Framework for change: fast-track to zero polio cases

27 October 2018

Context and background:

Afghanistan has 16 polio cases in 2018 of which 5 are from Eastern region (3 Kunar and 2 Nangarhar) and 11 are from the Southern region (8 from Kandahar; 2 from Helmand and 1 from Uruzgan).

Despite this setback, it is worth noting that 29 out of 34 provinces have not reported polio case in 2018 demonstrating that the strategies outlined in National Emergency Action Plan (NEAP) for Polio are successful in most of the areas.

In Afghanistan the implementation of NEAP is coordinated through the Emergency Operations Centers (EOCs) led by MoPH with support of implementing partners (UNICEF and WHO) and donor partners (BMGF, Rotary and US CDC).

In coordination with Pakistan, joint Northern and Southern Corridor action plans have been developed to focus on South and East region of Afghanistan and corresponding areas of Pakistan. However, the continued transmission in these corridors underlines need to relook at strategy to focus on addressing remaining and new emerging challenges in Eastern region and Southern region. Key feature of ongoing transmission in Afghanistan is as below.

Southern region:

1. Transmission of 2014-2016 was stopped in April 2016, highlighting the feasibility of stopping polio even in challenging contexts. However, transmission re-established in 2017 with epicenter in Kandahar. Key reasons for continued transmission are access related challenges (particularly in Northern Kandahar, Helmand and Uruzgan) and refusals especially in and around Kandahar city.
2. The most significant risk to the program is the continued ban on house-to-house campaigns in major parts of Southern region. Since May 2018, the ban on the house-to-house strategy in major parts of Helmand, Kandahar and Uruzgan. Out of a total target of 1.5 million children in these three provinces, the programme has not reached 790,000 children during that period.

Eastern region:

1. Repeated environmental samples positive along with 5 polio cases.

2. Unlike the Southern region which is having internal circulation, transmission in Eastern region is part of Northern corridor transmission which spans both Afghanistan and Pakistan.
3. Genetically similar viruses detected in Nangarhar, Kunar, Kabul and Khyber-Pakhtunkwa as well as Rawalpindi, Islamabad, and Lahore. Data strongly suggests significant movement of the virus back-and-forth across the border.

The Technical Advisory Group (TAG) for polio eradication in Afghanistan has indicated that if accessibility improves and is sustained, the program is on the right track to achieve the goal of stopping transmission in Afghanistan. Recent review by Independent Monitoring Board has also recognized inaccessibility and refusals for vaccination as key bottleneck and has urged the national program to look at alternate ways to address these.

In light of this, His Excellency the President has requested immediate review and bring required change to achieve stopping of polio transmission in Afghanistan. This *Framework for Change* is developed to address the remaining challenges in South and East region and will complement the existing approaches and strategies outlined in the National Polio Emergency Action Plan.

Challenges/risks to stopping polio in Afghanistan

- The most significant risk facing the program remains the continued **ban on the house-to-house strategy** in major parts of the Southern region.
- In the Eastern region small pockets of chronically inaccessible children and **high population mobility between Afghanistan and Pakistan**
- **Pockets of refusal** particularly in and around Kandahar as well as in Eastern region.
- Sub-optimal campaign quality in some key areas under control of AGE, due to management issues
- Low EPI coverage in areas with high risk for polio

Thematic changes:

1) 'Contingency plan' for polio immunization in inaccessible areas of Helmand, Kandahar and Uruzgan through a bundle of interventions i.e. targeted IPV+OPV (injectable polio Vaccine + oral polio vaccines), Permanent Polio Team (PPT) strategy, OPV vaccination during measles campaign, Strengthening Permanent Transit Team (PTT), Vaccination through mobile health teams (MHT) and EPI acceleration plan in the Very High RISK Districts (VHRDs) areas with house to house ban settings and inclusion of additional vaccinators to reach all villages.

2) External review of communication strategy and adopting to specific of contexts and with high impact strategy and interventions

3) Coordinated provision of other services related to health, water & sanitation, nutrition and education in Kandahar focusing on most affected districts including urban areas like Loya Walla and Manzil Bagh.

4) Strengthening routine immunizations in the seven provinces namely Kandahar, Helmand, Farah, Zabul, Pakitika, Nangerhar and Kunar to level of 90% penta-3 coverage

5) Increasing number of health facilities in very high-risk districts with sufficient number of vaccinators for fixed, outreach and mobile immunizations and deploying Community Based Outreach Vaccinators, recruited from the village, deployed in the village.

6) Empowering the provincial team and the regional EOCs through additional resources, replacing poor performers and reshuffling best national and international capacities to south

7) Establish framework of accountability, appraisal and reward schemes and the system at all level and applying corrective and disciplinary measures for poor performers and negligence.

Residual risks:

Situation of access and security is highly unpredictable and has potential of worsening in the coming few months in 2018 and 2019. Ability to maintain full access for polio vaccination in high-risk areas and neutrality of polio program presents great challenge.

Population movement between Afghanistan and Pakistan in northern corridor and its potential for harboring and spreading transmission needs close and transparent coordination between two countries to enable implementation of joint strategies.

Framework of changes- Strategic

Issues	Current strategies	Changes planned
Inaccessibility in South region 1. Ban on house-to-house vaccination in large parts of Helmand, Uruzgan and parts of Kandahar. 2. Chronic fragile access in Shahwalikot, Mianshin, Khakrez, Ghorak and parts of Maiwand, Arghistan, Maruf, Reg, Niash and Shorabak districts.	1. Community elder's engagement for advocacy at local levels 2. Dialogue at all levels (district, province and leadership levels) on reason of ban and negotiations 3. Expansion of permanent transit teams to cover all entry/exit from inaccessible areas 4. Vaccination from health facilities 5. Supplementary approaches including use of mobile health teams 6. Maintaining state of preparedness	1. Advocacy at the highest level for allowing house-to-house campaign- addressing apprehensions expressed by them. 2. When ban opens up: conducting 3 house to house campaigns within 2 months for catching up on missed opportunities. 3. Additional interventions planned to start in areas with ban, regardless of whether or not house to house campaigns are cleared to re-start: a. Combined IPV-OPV vaccination from fixed sites to start from 5th November (for example mosque to mosque/ village to village) b. OPV will be added to the planned fixed-site measles campaign starting on November 17, 2018 4. If ban is not cleared by End October: a. Strengthening permanent transit teams at all entry/exit points from inaccessible areas and all health facilities b. Intensified fixed site vaccination through site to site, schools to schools, house of village leaders, community health workers by beginning Nov, 2018 c. Community Based Outreach Vaccination (recruited from the village and based in the village, for all antigens) d. Involvement of Community Health Workers (CHWs) and Community Health Supervisors (CHSs) on community mobilization
Refusal for vaccination	1. Identification and analysis of refusals including where, who and why of the problem.	1. Systematize current interventions to develop an integrated approach, which is tailored for local needs.

Clustering of families in an area refusing vaccination to the children in family. This is predominantly issue inside and around Kandahar city. city: Kandahar city-Loyawala/Manzil Bagh areas, Spinboldak, Panjwayi, Shahwalikot, Arghandab, Zheray	2. Tracking of and focused interventions on chronic refusals 3. Identification and engagement of sphere of influencers, focusing in Kandahar a. Medical fraternity b. Religious leaders c. Other key influencers 4. Formation of team of mobile Mullahs 5. Refusal resolution committee at Province, district and supervisor cluster level 6. Monitoring of Intra Polio Campaigns (IPC) by ICN social mobilizers	2. Formation of refusal oversight committee at national and provincial level to guide, monitor and track progress. 3. Review existing list of influencers and refusal resolution committees and bring appropriate changes if needed. 4. Geographical cluster specific approach of campaigns to be modified to clusters by reasons. 5. Expansion and strengthening of Mobile Mullah approach. 6. Strengthened engagement of ministry of hajj and Auqaf 7. Review the number of visits to households for any campaign and strategize on reducing number of door knocks. 8. Coordinated provision of other services related to health, water, sanitation, nutrition and education. 9. Strengthening of supportive supervision and monitoring of pre-campaignH2H social mobilization and post campaign catch up activities.
Operational gaps in areas with access limitations In the areas under control/influence of Taliban, there are some pockets/districts where program has operational gaps. • Limited ability to directly monitor • Influence on selection of First Line Workers FLWs (vaccinators to supervisors and ICN). • Inability to implement accountability framework • Quality of training • Gaps in microplanning	1. Selection committees established in all provinces. 2. Monitoring of training quality. 3. Deployment of national staff for ensuring proper selection, training of FLWs and monitoring. 4. Remote monitoring of campaign quality using mobile technology and third party monitoring. 5. Sharing feedback on the gaps in quality and operations with concerned parties to ensure implementation of accountability framework.	1. Focused expansion of third party monitoring in HRD and Very High Risk Districts (VHRDs) 2. Increase pool of national staff (including mobilization from other provinces) who can be deployed to these districts for interventions and monitoring. 3. Review scope of remote monitoring and its effectiveness and increase sample size in south region. 4. Review formation and functioning of selection committee including areas with interference-Interference should be raised at the level of HE Health Minister 5. Review and modify modality of training including system of independent monitoring and feedback for corrective action.

• Corruption There is also limited use of data for corrective action at sub national level.		6. Support to Regions/provinces on use of program data for interventions-National level Operation Working Group (OWG) members to participate in Provincial Coordination Review (PCR) meeting of South region 7. Operation Working Group of EOC to coordinate the abovementioned interventions 8. Assess and Improve the quality, instead of multi round campaigns with approach to capture refusals. 9. Assess and review the possible duplication of human resource allocation, redistribution, changes of daily wage payments to coordinators to full payments scheme and additional resources at district level.
High risk mobile populations (HRMP) Cross border movement with Pakistan- Long distance travellers, nomads, straddling population and returnees • Carrying the transmission from one area to another Probability of missing vaccination on either side.	1. HRMP strategy developed and being implemented in coordination with Pakistan. 2. Vaccination of all children <10 yrs at borders in coordination with Pakistan and other UN agencies. 3. Vaccination at repatriation centers. 4. Nomad specific campaigns and vaccination points.	1. Continue full implementation of HRMP strategy in coordination with Pakistan including vaccination at border and repatriation centers 2. Coordinate with MOFA and MOI to make vaccination as precondition to entry in Afghanistan from Pakistan. 3. HRMP group at national level to review operationalization of nomadic strategy at provincial levels particularly in South and South east 4. As recommended by Technical advisory Group (TAG), fast track reviews of Polio Transit Teams (PTT) and Cross Boarder Team (CBT). 5. Full implementation of cross boarder plan
Low EPI coverage in high risk areas of seven provinces	1. PEI program supports monitoring of EPI sessions and provides feedback. 2. Information on under-immunized children shared with BPHS implementers 3. EPI team at national level and provincial level closely engaged in all polio related meetings 4. Mobile health teams deployed in white areas for filling in the gaps	1. Implementation of EPI acceleration plan in Helmand and Kandahar and expansion to all seven high risk provinces. 2. PEI support to EPI a. Enhance supervision monitoring by mobilization of PEI resources for EPI support. b. Sharing of information of under immunized children with BPHS NGOs. c. More engagement of ICN staff in demand creation for RI.

		d. Technical support in RI microplanning at district level 3. Developing an add on plan through other sources for vaccination in white areas a. Establish at least **20** health sub centers with EPI package to cover white and underserved area and increase access in Kandahar b. Upgrading all existing SHCs with EPI cold chain and vaccinators in all seven provinces c. Support BPHS implementing agencies to expand EPI outreach at white area of south d. RI micro plan to be revised and updated in all districts of south regions e. Additional vaccinators for BHC, CHC, DH having daily client more than 50. f. Strengthening communication activities for RI program g. Develop specific urban strengthening immunization plan

Framework of changes- Managerial

Area	Interventions planned
Human resources	1. Review of existing human resources at regional, provincial and district level across the partnership by SWG at National level. Make necessary changes to ensure that the team is fit for purpose including deployment of best assets from other regions to south region 2. Increasing the pool of provincial national staff who have capability to go to the AGE controlled insecure areas 3. Conduct exposure visits among regional EOC staff to cross-fertilize their field experiences and for lesson learnt. 4. Increase women engagement at regional, provincial and district level management 5. Hiring of District EPI Management Team, (DEMT) in remaining districts of Kandahar. 6. Review the performance of the current ICN contractor and bring appropriate changes.
Coordination	1. Further strengthen and empower REOC and their provincial teams 2. Delegate responsibilities of this framework to specific working groups to address specific challenges with clear accountabilities 3. Visit from National EOC to REOC with only specific and clear scope of visit and purposes. The visit should be well coordinated among the partnership at National level 4. Making single partner organization as "focal organization" to enhance the governance and stewardships role and enhance capacity of PEMTS, REMTs (R-EOCs) of south and east to a level of high performance and take full leading. 5. Enhance coordination with sectoral departments at provincial level to support SIA implementation in the field. MOUs to be signed and plan of action to be developed.
Accountability	1. Revise the existing accountability framework to bring in stronger accountability across the organizations. Partner agencies to reflect this accountability framework in performance management system for their staff. 2. Committee comprising of key implementing partners and MoPH in REOC should together implement accountability framework on objective basis. National EOC should follow up with REOC after every campaign. 3. Enhance mechanisms of financial accountability in whole program 4. Develop SOP (short version) for south and east provinces with clear roles and responsibilities and improve the areas with gaps.
Monitoring	1. Critical review of the monitoring system and means and bring necessary changes to be responsive to need of the today's program.

Note: up on approval of this framework, the NEOC and the partners will develop implementing plans