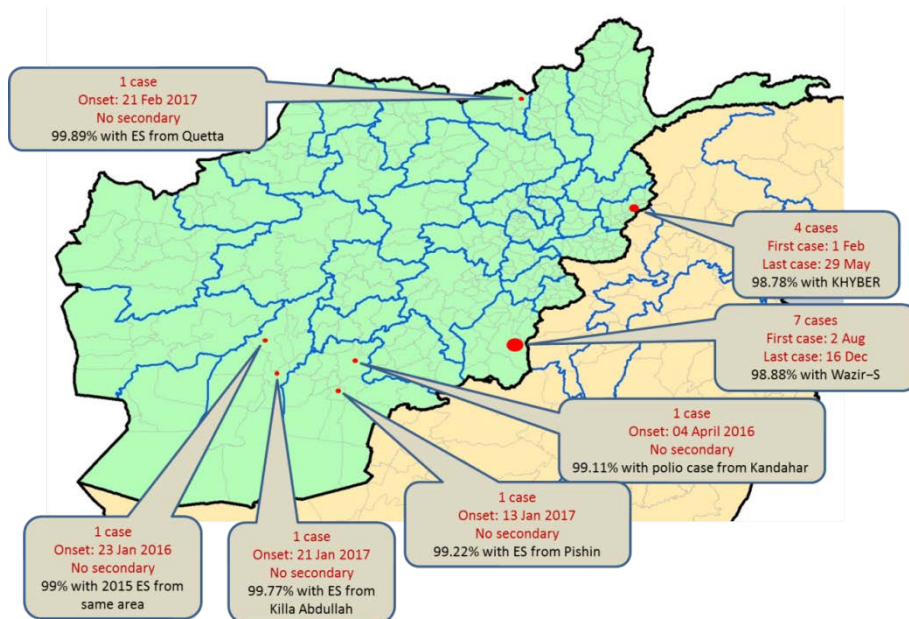
TAG appreciates the significant progress seen in implementation of the NEAP 2016–2017 and the tracking mechanism in place at the national level. The current NEAP has helped the country to improve the programme.

*Epidemiology*

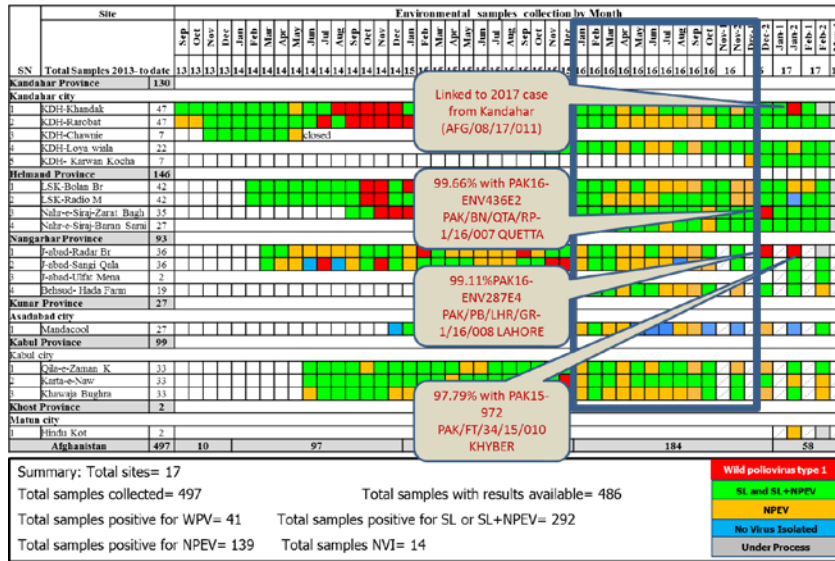
There is significant progress as evidenced by epidemiology; the number of infected districts has reduced from 16 in 2015 to 4 in 2016. In 2017 to date three districts are infected, each with a virus of a different lineage (Figure 1, Figure 2).



**Figure 1: Reducing geographic spread of WPV1, 2014–2017**



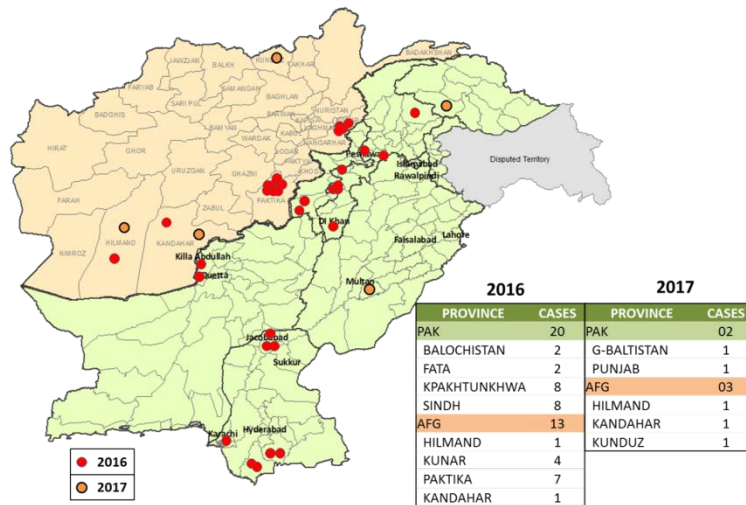
**Figure 2: Poliovirus transmission, 2016–2017**



**Figure 3: Environmental surveillance results, 2016–2017**

In 2016 no WPV was detected in ES samples for a period of 11 months between January and November showing a reduced virus load in the country. However, since December 2016, four samples have tested positive for WPV, again each with a different lineage (Figure 3).

Genetic sequencing data of recent transmission in Afghanistan shows that there is a continued low-level transmission in corridors of the common reservoir area, particularly in the Quetta-Kandahar corridor (Figure 4). The WPV1 positive ES sample from Jalalabad in January 2017 is an orphan, with closest linkages to case isolates from Khyber in 2014–2015 and Shigal in 2016, signalling a surveillance gap along the eastern/northern corridor. The surveillance data indicate however, that the country has been able to interrupt the transmission of 2015 in the south and east and new transmissions in 2016/2017 have so far been temporally and geographically restricted.



**Figure 4: WPV1 cases of the Afghanistan and Pakistan, January 2016–March 2017**



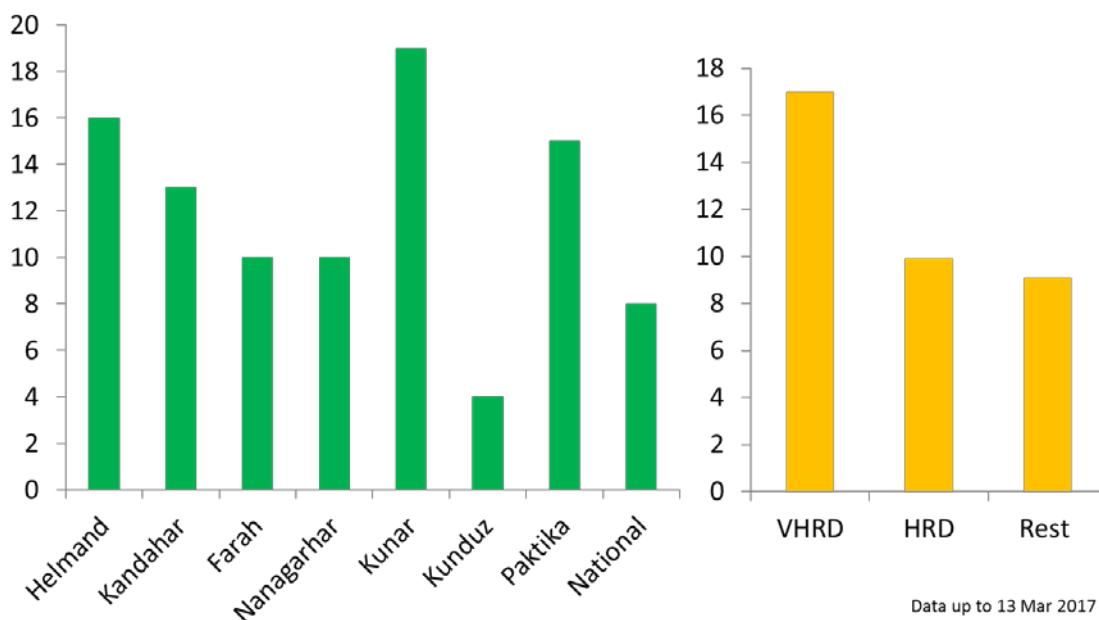
The transmission detected during 2016/2017 illustrates the importance of population movement for poliovirus transmission in the common reservoir and the transmission in Shigal and Bermel districts demonstrates that pockets of unreached children, however small, remain at risk. Though the country responded rapidly and strongly to the transmission in Bermel district, considering the existing access challenges, the TAG is not assured that transmission has been stopped in the area.

The recent transmission detected in Kunduz has the potential of spreading/establishing, particularly given that approximately 180 000 children in this area were inaccessible for vaccination for 18 months. However, the TAG appreciates the swift outbreak response which is now being implemented.

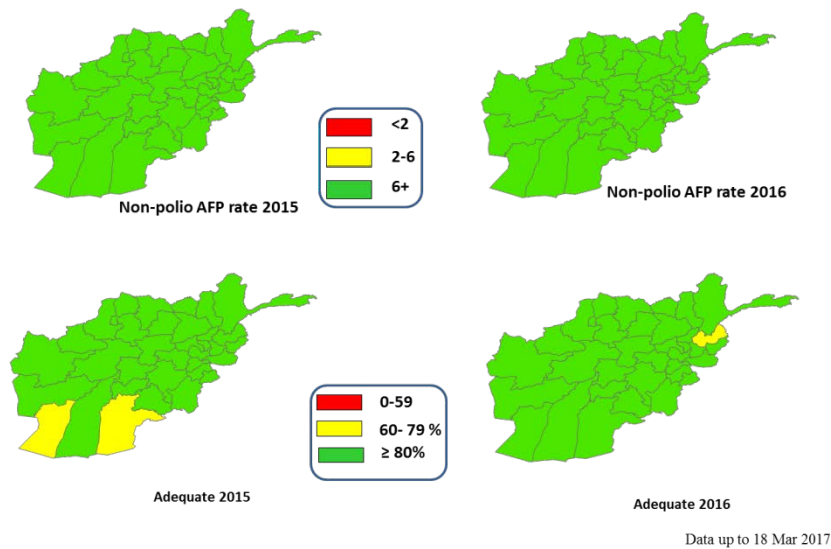
Although the transmission detected in Helmand and Kandahar in 2017 has not resulted in secondary transmission, the risk of spread/reestablishment of transmission cannot be ruled out until the entire reservoir is free of WPV.

#### *Population immunity*

TAG observes that SL virus isolation from Helmand, Kandahar, Farah, Nangarhar, Paktika and Kunar provinces is higher than national levels showing improved vaccine reach to these high-risk provinces (Figure 5). There is evidence of improved vaccination status in NPAFP cases, particularly in Helmand, Kandahar and Farah provinces. Despite this progress, the proportion of under-immunized NPAFP cases remains high in Kunar and Paktika.



**Figure 5: Percent SL isolation from AFP cases in high-risk provinces, VHRDs and HRDs and national, 2016–2017**



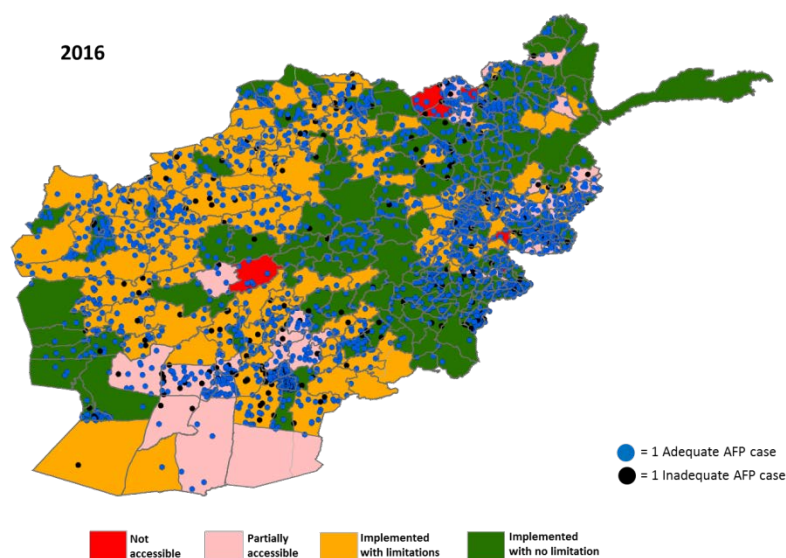
**Figure 6: AFP surveillance key indicators, 2015 and 2016**

*Outbreak response*

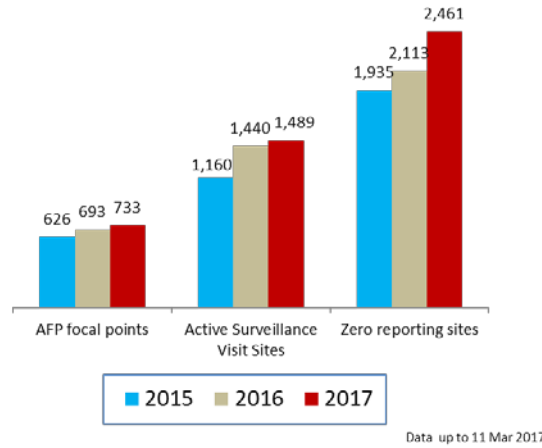
The outbreak response plan followed by the country is commendable, particularly the speed and scope of response to recent transmission in Kunduz. TAG also notes that the country is prepared to respond to any VDPV2 transmission within 14 days of notification. However, joint monitoring and reporting of outbreak response with Pakistan in bordering areas is not taking place.

*Surveillance*

TAG recognizes that the country has a sensitive surveillance system, including areas affected by conflict (Figure 6, Figure 7). The country continues to expand its reporting network (Figure 8) and environmental surveillance.



**Figure 7: AFP cases of 2016 on accessibility map of November 2016 NID**

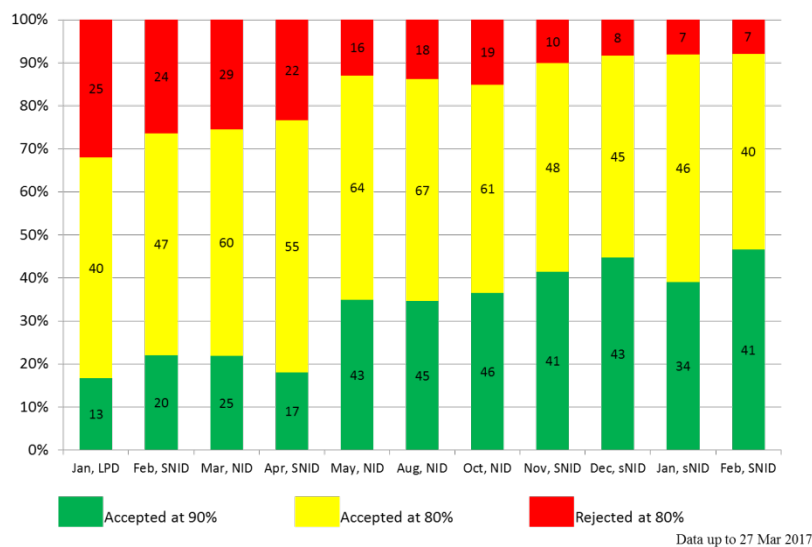


**Figure 8: AFP surveillance network expansion, 2015–2017**

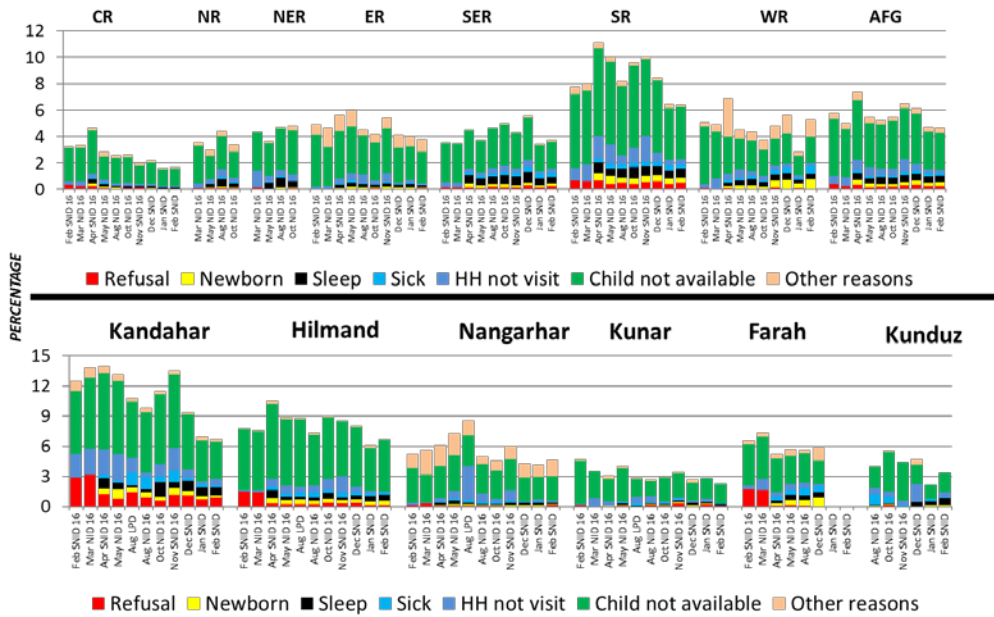
The creative solution implemented by the Afghanistan and Pakistan programmes to ensure uninterrupted stool sample shipment to RRL during border closure is appreciated. However, the alternate contingency mechanisms for stool sample shipment in case of border closure are not yet fully operational.

*Quality of SIAs*

Quality of campaign activities in accessible areas have improved as evidenced by reduction of failed LQAS lots from 26% in February 2016 SNID to 7% in February 2017 SNID (Figure 9). There is also a reduction in proportion of missed children in PCM, particularly in Kandahar from 12% in February 2016 to less than 7% in February 2017 (Figure 10). However, the TAG notes that there is still room for improvement which would be signalled by a reduction in both failed lots and lots passed at 80%, alongside continuing increasing number of lots passed at 90%. There are also remaining clusters of missed children due to ‘absent’ and ‘refusal’ that need to be identified and addressed.



**Figure 9: Improved quality of SIAs, 2016–2017**



Source: PCM data

Figure 10: Missed children by reason by region and selected high-risk provinces, 2016–2017

The initiative of microplan validation across the country is helping to find previously unreached children and rationalize workloads. The initiatives of third party and remote monitoring in security-compromised areas (Figure 11), PCM/LQAS validation, triangulation of data and engagement of NEOC focal person are commendable. However, the programme should avoid becoming swamped by multiple streams of data. Different data sets should be combined to ensure they support a clear operational strategy nationally, and within each region.

The programme continues making efforts to engage women as front-line workers and is tracking it over the rounds. However, the proportion of female vaccinators still remains low at 12% with significant regional variations.

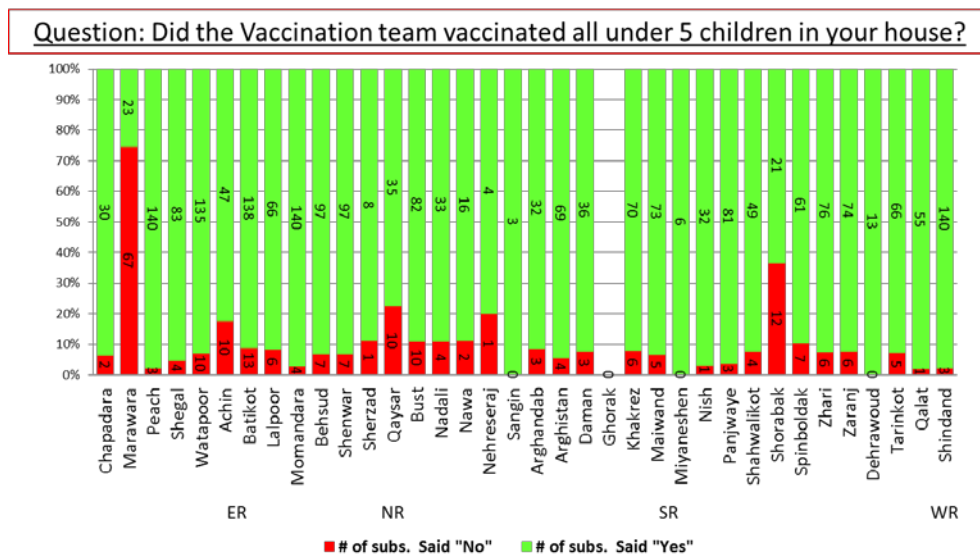


Figure 11: Sample of remote monitoring conducted for access compromised districts of eastern, northern, southern and western regions during February 2017 SNIDs.

TAG appreciates the implementation of inactivated polio vaccine and oral polio vaccine (IPV+OPV) SIAs in most of the high-risk areas. However, it notes that the implementation in some of the VHRDs is delayed from the original schedule in the NEAP 2016–2017.

### High-risk mobile populations

The TAG is pleased to observe that the country has various strategies in place to identify and vaccinate HRMP groups and that these strategies are being implemented (Figure 12–15). The ongoing coordination with UNHCR, IOM and OCHA on this component is appreciated. In addition, the country is planning to collate the available information at national level and conduct joint mapping/planning with Pakistan.

	# households with special population (as per ICN register)	# households with AFG returnees	# households with PAK refugees	# households with internally Displaced People (IDP)	Number US children belong to Returnees/Refugees/IDP/Guests Population	#Hhs belong to Returnees/Refugees/IDP population [exclude guests]	#US children belong to Returnees/Refugees/IDP population [exclude guests]	#Hhs with guests	#US guest children
<b>Southern Region</b>	<b>3,139</b>	<b>628</b>	<b>99</b>	<b>1,784</b>	<b>6,676</b>	<b>2,511</b>	<b>7,144</b>	<b>610</b>	<b>1,532</b>
<b>Kandahar</b>									
Kandahar City	2,571	407	71	1,536	6,866	2,014	5,555	539	1,311
Spinboldak	568	221	28	248	1,810	497	1,589	71	221
<b>Eastern Region</b>	<b>15,614</b>	<b>8,526</b>	<b>297</b>	<b>5,775</b>	<b>52,656</b>	<b>14,552</b>	<b>50,086</b>	<b>1,073</b>	<b>2,570</b>
<b>Kunar</b>									
Asadabad	467	118	30	295	1,410	442	1,366	24	44
Chapadara	150	41	1	93	487	135	454	17	33
Marawara	141	30		99	387	129	368	12	19
Pech	239	96	14	79	589	189	478	50	111
Shegal	200	108	7	70	603	185	574	15	29
Watapoor	184	88	7	13	483	108	328	76	155
<b>Nangarhar</b>									
Achin	570	109		366	2,082	475	1,808	97	274
Baticot	773	478	28	253	2,858	759	2,826	14	32
Beshoud	6,487	4,237	65	1,953	22,035	6,250	21,480	226	555
Jalalabad	3,072	1,956	49	646	8,864	2,649	7,859	425	1,005
Lalpura	268	61	2	205	976	268	976		-
Momandra	705	238	20	418	2,799	676	2,664	26	135
Shinwar	1,250	192	49	1,017	5,665	1,253	5,657		8
Surkhrod	1,108	774	25	268	3,418	1,034	3,248	91	170
<b>Southeastern Region</b>	<b>1,416</b>	<b>202</b>	<b>419</b>	<b>327</b>	<b>5,510</b>	<b>948</b>	<b>3,771</b>	<b>620</b>	<b>1,739</b>
<b>Khost</b>									
Alishir	876	143	135	240	3,562	518	2,189	466	1,373
Gurbaz	540	59	284	87	1,948	430	1,582	154	366
<b>Grand Total</b>	<b>20,169</b>	<b>9,356</b>	<b>815</b>	<b>7,886</b>	<b>66,842</b>	<b>18,011</b>	<b>61,001</b>	<b>2,303</b>	<b>5,841</b>

Figure 12: Example of ICN data on households with long-distance travellers, March 2017

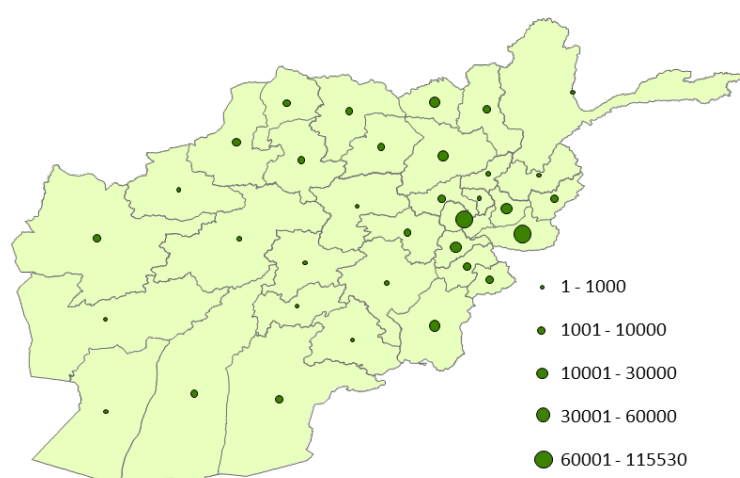


Figure 13: Mapping of final destinations of returnee refugees by province, 2016

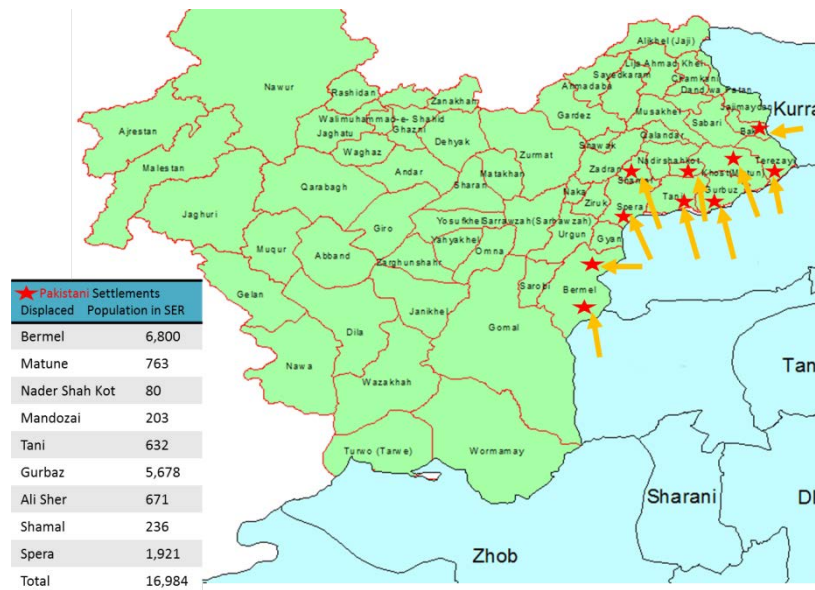


Figure 14: Example of straddling populations in the southeastern region

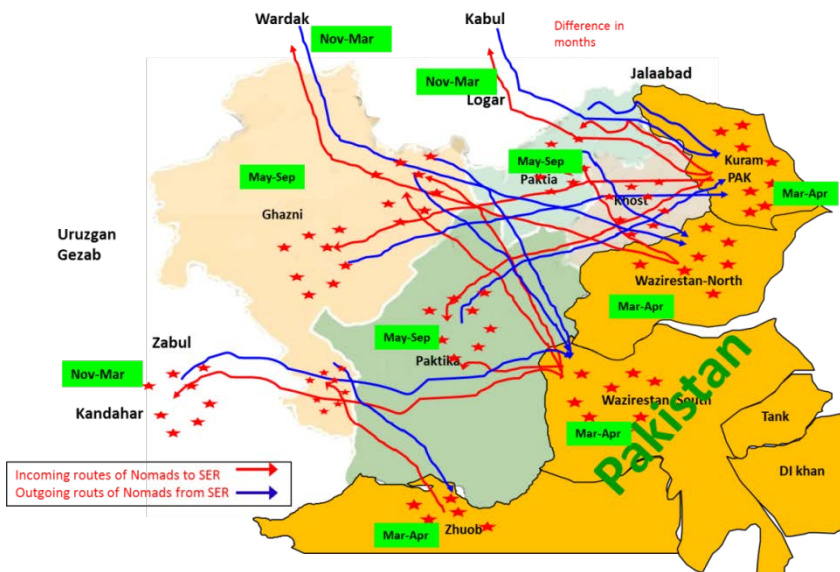
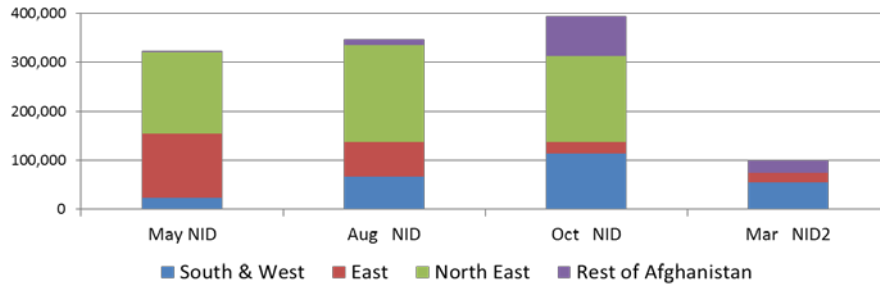


Figure 15: Nomadic routes and seasonality in the southeastern region

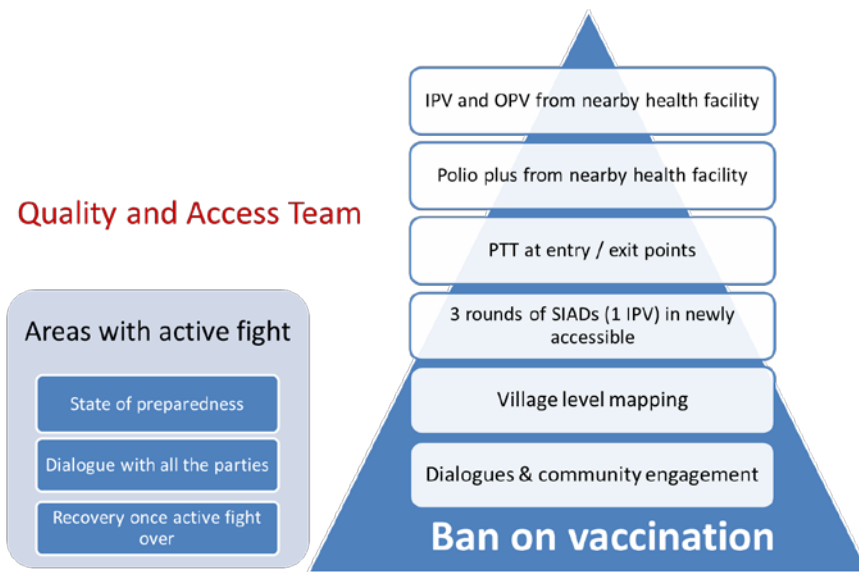
Access

Access has improved in eastern and northeastern regions with reduction of inaccessible children from over 300 000 in May 2016 to less than 100 000 in March 2017 (Figure 16). These results demonstrate the appropriateness of the plan implemented by the country to address inaccessibility (Figure 17); however the TAG remains concerned about continued challenges in the southeastern, eastern and southern regions.



Region	May NID	Aug SNID	Aug NID	Oct NID	Nov SNID	Dec SNID	Jan SNID	Feb SNID	Mar NID
East	131,781	73,355	71,085	23,204	24,213	17,488	19,156	18,932	21,002
North	3376	0	0	6,206	0	0	0	0	0
NE	165,333	101,434	197,192	176,377	105,539	105,024	104,200	104,280	0
South	22,811	49,403	28,798	141,142	120,597	18,192	78,254	12,416	40,989
SE	400	1,215	12,101	46,808	13,827	12,651	1,500	20,455	24,051
West	0	132,806	38,260	0	0	749	183,100	0	12,970
Central	0	0	70	0	75	75	0	0	0
<b>Total</b>	<b>323,701</b>	<b>358,213</b>	<b>347,507</b>	<b>390,373</b>	<b>264,251</b>	<b>154,178</b>	<b>386,207</b>	<b>156,083</b>	<b>99,012</b>

**Figure 16: Children inaccessible for vaccination campaigns, May 2016 – March 2017**



**Figure 17: Addressing inaccessibility**

*Communication*

The TAG acknowledges the comprehensive and evidence-based communication strategy which includes household and community engagement supplemented by other communication platforms and partnerships. The expansion of full-time ICN into the VHRDs is an important achievement. The programme now has a better picture of the reasons for missed children, including clustering of missed children and chronic refusals and has a well-developed package of solutions to overcome these challenges.

The TAG appreciates the efforts to ensure that communication approaches are fully integrated with operations, including microplanning, tracking of high-risk mobile populations, training, and district specific plans. Increased emphasis now needs to be placed on strengthening capacity, supervision and monitoring of the ICN to ensure they are fully integrated and accountable for reaching all children. In particular, TAG acknowledges the rationale for combining ICN mobilizer and vaccinator in a single team structure and encourages the programme to proceed with this consolidation, but to ensure transparent planning, and assessment of effectiveness in terms of campaign coverage and rates of missed/persistently missed children.

*The TAG concludes*

- There is a strong political commitment and continued strong partnership between the government, UNICEF and WHO at the national and regional levels.
- The country has been able to interrupt the transmission of 2015 in the south and east. New transmission during 2016/2017 has so far been temporally and geographically restricted.
- Genetic sequencing data of recent transmission in Afghanistan shows continued low-level transmission in corridors of the common reservoir area, particularly along the Quetta-Kandahar corridor.
- The recent transmission detected in Kunduz has the potential of spreading/establishing. However, TAG appreciates the swift outbreak response which is being implemented.
- The risk of continued transmission in Bermel, Helmand and Kandahar cannot be ruled out.
- The transmission in Shigal and Bermel districts demonstrates that clusters of unreachd children, however small, remain at risk.
- Transmission detected in 2016/2017 illustrates the importance of population movement for poliovirus transmission in the common reservoir. The country has various strategies in place to identify and vaccinate HRMP groups and efforts to collate available information and conduct joint mapping/planning with Pakistan are appreciated and urgently needed.
- The country has a sensitive surveillance system including areas affected by conflict and continues to expand its reporting network and ES.
- Systematic implementation of the NEAP 2016–2017 is paying results.
- Improved quality of the campaigns is evidenced by reduction of failed LQAS lots from 26% in February 2016 SNID to 7% in February 2017. However, TAG urges the programme to continue pushing for further improvement in SIA quality (reducing both failed LQAS lots and lots passed at 80% in favour of increasing the proportion of lots passed at 90%).
- TAG appreciates the initiatives of microplan validation, of remote and third party monitoring in security-compromised areas, PCM/LQAS validation, triangulation of data, and ICN.
- Access has improved in eastern and northeastern regions; however the TAG expresses concern about continued challenges in the southeastern, eastern and southern regions.



## 2. Recommendations

1. TAG endorses the OPV SIA and IPV+OPV plan presented (Annex II, Annex III) and urges the IPV+OPV campaigns planned in the NEAP 2016–2017 for high-risk areas to be implemented before end of Q3 2017.

### *Oversight, coordination and programme management*

2. Continue engagement of political leadership at all levels; further engage line ministries and strengthen coordination among EOCs.
3. Strengthen the EOC in the southeastern region and the regional structures in the regions without EOC by July 2017.
4. Fully implement the new SOP of PEI support to EPI; hold BPHS NGOs accountable for involvement in polio eradication activities and in improvement of routine immunization coverage.
5. Continue coordination within the common reservoir at national and subnational levels including regular VCs and face-to-face meetings.
6. Continue implementing accountability framework at all levels with a focus on district and front-line worker levels.

### *Priorities*

7. Fully implement the response plan to Kunduz case and coordinate with WHO Regional Office for Europe on response activities in bordering areas.
8. Rapidly address the remaining challenges in Bermel district and other similar pockets in the southeastern region to ensure that transmission is stopped.
9. As the core reservoir areas remain the greatest risk to polio eradication, the programme should continue focusing on VHRDs (Annex IV, Annex V).
10. Continue identifying areas with possible immunity gaps similar to Bermel and take preventive measures.
11. Compile information on high-risk mobile populations at the national level. Standardize detailed analysis of data to establish a country-wide overview of high-risk mobile populations and their movements by June 2017. Coordinate closely with Pakistan programme on joint mapping of:
  - population moving across common reservoirs;
  - at-risk border communities;
  - nomadic movement patterns; and
  - returnees
12. In close coordination between regions and with Pakistan, fully implement HRMP strategy (Annex VI) presented to the TAG for long distance travellers, straddling populations, nomads and returnees.
13. Continue close coordination with UNHCR, IOM and OCHA at all levels for reaching high-risk mobile populations and engage them for the next TAG.

*NEAP*

14. Continue the systematic implementation and tracking of progress of the NEAP 2016–2017. TAG endorses the plan to review the current NEAP in June 2017 with subsequent extension to include the second half of 2017, and development of a new NEAP for the calendar year 2018 in December 2017.

*Reducing missed children*

15. Complete the ongoing household based microplanning exercise across the country by June 2017.
16. TAG agrees in principle with the idea of deploying ICN social mobilizers as one member of the 2-person vaccination teams, with the aim of ICN and vaccinators becoming a single operational unit with single data stream and single accountability. However, it recommends that the programme elucidate a clear strategic plan for this consolidation, and start with one district each in the south and east to better understand possible challenges and then explore the feasibility of expanding in subsequent SIAs.
17. Implement specific focused interventions to address clusters of ‘refusals’ and ‘not available’.
18. Intensify efforts to engage more female front-line workers.
19. Streamline interpretation and analysis of multiple data sources, to ensure a clear, unified application to operational strategy, including information from various sources, particularly at the regional level, including data from intra-campaign monitoring, administrative coverage, post-campaign monitoring, LQAS, ICN and remote monitoring.
20. Review and modify the transit strategy implemented during campaigns to increase the number of mobile children reached.

*Inaccessible areas*

21. TAG endorses the strategies presented for inaccessible areas, urges the country team to continue tracking access at the lowest level and to fast-track implementation of the strategies.
22. IFRC to share the interventions done and results achieved in reaching children from inaccessible areas.
23. Resolve the remaining issues of campaign quality due to security challenges in Helmand and Kandahar provinces.

*Surveillance*

24. TAG endorses expansion of ES in a phase-wise manner and requests the country programme to coordinate with the RRL on the sample load. TAG reiterates its earlier recommendation to fast-track establishment of alternate modalities for stool shipment as a contingency in case of any border closures.

*Outbreak response*

25. As of April 2017, any isolation of WPV will be treated as an outbreak and responded to with three SIAs covering at least 500,000 children.
  - 1st campaign within 14 days (age group as per epidemiology)
  - 2nd campaign (age group as per epidemiology)
  - 3rd campaign with IPV+OPV (in areas where feasible and where no IPV-OPV SIAs implemented in the past two years)
26. Any VDPV2 isolation to be responded as per the global SOPs.
27. TAG reiterates its earlier recommendation of joint outbreak response planning, monitoring and reporting in border areas.

*Communication*

28. Further tailor the media approaches for each region based on their specific contexts.
29. Explore different approaches/strategies as alternatives to full-time social mobilizers in areas where ICN network is not feasible and assess the impact.
30. Further strengthen the ICN network through continued capacity-building, supervision and monitoring. Special emphasis to be placed on ensuring full alignment with the operations teams, as noted above in the TAG-endorsed proposal to merge ICN mobilizer and vaccinator in single SIA team structure.
31. Conduct further qualitative analysis to enhance understanding of reasons for missed children.

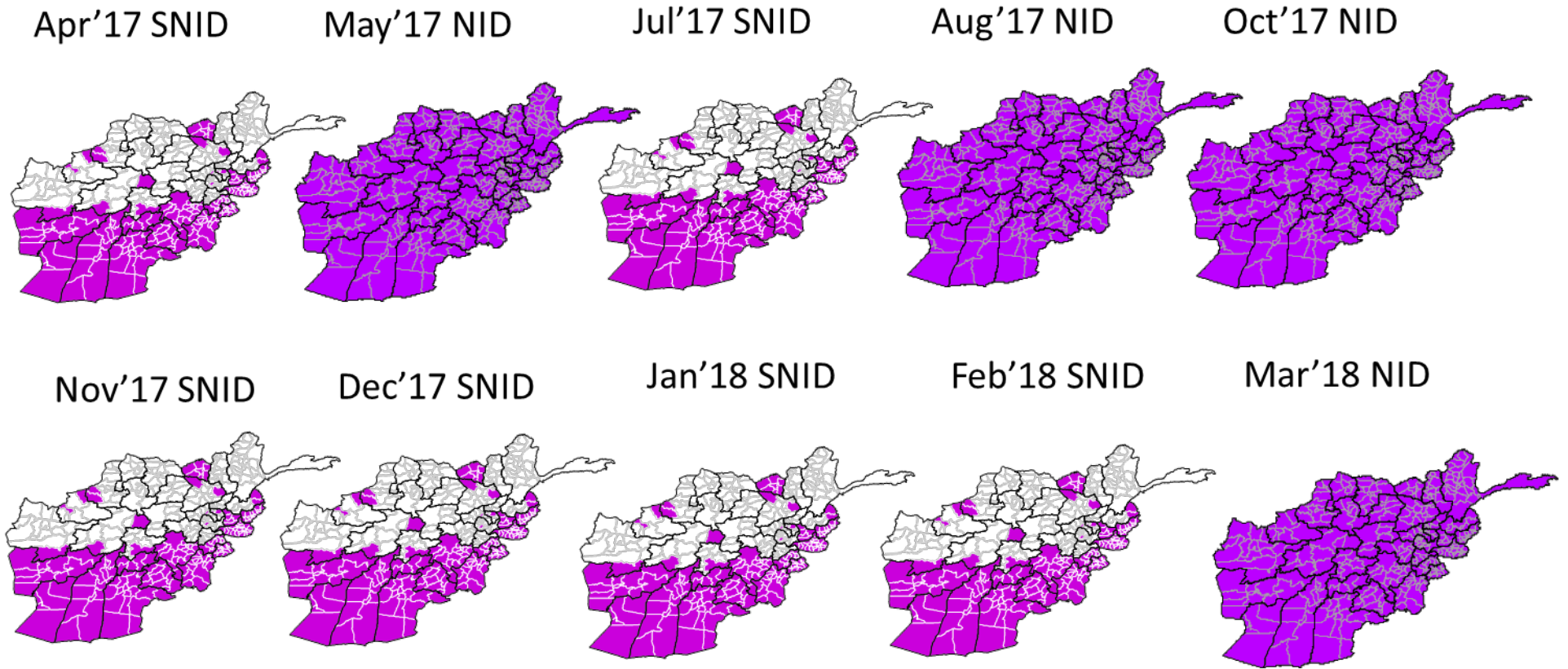
**Annex I**

**RESPONSE TO THE QUESTIONS FROM THE COUNTRY**

- Is the plan for the NEAP updating and risk categorization appropriate?
- *The TAG agrees with the plan.*
- Is the risk mitigation plan presented appropriate?
- *The plan presented is appropriate and the TAG suggests incorporating these in the NEAP.*
- Does the TAG agree with the expanded SNID scope and the SIA schedule presented?
- *TAG endorses SIA plan presented.*
- Does the TAG agree with the plan to use National EOC focal points instead of deployment of Monitoring and Accountability Officers?
- *Yes, the TAG agrees with the plan.*
- Does the TAG agree with the deployment of ICN social mobilizers as one member of the 2-person vaccination teams?
- *Yes, in principle; it is suggested to start with one district each in the south and east and then explore feasibility for expansion.*
- Is the approach presented for high-risk mobile populations appropriate?
- *Yes; a coordinated approach between regions and with Pakistan is recommended.*
- Does the TAG agree with expanding ES to Kunduz, Mazar and Herat?
- *Yes, however before conducting the feasibility assessments, investigate the RRL capacity to absorb the additional sample load.*
- Does the TAG endorse the outbreak response approach with possible expanded age group and use of IPV+OPV?
- *Yes, however target age group to be flexible and determined by epidemiology.*
- What is the view of the TAG on vaccinating returnee population of all age groups?
- *Vaccine can be offered to returnees of all age groups at UNHCR and IOM Sites.*

Annex II

AFGHANISTAN SIA SCHEDULE FOR OPV



## Annex III

## AFGHANISTAN IPV+OPV SIA PLAN FOR APRIL – DECEMBER 2017

Reason	Province	District	NEAP 2016–2017	Target pop	IPV
High-risk	Farah	Khak-e-Safed	No	9,830	11,796
High-risk	Helmand	Deh-e-Shu, Garmsher, Reg	No	52,025	62,430
High-risk	Kunar	Ghaziabad, Sarkani	No	10,686	12,823
High-risk	Faryab	Qaysar	Yes	43,783	52,540
High-risk	Helmand	Lashkargah, Musaqalah, Nad-e-Ali	Yes	191,313	229,576
High-risk	Kabul	Kabul	Yes	74,000	88,800
High-risk	Nangarhar	Behsud, Jalalabad	Yes	164,283	197,140
High-risk	Nimroz	Zaranj	Yes	46,976	56,371
High-risk	Uruzgan	Dehrawud, Tirinkot	Yes	71,871	86,245
High-risk	Zabul	Qalat	Yes	27,579	33,095
Inaccess	Kunar	Watapur, Marawara, Dara-e-Pech, Chapadara, Nari	Yes	17,814	21,377
Inaccess	Kunduz	Kunduz, Emamsaheb, Qala-e-Zal, Chardarah, Aliabad, Khanabad, Dasht-e-Archi	Yes	152,336	182,803
Inaccess	Nangarhar	Pachieragam, Kot, Achin	Yes	11,867	14,240
Inaccess	Nuristan	Kamdes	Yes	590	708

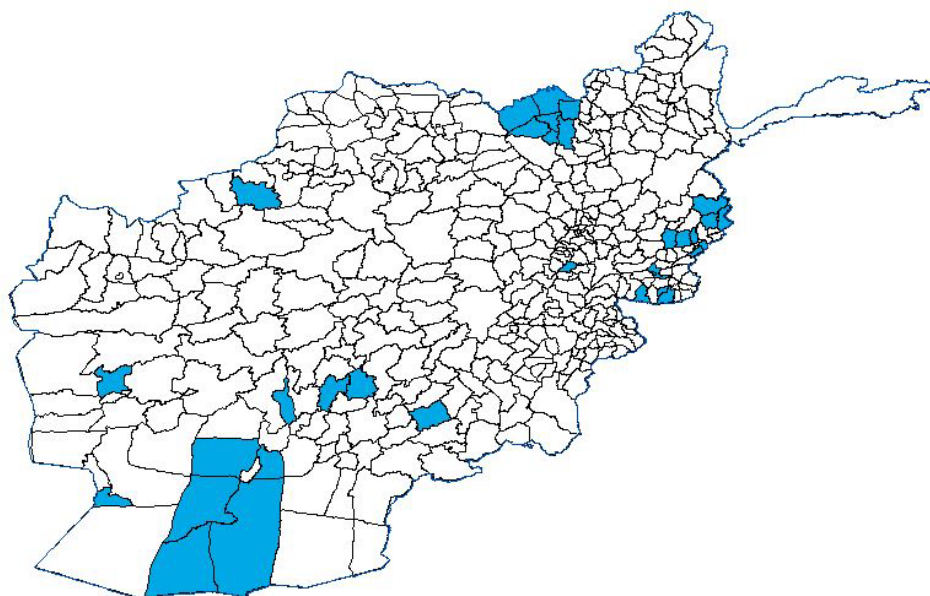
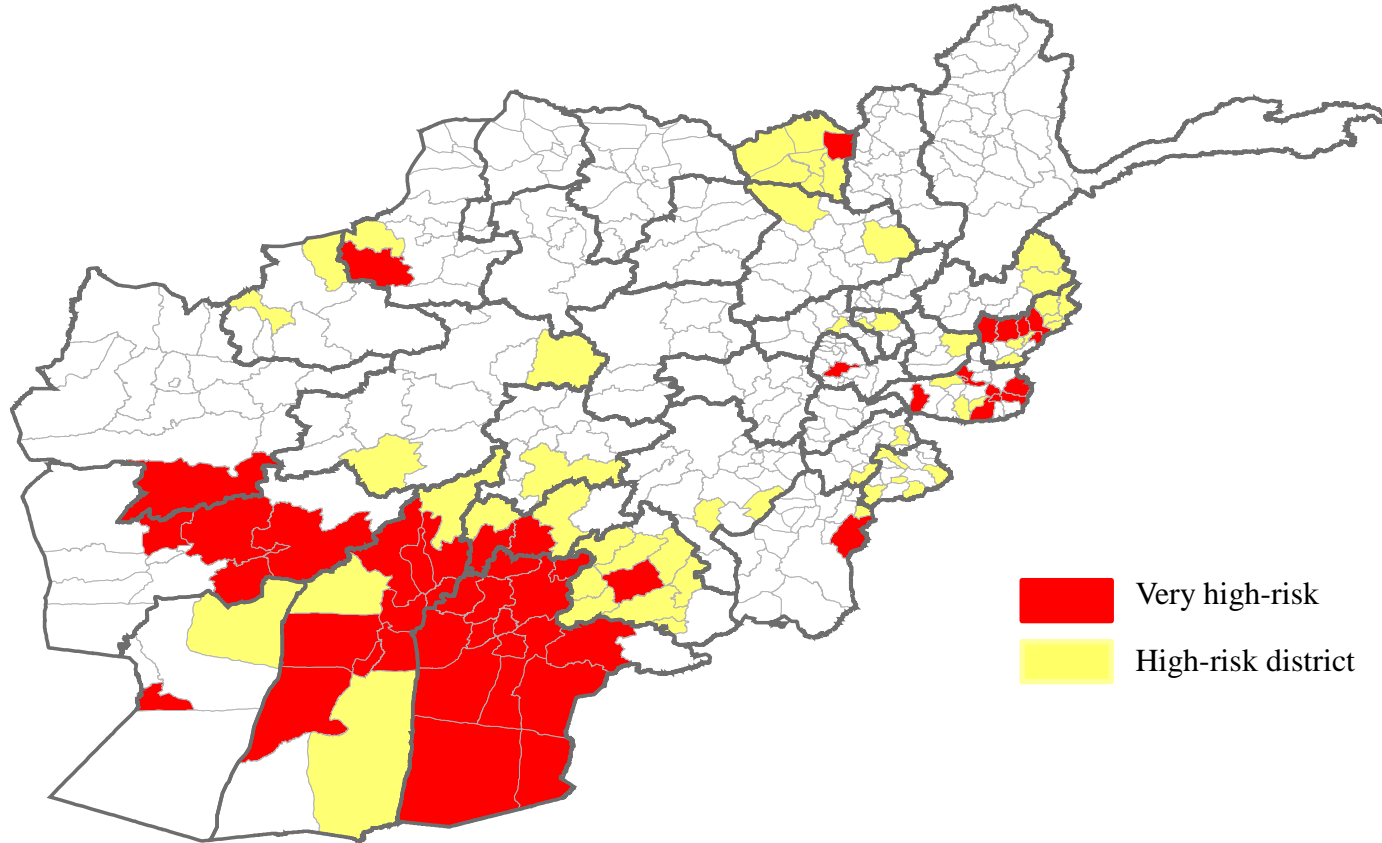


Figure 18: IPV+OPV SIA plan for April – December 2017

**Annex IV**

**MAP OF VERY HIGH-RISK DISTRICTS AND HIGH-RISK DISTRICTS, APRIL 2017**



## Annex V

## LIST OF VERY HIGH-RISK AND HIGH-RISK DISTRICTS, APRIL 2017

## Very high-risk districts

Province	District
Farah	Bakwa
Farah	Balabuluk
Farah	Gulestan
Farah	Khak-e-Safed
Faryab	Qaysar
Hilmand	Kajaki
Hilmand	Lashkargah
Hilmand	Musaqalah
Hilmand	Nad-e-Ali
Hilmand	Nahr-e-Saraj
Hilmand	Nawa-e-Barakzaiy
Hilmand	Reg
Hilmand	Sangin
Hilmand	Nawzad
Hirat	Shindand
Kabul	Kabul
Kandahar	Arghandab
Kandahar	Arghestan
Kandahar	Daman
Kandahar	Ghorak
Kandahar	Kandahar
Kandahar	Khakrez
Kandahar	Maywand
Kandahar	Miyanshin
Kandahar	Nesh
Kandahar	Panjwayi
Kandahar	Reg
Kandahar	Shahwalikot
Kandahar	Shorabak
Kandahar	Spinboldak
Kandahar	Zheray
Kunar	Chapadara
Kunar	Dara-e-Pech
Kunar	Marawara
Kunar	Watapur
Kunar	Sheegal
Kunduz	Dasht-e-Archi
Nangarhar	Achin
Nangarhar	Batikot
Nangarhar	Behsud
Nangarhar	Jalalabad
Nangarhar	Lalpur
Nangarhar	Muhmand Dara
Nangarhar	Sherzad
Nangarhar	Shinwar
Nimroz	Zaranj
Paktika	Bermel
Uruzgan	Dehrawud
Uruzgan	Tirinkot
Zabul	Qalat

## High-risk districts

Province	District
Badghis	Ghormach
Badghis	Muqur
Baghlan	Baghlan-e-Jadid
Baghlan	Khost Wa Fereng
Daykundi	Gizab
Faryab	Almar
Ghazni	Giro
Ghor	Lal Wa Sarjanganal
Ghor	Taywarah
Hilmand	Baghran
Hilmand	Garmser
Hilmand	Washer
Kapisa	Mahmud-e- Raqi
Kapisa	Nejrab
Khost	Gurbuz
Khost	Mandozayi
Khost	Musakhel
Khost	Terezayi
Khost	Spera
Kunar	Asadabad
Kunar	Barkunar
Kunar	Dangam
Kunar	Ghaziabad
Kunar	Khaskunar
Kunar	Narang
Kunar	Nari
Kunduz	Aliabad
Kunduz	Chardarah
Kunduz	Emamsaheb
Kunduz	Kunduz
Kunduz	Khanabad
Kunduz	Qala-e-Zal
Laghman	Alingar
Nangarhar	Dehbala
Nangarhar	Kot
Nangarhar	Surkhrod
Nimroz	Khashrod
Nuristan	Barg-e- Matal
Nuristan	Kamdesh
Paktya	Chamkani
Paktya	Zadran
Paktika	Gyan
Parwan	Charikar
Uruzgan	Chora
Uruzgan	Shahid-e-Hassas
Zabul	Arghandab
Zabul	Atghar
Zabul	Daychopan
Zabul	Mizan
Zabul	Nawbahar
Zabul	Shahjoy
Zabul	Shinkay
Zabul	Tarnak Wa Jaldak



**Annex VI****HIGH-RISK MOBILE POPULATIONS STRATEGY***Background*

The polio epidemiology in Afghanistan in 2016–2017 and experiences from other endemic countries highlight the crucial role of mobile populations in sustaining and spreading polio transmission. These populations are particularly important in the current epidemiological context of Afghanistan as well as Pakistan as they are instrumental in carrying the transmission across borders and making the two countries a single epidemiological block. Therefore, strategies are being strengthened to track and reach these mobile populations termed as High Risk Mobile Populations (high-risk mobile populations). This document elaborates the types of high-risk mobile populations and interventions to improve their immunity against poliovirus.

*Types of high-risk mobile populations*

The programme has identified four main categories of high-risk mobile populations that are of importance for polio eradication. These are:

1. **Long distance travellers within the reservoir areas;** particularly between Karachi, Quetta, Kandahar, Helmand, Farah and Faryab, and Peshawar, Nangarhar, and further to Northern provinces like Kunduz. These travels are mostly due to social and economic reasons and the travellers are absorbed in the host community as guests.
2. **Straddling population along the bordering areas;** some tribal communities living around border maintain their living bases on both sides of the border and continuously shift across borders based on their needs and convenience. The straddling populations are predominant in Paktika, Paktia, Khost, Nangarhar and Kunar provinces.
3. **Nomadic populations;** these are population groups which move from one place to other including cross border for livelihood, predominantly for grazing and trading of their livestock.
4. In general, these groups follow a pattern in their movements, both seasonally and geographically.
5. **Returnee refugees;** due to political and other reasons, a huge surge of Afghan refugees returnees has been witnessed since June 2016. More than half a million refugees have returned to Afghanistan in 2016. The registered returnee refugees are given financial assistance by UNHCR while unregistered returnees are given material support by IOM. The returnees mostly settle within the settled host populations, rarely in temporary camps for a short period. Nangarhar, Kabul, Paktika, Baghlan, Kunduz, Kandahar and Helmand are amongst the provinces with highest number of returnee refugees.

*Strategies to vaccinate high-risk mobile populations*

Specific strategies have been developed for all these four categories of HRMP. Implementation of these strategies is being done in close coordination with Pakistan National

EOC. The coordination with Pakistan on HRMP is being further strengthened and joint identification, mapping is being developed.

### **Long distance travellers within the reservoir areas:**

Apart from strengthening quality of SIA campaigns in the core reservoir areas, following strategies are being implemented to reach this population group:

#### *Identification and mapping*

Areas with higher proportion of guest children/visitors are being identified through house to house survey by social mobilizers after every campaign. Information is collected on area of origin, duration and seasonality.

#### *Focus during the SIA campaigns*

Training is modified to focus on identifying and vaccinating non-resident children. Vaccinators, social mobilizers and supervisors focus on visiting/guest children to ensure that no such child is missed. Intra-campaign and post campaign monitors also focus on the visiting children during process of monitoring.

#### *Vaccination during movement*

Cross-border vaccination posts and permanent vaccination points to vaccinate children travelling across epidemiological corridors between two countries

### **Straddling population along the bordering areas**

#### *Identification and mapping*

All settlements with population which frequently moves across the border is identified and mapped focusing on Kunar, Nangarhar, Khost, Paktia, Paktika and Kandahar provinces. Information is also gathered about the movement pattern including relation across the border.

#### *Vaccination during SIAs*

All such identified settlement are included in microplan. These areas are considered as high risk areas and focused for supervision and monitoring.

#### *Vaccination during movement*

Cross border vaccination point and permanent transit points are reassessed and deployed to vaccinate during the movement.

## **Nomadic populations**

### *Identification and mapping*

Program has identified and mapped nomadic groups, routes, seasonality and places of settlements. This information is further streamlined through interregional coordination to get a comprehensive picture for whole of Afghanistan.

### *Vaccination during the movement*

Nomad specific PTT are deployed along the major movement routes using the information on movement pattern. This is further reviewed and strengthened.

### *Nomad specific SIA*

Nomad specific SIAs at the place of settlement are being conducted in South-eastern region when the population first enters in Afghanistan. This strategy will be continued and further strengthened.

### *Inclusion in SIA*

All nomadic settlements are included in SIAs.

## **Returnee refugees**

### *Vaccination at point of entry*

Cross-border posts strengthened to cater to increased flow through borders, particularly Torkham border in Nangarhar and Friendship gate in Kandahar

OPV, IPV and measles vaccination at UNHCR and IOM centers while the returnees visit to collect assistance benefits

### *Vaccination at place of settlement*

Program coordinates with UNHCR and IOM to get data on villages/districts of final settlement of returnee populations and flagging areas with high number of returnees for inclusion in microplan.

Survey is being done before campaign in the districts with higher inflow, to identify new settlements.

All newly identifying settlements are included in microplan and are focused during the campaign for supervision and monitoring.

*Cross border coordination*

Following steps are being taken for further systemizing coordination between Afghanistan and Pakistan for high-risk mobile populations:

1. A HRMP task team comprising of technical officers from both countries has been established
2. Tools for collecting information and mapping are being synchronized
3. Information from each country is integrated at local and national level
4. Strategies of both countries are synchronized

**Annex VII**

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