

Global Polio Eradication Initiative

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

Meeting Report, 22 & 25 June 2020

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## Acronyms

AGE	Anti-Government Elements
EMRO	(WHO) Regional Office for the Eastern Mediterranean
EPI	Expanded Program on Immunization
FLW	Frontline Worker
GPEI	Global Polio Eradication Initiative
H2H	House-to-House (immunization activity)
ICN	Immunization Communications Network
IDM	Institute of Disease Modeling
IAG	Islamic Advisory Group
LQAS	Lot Quality Assurance Sampling
NEOC	National Emergency Operations Center
NID	National Immunization Days
sNID	sub-National Immunization Days
NITAG	National Immunization Technical Advisory Group
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
S2S	Site-to-Site (immunization activity)
SIA	Supplementary Immunization Activity
TAG	Technical Advisory Group (for polio eradication)
TORs	Terms of Reference
cVDPV2	circulating Vaccine-Derived Poliovirus type-2
WPV1	Wild Poliovirus type-1

## Introduction

### **Context**

The Polio Eradication Initiative (PEI) in Afghanistan in 2020 is facing extraordinary circumstances challenging its ability to reach the goal of stopping all poliovirus transmission: co-circulation of both WPV1 and cVDPV2 in the context of the continued ban on mass vaccination by Anti-government Elements (AGE) amidst a complex and fluid political climate, and a new government following general elections and the associated change of senior leadership in Ministry of Public Health. In addition, a new challenge emerged in 2020: the COVID-19 pandemic.

The COVID-19 pandemic has caused a pause in the implementation of SIAs. As importantly, TAG is concerned about the extent to which COVID-19 is impacting on the country polio team, with many staff at all levels infected and others working remotely. Despite this challenge, the team has not only maintained essential functions, but also has heroically supported response to the COVID-19 pandemic.

Afghanistan has, at least twice, interrupted WPV transmission in the past decade in the two endemic reservoirs of the Southern and Eastern Regions. TAG firmly believes the program can again interrupt transmission with restoration of access and sustained improvements in the quality of SIAs.

### **Revised TAG Process**

Led by a multi-agency working group within the GPEI Hub, the process of reviewing and revising the Afghanistan TAG Terms of Reference (TORs) and membership was started in late 2019 and finished with TORs approved by the Regional Directors of WHO EMRO and UNICEF ROSA on 8 June 2020. The review process consulted widely and incorporated feedback from within the GPEI Hub, the GPEI Strategy Committee, the Regional Health Advisor ROSA and Polio Director EMRO. Key changes from the previous TAG TORs include:

- TAG membership (to be implemented after the June 2020 meeting): increased transparency in member selection through formal call for nominations; ensuring representation of relevant areas of technical expertise; increased gender balance; time-limited tenure;
- TAG Secretariat: increased GPEI ownership in supporting preparation/facilitation/coordination of the TAG meetings by the GPEI Hub TAG Secretariat, including use of GPEI-wide resources as necessary;
- TAG Rapporteur sourced from outside the country program to ensure TAG's independent voice;
- Meeting frequency: once-yearly in-person; once-yearly virtual;
- Process of meeting preparation and format: specific questions to be submitted in advance by the program; TAG sub-committee to review evidence and develop documents to be presented to the TAG prior to meeting; meeting interaction to be more focused on technical discussion on identified questions;
- Increased formalized linkage with RI through NITAG; and
- Facilitation and oversight of implementation: formalizing the role of the RD EMRO and RD ROSA in facilitation and oversight of implementation of recommendations.

In line with the revised TAG TORs, the Afghanistan NEOC sought guidance from the TAG on different aspects of the program with defined questions. Working groups were formed within the TAG to address the questions and pre-TAG videoconferences were held with the country team, experts and stakeholders to further understand local context and perspectives and to dive into technical issues prior to the TAG meeting.

The virtual TAG meeting was conducted in two sessions: a full day on 22 June 2020 for country team (national and regional) presentations and focused discussions, followed by a feedback session on 25 June 2020. The interval between the two sessions allowed for further consultations, facilitating the participatory process and inclusiveness of the TAG recommendations. For both sessions 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). The TAG Chairperson appreciated the TAG Members active participation throughout the extended period of pre-TAG and TAG meetings, particularly in light of the constraint of being spread across 13 time zones.

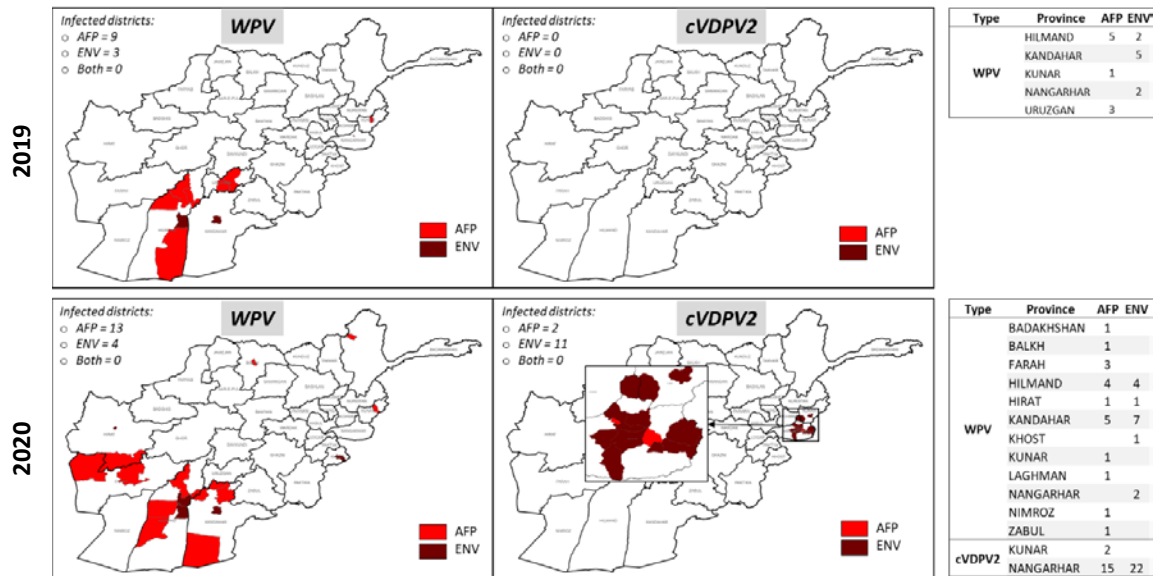
## Questions to TAG

The NEOC submitted 13 questions to the TAG in advance of the meeting as per the revised TAG TORs. These questions were grouped into the following five categories:

- *Polio outbreak risk, SIAs planning in light of COVID-19*
- *Access*
- *Communication*
- *Surveillance*
- *Integrated service delivery and Routine Immunization*

## Epidemiology and Risks

**Afghanistan Infected Districts: WPV and cVDPV2, March – May, 2019 - 2020**



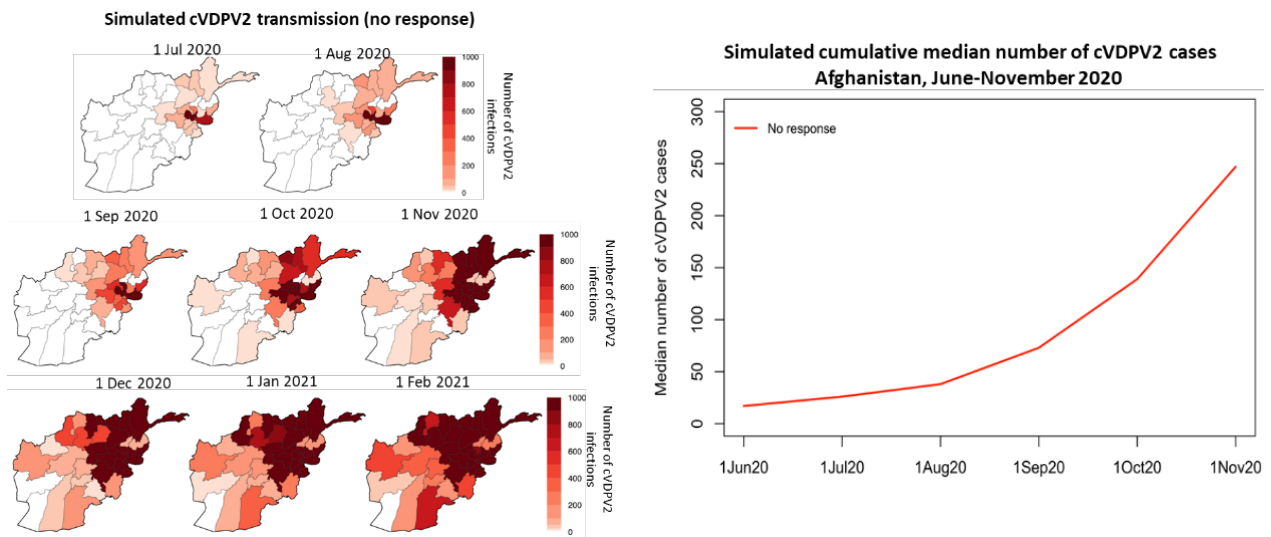
### cVDPV2

An outbreak of cVDPV2 is expanding in East Region following the first ES detections in Jalalabad in early January 2020. As of 26 June 2020, 17 cVDPV2 cases and >20 ES+ samples have been reported, all related to the PAK-GB1 cVDPV2 emergence. Cases have been reported from 10 (of 20) districts in Nangarhar

Province and from 2 (of 12) districts in Kunar Province. In addition, there have been isolations of Sabin-like type-2 viruses detected through ES since November 2019 despite there not having been any type-2 OPV immunization in Afghanistan since type-2 OPV cessation in 2016. Given the expanding outbreak, on 11 May 2020, the mOPV2 Advisory Group approved type-2 vaccine to cover two SIA rounds in Nangarhar, Kunar and Laghman provinces (target <5 years population = 1.1 million). Subsequently, based on TAG recommendation, the mOPV2 Advisory Group approved the addition of Kabul City District to the response plan (target <5 years population = 1.05 million). SIAs are currently suspended due to COVID-19, increasing not only the risk of further cVDPV2 spread within Afghanistan, but also further expansion internationally.

**cVDPV2 Modeling Projections**

In the context of the large nationwide accumulation of populations susceptible to type-2 polio (OPV2-containing vaccine last used in April 2016) and uncontrolled circulation for 6+ months, models developed by the Institute of Disease Modeling (IDM) project that between 10-15% of provinces in Afghanistan would be infected with cVDPV2, corresponding to ~250 cVDPV2 cases, by November 2020 if no type-2 SIAs are conducted in the remainder of 2020.



**WPV1**

There has been a dramatic increase in WPV1 cases in 2020, as anticipated given the ongoing ban on polio vaccination by AGE. As of 26 June 2020, Afghanistan has reported 26 cases from 12 provinces, compared to 13 cases from 3 provinces at the same point in time in 2019, and positive environmental samples continue to be reported in 2020, particularly from Helmand and Kandahar. WPV1 is driven by the transmission in the Southern region, which has been uninterrupted since 2017, and expansion to previously polio-free provinces in the north (Badakhshan, Balkh provinces) and west (Badghis, Herat, Farah and Nimroz provinces). In contrast, AFP and environmental surveillance show lower-level WPV1 transmission ongoing in Eastern Region in 2020, with one case each from Kunar and Laghman provinces. There have been no cases reported from Nangarhar Province in 2020, and only two ES+ samples were reported from January 2020.

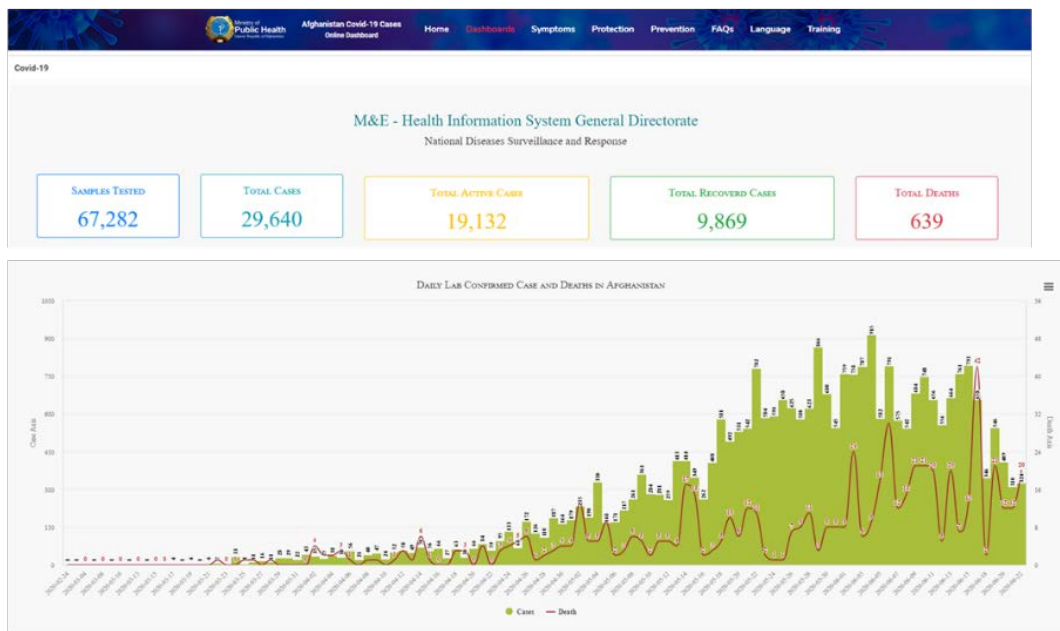
### **WPV1 Modeling Projection**

Modeling forecasts expansion of wild polio transmission in the Southern and Eastern regions, re-established transmission in the West and North regions, and introduction into the Southeast Region if no type-1 SIAs are conducted in the remainder of 2020.

### **COVID-19**

As of 24 June 2020, Afghanistan has reported 29,640 COVID-19 cases across the country, and models have shown that COVID-19 cases may continue to rise into Q3 2020, although it is difficult to predict the timing of the peak of the epidemic. COVID-19 has taken a very unfortunate toll on healthcare workers: at least 20 healthcare workers have died; 24% of polio field operations/surveillance staff have tested COVID-19 positive – 90% in the Western Region where the outbreak started; and 5% of polio communication staff have tested positive. While the opening of restricted movement started after Eid, there are significant negative impacts on essential health services (provision and uptake), including immunization. Polio eradication activities have also been affected, including the cancellation of SIAs and a reduction in AFP case detection.

### **Data from Ministry of Public Health COVID-19 Dashboard**



Snapshot as of 24 June 2020

### **Potential impact of SIAs on COVID-19 transmission**

Modeling by the Institute for Disease Modeling (IDM) shows that SIAs are likely to result in only temporary, small (<2%) increases in COVID-19, assuming risk mitigation measures are implemented:

- Avoiding SIA modalities that may introduce COVID-19 to communities not previously infected
- Recruiting polio workers from the same communities into which they are deployed
- Screening polio workers for symptoms to reduce risk to households
- Reducing risk to households: polio workers should use a face mask (of a standard meeting current WHO guidance) and hand sanitizer and limit physical contact as much as possible, particularly with

adults (current evidence suggests children may be at lower risk for COVID-19 infection acquisition and transmission)

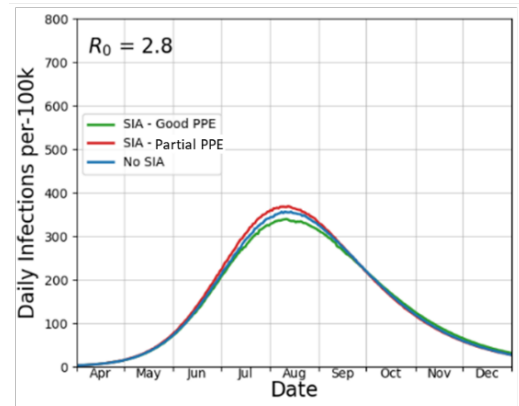
- Reducing risk to polio workers:
  - Avoid contact with symptomatic individuals (esp. adults)
  - Reduce unnecessary contacts
  - Reduce risk of infection (face mask and hand sanitizer, physical distancing)

### Polio risks and decision framework to resume SIA

The decision to restart polio SIAs in Afghanistan must be made by the highest level of political leadership. SIAs can be resumed, provided the following conditions are met:

- Political commitment at all levels, in all areas
- Careful assessment of health and availability of health workers and polio volunteer workforce
- Adaptations to SIA operations to reduce COVID-19 risk
- SIA plan informed by clear understanding of community perceptions and attitudes, and rationale for SIAs credibly communicated to workers and communities
- Consideration given to using SIAs to assist COVID-19 response and recovery efforts

Impact of a door-to-door urban campaign\*



Assumptions: 80% of a HCW's contacts are with children <5yrs during SIA periods. Good PPE = 95% reduction in infectivity rates. Partial PPE = 50% reduction in infectivity rates.

## Findings and Recommendations

Strategic Program Objectives and SIA Principles until end-2020	
Strategic Program Objectives	SIA principles to meet objectives
Eliminate cVDPV2 nationwide	<ul style="list-style-type: none"> <li>• Two mOPV2 SIAs in eastern region + Kabul in July / August</li> <li>• Increase surveillance sensitivity now</li> <li>• Develop contingency plan for any additional cVDPV2 detection including:               <ul style="list-style-type: none"> <li>• Rapid response (within 2 weeks of notification)</li> <li>• Prepare for possible large-scale type 2 SIAs in Q4 if cVDPV2 cases spread geographically or transmission persists through September</li> <li>• “Reserve” type 2 vaccine with GPEI for additional Q4 SIAs if required</li> <li>• Prepare for large scale nOPV2 use in 2021 if required</li> </ul> </li> </ul>
Eliminate WPV1 from Eastern Region and non-endemic areas	<ul style="list-style-type: none"> <li>• 2 NIDs with bOPV</li> <li>• sNID with bOPV in December</li> <li>• Rapid outbreak response to WPV1 in non-endemic areas</li> </ul>
In Southern Region: <ul style="list-style-type: none"> <li>• Contain WPV1, if no access</li> <li>• Establish mutually agreed effective approaches in AGE areas</li> </ul>	<ul style="list-style-type: none"> <li>• Improve SIA quality in accessible areas</li> <li>• Progress in access negotiation; structured Integrated Services approach; effective site –to-site, etc. (see access section) – whatever can deliver repeated polio immunizations (4-5 times in 6 months) to &gt;90% of children &lt;5yrs</li> </ul>



## SIA resumption and SIA plan for 2nd half of 2020

*Questions to TAG: Does the TAG support the restart of polio campaigns in early July in the midst of the COVID-19 outbreak in Afghanistan? What is the further advice on this? What operational and planning adjustments are needed so that local transmission of COVID-19 is not amplified, health workers and communities are protected, and everyone feels safe?*

The scale of changes to restart SIAs requires additional planning time for: understanding community perceptions related to PEI during the COVID-19 pandemic, supply of face masks and hand sanitizer, micro-plan adjustments, and training of FLWs on the adjustments to SIA implementation.

As there are possible risks of a negative reaction among communities to a “polio-only SIA” approach given COVID-19 disruptions and community needs, before mass scale SIAs restart, it is imperative that the polio program carefully consider the SIA design, informed by data on perception from communities and health workers.

### **TAG Recommendations on operational and planning adjustments for SIA resumption**

TAG recommends that SIAs are designed within the broader context of COVID-19. Operational adjustments include:






- Strictly deploy only local vaccinators
- Minimize other staff from outside (monitors, etc.), all workers with face masks and hand sanitizer and physical distance from everyone – other vaccinators and community
- Modify ‘external’ monitoring – seek alternative methods but ensure transparency and robustness
- Screening vaccinators – no COVID-19 symptoms
- Selective physical distancing, particularly with adults
- Masks and hand sanitizer
- Low-contact vaccine administration
- Robust training
- Revised microplanning for higher workload

*Questions to TAG: Does TAG agree with the mOPV2 response strategy in the Eastern Region as planned? What additional measures should be taken by the program in Eastern region and other areas for cVDPV2 transmission? Does TAG agree with the outbreak response plan in non-reservoir areas - 3 bOPV rounds in infected districts between August and December? What additional measures should be taken? Which SIA option does the TAG endorse?*

In line with the need to start small and learn lessons and to be consistent with the stated principles to prioritize stopping cVDPV2 transmission and reducing the geographic footprint of WPV1, the TAG proposes the following modified SIA schedule:

**Proposed example SIA schedule consistent with Objectives and Principles for 2nd half of 2020**

Expand to include Kabul if operationally feasible      Convert some areas to mOPV2/tOPV if needed\*

July	August	September	October	October	November	December
			If needed, additional SIA			
1,101,740 children	1,101,740 children	9,999,227 children		9,999,227 children		3,892,388 children
mOPV2	mOPV2	bOPV*	mOPV2/tOPV	bOPV		bOPV

**NB: The use of mOPV2 or tOPV must include proper vaccine management to ensure that every vial – used or unused – is tracked and retrieved to avoid unintended use of these vaccines.**

*Question to TAG: What additional measures should be taken to improve quality further in the accessible areas of the South on top of recent steps to improve quality?*

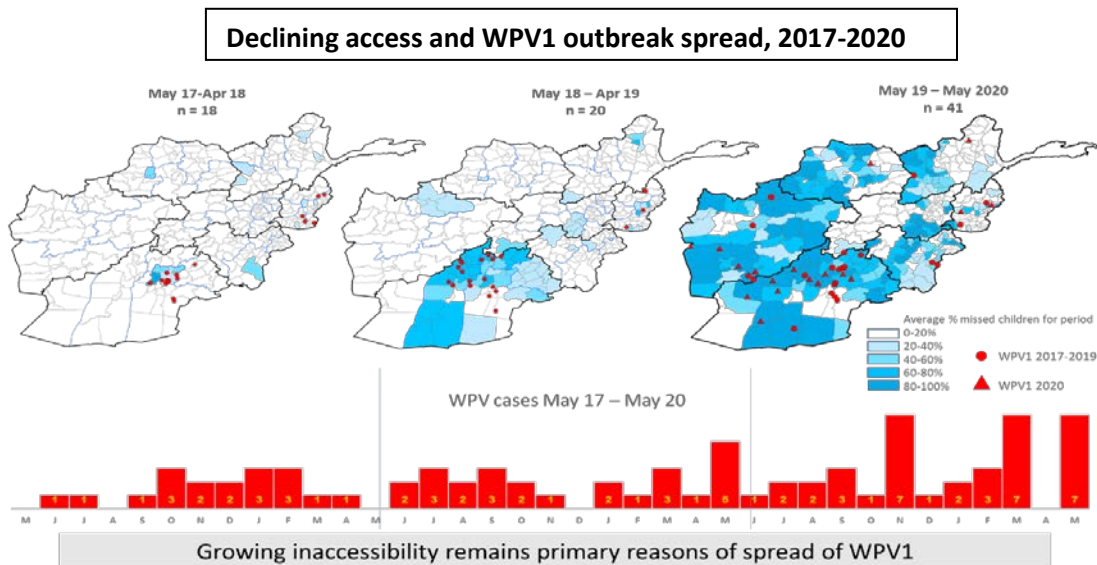
The TAG noted that there has been mixed progress in taking actions aimed at strengthening SIAs in accessible areas of Southern Region: female team recruitment increased from 32% to 51% in Kandahar City; female Cluster Communication Supervisors in the Immunization Communications Network (ICN) increased from 15% to 35%; microplan revalidation and workload revision have been conducted, and the revisit strategy has been modified; and FLW payment arrears have been cleared. However, female team recruitment increased only slightly in Lashkargah (from 22% to 26%); overall CSOs in ICN are still 80% male in Helmand and 66% male in Kandahar; 80% LQAS lots were rejected at 90% in December 2019 and February 2020; and timely payment of FLWs has yet to be resolved.

These challenges exist in a context of rising numbers of refusals in Kandahar, as interventions to create an enabling environment are not yet achieving the desired impact.

**TAG Recommendations on Improving SIA Quality**

Accelerate improvements in core SIA performance factors by end 2020:

- Recruit females for at least 80% of vaccine teams to increase to 100% (at least one female member in 100% of the teams before end 2020), ICN, senior female positions and female recruiters/selectors - target 100%
- Further reduce interference with recruitment: exclusively local vaccinators and social mobilisers for community acceptance and COVID-19 risk reduction
- Monitor and evaluate FLW training (including COVID-19 vaccination SOP)
- Enhance supervision and monitoring, and sanction non-performance
- Achieve functionality and efficiency of payment systems of FLW, monitor timeliness
- Systematically investigate the recent improvement in household acceptance of OPV to identify factors associated with the improvement, apply lessons to reverse entrenched 'still refusals'



*Questions to TAG: Program will keep on advocating for full H2H access. If only S2S campaigns are allowed, program will increase sites, tailor communication and mobilization efforts, and offer plusses. What additional measures does the TAG recommend?*

*Questions to TAG: Should the program use a neutral third party to implement vaccination campaigns? If so, what measures should be taken to ensure quality sufficient for interruption and eradication?*

*Questions to TAG: AGE requested support for COVID-19 response in South. Program is seeking to leverage support to build trust, but to date AGE have maintained campaign restrictions. What does the TAG recommend as a way forward?*

The TAG considers the lack of access for polio campaigns in many parts of the country due to constraints imposed by AGE to be the main obstacle to polio eradication in Afghanistan. The vast majority of cases in 2020 have come from inaccessible areas. Less than 70% of target children were accessible for house-to-house (H2H) or site-to-site (S2S) vaccination during the February campaign. The situation is even worse in the main reservoir of Afghanistan – the Southern Region where <50% of target children were accessible for H2H or S2S. Currently, no polio mass vaccination activity is allowed in AGE-controlled areas of the Southern Region, not even site-to-site.

To address this situation, the program has broadened and intensified negotiations at all levels but no breakthrough has been achieved. COVID-19 response support presents an opportunity to build trust and pave the way for delivery of routine and supplementary immunizations and potentially open the door to H2H or S2S campaigns and the TAG congratulates the partners on the significant support provided to the COVID-19 response in AGE areas.

## TAG Recommendations on Addressing Access

- TAG recommends continued dialogue for access at all levels within a coherent and coordinated process across partners with agreed messaging, asks and red lines (non-negotiable).
- Dialogues at all levels should be coordinated to ensure common messaging.
- The program should continue to pursue new approaches to gaining access including leveraging COVID-19 response support and utilizing other partners with established relationships with AGE.
- The program should strive for H2H access and be prepared to conduct at least 3 campaigns in newly accessed areas.
- If S2S access is gained, the program should seek to reach >70% coverage by ensuring independent monitoring, establishing a high number of sites (e.g., >1 site per 20 houses), intensifying social mobilization (i.e., adding mobilizer to vaccination team), and adding plusses.
- If no additional access is gained, the program should use every opportunity to vaccinate kids, including extending coverage of basic health services, intensifying outreach activities, implementing high-quality multi-antigen campaigns, and ensuring independent monitoring.
- The TAG welcomes other 3<sup>rd</sup> parties to implement campaigns, if feasible. The program should map the existing actors who are acceptable to AGEs and ensure they have the capacity to reliably implement vaccination campaigns in inaccessible areas.
- The program should consider piloting in one inaccessible district of Kandahar, including:
  - Clear accountability mechanisms linked to process and output indicators and built into contractual arrangements;
  - Monitoring by credible monitors; and
  - If pilot successful, expand to other inaccessible districts of Southern Region.
- Critically, the program absolutely needs a breakthrough on access and should be as flexible as possible to achieve such a breakthrough, including in terms of implementing partners and implementation models (e.g., S2S, multi-antigen campaigns, plusses).
- OPV must be included in any multi-antigen or catch-up activity.

## Communication

*Question to TAG: What adjustments does the TAG recommend to the communications strategy in light of COVID-19 pandemic especially in South?*

Communication challenges continue to be a major obstacle to eradication particularly in the South and Southeast where refusals and access remain significant issues. There has been progress in communication planning and strategy as demonstrated in the development of an integrated PEI national communication plan with region-specific strategies responding to previous TAG recommendations and the December 2019 communication review. The TAG also notes a range of revised or expanded communication, social mobilisation and community engagement activities designed to improve communication impact. However, full implementation of this plan was disrupted by the unexpected ICN scale-down during the first half of 2020 and the impact of shifting resources from SIAs to COVID-19 support. Evidence regarding the impact of these interventions on core SIA objectives – SIA coverage/rates of missed children (including NA and refusal) – remains weak.

Resuming SIAs in the context of COVID-19 presents potential challenges to PEI and requires a clear understanding of community perceptions of immunisation and the likely response to restarting house to

house campaigns in accessible areas and site-based campaigns in inaccessible ones. There is a possible risk of misreading community sentiment and seeing an increase in refusals, a reduction in campaign quality and increased resistance to OPV, particularly by the AGE. The COVID-19 response presents PEI with an opportunity to reposition the program as part of the wider provision of integrated essential health services. PEI support to COVID-19 activities (e.g. hygiene kits, soap etc.) may constitute an opening for a renewed local access negotiation, but this needs to be robustly assessed. In order to take advantage of these opportunities and mitigate risks the program will need to strengthen its ability to rapidly assess community perceptions and attitudes in the lead up to resumption of SIAs, bring greater focus to its interventions, and pay more attention to evaluating them against core SIA objectives of coverage and reducing missed children.

The TAG identified three main areas for immediate attention – ICN, mass and social media, and impact measurement.

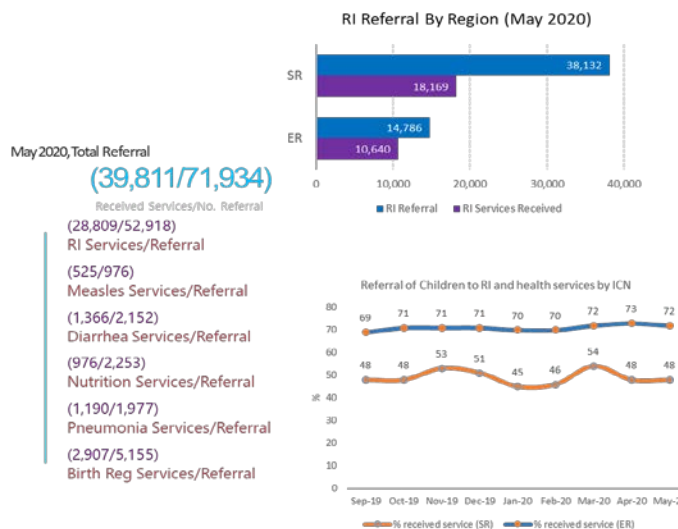
### Immunization Communications Network (ICN)

#### ICN – creating enabling environments

ICN remains a relevant structure for the program as it has demonstrated impact in the East Region. It has demonstrated its ability to increase female recruitment and support multiple activities such as partnerships with Wakil-i-Guzar and the IAG, interactive media through radio, round tables and local participation, and increased community accountability. However, in accessible areas like Kandahar City where ICN has been in place for a significant period, we see stagnant or worsening rates of refusal and ‘remaining refusal’. The impact of ICN, through positive community engagement, on SIA vaccination acceptance remains unclear. ICN’s role in communicating and facilitating referral and uptake of integrated services among communities is poorly defined with limited evidence of positive effect.

#### ICN – Referral

ICN impact on service referrals has shown some success, but unevenly. In the East, ICN referrals for routine immunisation and other health services have been stable and relatively high. In the South RI referral completion rates are lower and more volatile. Differences in context (literacy, access to health care, community attitudes, security and the influence of AGE) may explain these regional differences but need to be better documented and analysed to refine regional approaches to ICN deployment.



TAG noted that communication capacity in the Southeast is lower than in the East and South and has been cut further due to ICN reductions. Given the risk of HRMP in areas bordering on Pakistan with high current rates of viral transmission, combined with localised inaccessibility and high rates of refusal, this situation is worrisome and communication and engagement strategies need to be quickly developed to ensure the PEI is able to vaccinate adequately high-risk communities.

## TAG Recommendations on ICN

- Maximize recruitment of female ICNs in South region - 100% female ICN in Kandahar City by December 2020
- Review ICN SOP in the South to focus on continuous community engagement to maximize household vaccine acceptance during SIAs
- Rapidly identify alternative communication capacity in Southeast, with focus on hard-to-reach HRMP groups in Paktika/Bermal
- Review and agree on ICN role in supporting integrated service delivery (ISD) as a strategy for improving SIA performance, and measure impact against rates of missed children and refusals

## Mass & Social Media

The media strategy has been strengthened under the 2020 action plan with revised media mapping for the South, Southeast, East and West regions; partnerships with national and local media; the development of new messages and materials; edutainment programs; and journalist training. It was rapidly deployed as part of polio support to the COVID-19 response.

The social media strategy continues to evolve using a variety of platforms including Facebook, Twitter, YouTube and Instagram but focusing on Facebook which is the most widely used in Afghanistan. The use of the polio Facebook site for dissemination of COVID-19 information generated a significant spike in April in Facebook engagement. A pilot WhatsApp initiative allowing FLWs to form groups to share information on rumours and materials to counter those rumours will require careful management and monitoring to ensure that online response to rumours is effective rather than counterproductive. Capacity to analyse social media data is still in early-stage development, coordination and cross-learning with Pakistan has started. These are positive developments, but social media can be unpredictable, so care must be taken to avoid amplifying and/or giving legitimacy to negative messages.





### **TAG Recommendations on Mass & Social Media**

- Continue to develop social media capacity, but with a cautionary approach – ‘do no harm’ (e.g. risks of uncontrolled negative coverage)
  - Build analysis capacity, including third-party support, to track major movements in public perception and identify where they are happening
  - Leverage Pakistan program social media techniques and strategies, as well as coordinating work with common platforms like Facebook
- Explore establishing a formal relationship with Facebook using example of other countries

### **Communication: Measuring Impact**

The communication action plan has multiple sub-strategies and activities. Some of these are new, such as the partnership with Wakil-i-Guzar, others are being renewed such as the partnerships with the Islamic Advisory Group (IAG) and local religious leaders, and some are long-standing but in the process of being reviewed and strengthened such as referrals, interactive media and community engagement. As these strategies and activities are implemented, they need to be carefully evaluated against the core PEI program outcomes – increasing SIA acceptance and coverage, reducing missed children and refusals – to better focus investment on the *most effective interventions*.

### **TAG Recommendations on Measuring Communication Impact**

- Evaluate ICN performance in accessible areas like Kandahar City against core SIA outcomes (coverage, missed children, refusals, change in acceptance)
- Identify households/communities which have converted from refusal to OPV acceptance and assess the reasons they give for this change, to inform wider interventions on refusal clusters
- Develop operational measures to assess community trust in the program
- Assess impact of media/social media messages on household perceptions

### **Surveillance**

*Questions to TAG: What additional interventions TAG recommend limiting Impact of COVID-19 on AFP surveillance?*

The unfortunate impact of the COVID-19 pandemic on polio surveillance has been a reduction in AFP case notification and some delays in specimen transport to the laboratory in Pakistan since March 2020. However, other surveillance processes continue to be well-managed, e.g. there has been no notable negative impact on case investigation and sample collection. The reduction in AFP case notification may be due to communities not seeking healthcare due to fear of COVID-19 and the closure of health facilities.

Surveillance is functional throughout Afghanistan – surveillance indicators are comparable across access categories and cases are reported from areas that are inaccessible for SIAs. There are just a few pockets

that are inaccessible for surveillance activities in Uruzgan Province (Southern Region), Herat Province (West Region) and Ghor Province (Central Region).

#### **TAG Recommendations on Surveillance**

- Take urgent measures to mitigate and reduce COVID-19 infection among program staff
- Identify approaches to facilitate resumption of AFP case identification during the pandemic
- Increase frequency of ES in Kabul, Kandahar and Helmand to at least fortnightly through end 2020, as response to cVDPV2 outbreak
- Review and reassess the storage capacity at peripheral levels for specimen & shipment practices to avoid unnecessary delays of specimens reaching the lab
- Organize virtual awareness sessions with Health Care Providers
- Coordinate with communication team to ensure all communication initiatives being developed include surveillance messages

*Question to TAG: What guidance does the TAG have isolation of 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 are two clusters of orphan/long-chain WPV1 from 2019-2020 in Afghanistan that are particularly concerning. Since both of these clusters are part of related circulation already detected in the known outbreak zones, the inference is that the reservoir for these orphans was established in Afghanistan at least from 2018, i.e. there are unidentified areas of missed circulation over at least two years. In addition, there is a very small number of polio-compatible cases compared to the number of cases with inadequate specimens (with no residual weakness), which raises concern about possible lack of follow-up/over-discarding of potential compatible cases – cases that could signal unconfirmed poliovirus transmission.

#### **TAG Recommendations on Surveillance: Orphan Viruses**

- Additional analysis of 2018 WPV1 orphan and long chain viruses should be conducted in the context of access to identify patterns in specific genetic chains of transmission to infer the possible location of undetected circulation
- Review the process and criteria for classifying compatible cases

### Routine Immunization & Integrated Services

*Question to TAG: Does the TAG endorse multi-antigen campaigns in Southern Region?*

Multi-antigen campaigns present an additional opportunity for providing polio vaccines in inaccessible areas. Campaigns have been conducted in parts of in Kandahar and Urozgan - 3 rounds in some districts of Kandahar and 1 round in a few districts of Uruzgan. It is noted that the campaigns could not be conducted in inaccessible areas of Kandahar.

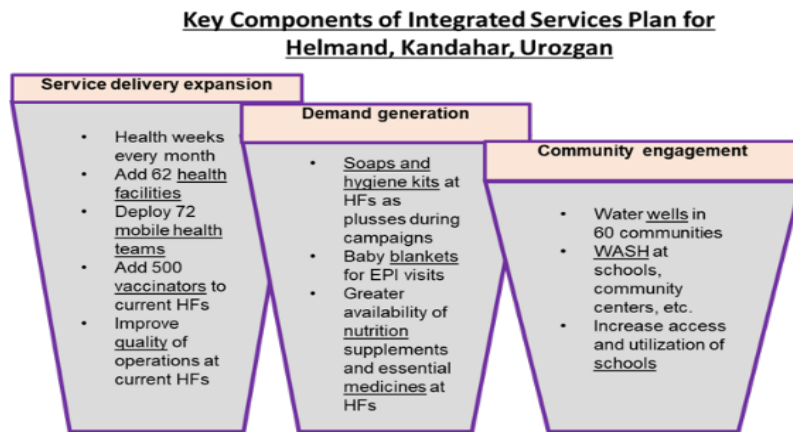


## TAG Recommendations on Multi-antigen Campaigns

- The TAG urges the rapid completion of the multi-antigen campaign in Urozgan and Helmand with the following guidance:
  - Coverage was low and some areas could not conduct them so document lessons from the campaigns conducted so far to improve planning for the upcoming campaigns
  - EPI and Polio program should both be deeply engaged in the planning, implementation, and monitoring of these multi-antigen campaigns.
  - Polio vaccine must be included in all multi antigen campaigns
  - Independent monitoring, including by WHO and UNICEF as feasible, must be ensured

*Question to TAG: Does the TAG agree that integrated service plan will boost EPI and PEI in the inaccessible and hard to reach districts?*

TAG notes the range of complementary service delivery strategies – COVID-19 plusses, multi-antigen campaigns, integrated services, and BPHS+ – being delivered in accessible and inaccessible areas. These are important approaches given the ongoing access challenges and the underlying long-run humanitarian conditions of poverty and marginalization in critical communities.



TAG appreciates the development of the Integrated Services plan. A key part of the plan is the concept of vaccine demand-generating complementary services (e.g., baby blankets, soap, etc.) These show some promise in widening acceptance and access but need to be rigorously evaluated for impact. Strong coordination with the Sehatmandi project as well as with other key partners focused on RI is important. Funding is also urgently needed to support full implementation of the Integrated Services plan and to drive rapid impact.

## **TAG Recommendations on Routine Immunization and Integrated Services**

- TAG supports full implementation of the Integrated Services plan in Helmand, Kandahar and Urozgan and requests the program to rigorously document implementation and impact, especially for the demand-generating complementary services (e.g., baby blankets, soap, etc.), specifically:
  - Identify goals and measure outcomes (perception changes or access);
  - Systematically document what's being done where; and
  - Prepare for TAG to evaluate at end-2020.
- TAG urges donors to urgently provide sufficient funds for Integrated Services plan and recommends MoPH to provide evidence of impact of Integrated Services to donors and work with them to transition to sustainable funding sources for the long-term.
- The TAG requests the MoPH to expand age target for OPV delivery in health facilities from 16 provinces to all provinces.

### **Essential immunization (BPHS+)**

- The TAG requests MoPH and Sehatmandi partners/donors to use mid-term review to incorporate successful elements of BPHS+.
- Consideration should be given to:
  - Revision of P4P to enable outreach immunization and improve balanced scorecard indicator of Penta3 coverage;
  - Addition of process indicators to evaluate effectiveness of BPHS:
    - Reaching at least 80% of the target population
    - At least X% of functional facilities
    - No more than X% of stockouts
    - At least X% of timely payment of staff salaries
- TAG urges the program to:
  - Establish process to provide feedback to BPHS implementers and ensure changes are made leveraging MoPH efforts to improve management and accountability of EPI (e.g. Acasus).
  - Monitor all HFs in Helmand, Kandahar, and Urozgan at least 1x per month with standard checklist
  - Incorporate measures of community perception/trust in services and service providers
- Expand age target for OPV to under five in RI from 16 provinces to all provinces

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