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Reaching the unreached with polio vaccine and other child survival interventions through partnership with military in Angola

Lemma Fekadu [a], Joseph Okeibunor [b,*], Peter Nsubuga [c], Jean Marie Kipela [a], Pascal Mkanda [b], Richard Mihigo [b]

[a] World Health Organization Country Representative Office, Luanda, Angola
[b] World Health Organization Regional Office for Africa, Brazzaville, Congo
[c] Global Public Health Solutions, Atlanta, GA, USA

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ABSTRACT

Background: Growing conflict and insecurity played a major role in precipitating polio outbreaks in the Horn of Africa and the Middle East. In Angola, the early post-conflict situation was characterized by the presence of many inaccessible zones and districts due to insecurity and poor infrastructure. Partnership with the Angolan Army health service (AAHS) was one of the innovative strategies that the Polio Eradication Initiative (PEI) introduced into the country to support the polio vaccination campaigns in insecure and hard to reach zones.
Methods: Before embarking on creating a partnership with Angolan military it was essential to make high-level advocacy with top military decision makers to engage the leadership in the process for better and sustainable support to the strategy. The principal supports provided by the AAHS were the administration of oral polio vaccine, vitamin A, deworming agents, social mobilization, monitoring campaign quality, and surveillance. Distribution of logistics using military vehicles and helicopters to hard to reach and insecure zones was also part of the support.
Results: Using this partnership it was possible to reach a significant number of children in insecure and hard to reach areas with polio vaccine and other child survival interventions. The military partnership also contributed in increasing the demand and addressing rejection for the polio vaccine.
Conclusion: Military is a potentially productive force that can be used for any development activities in any country. The Angolan experience has demonstrated that it is possible to form a partnership with the military for basic health intervention activities with little training and investment.

1. Introduction

Since the establishment of the global goal of eradicating polio in 1988, huge progress has been made. The number of endemic countries has dropped from 125 to only two, Pakistan and Afghanistan. These successes were achieved through effective and safe vaccines, strong surveillance and global and local innovative strategies [1].

Growing conflict and insecurity in 2013 played a major role in precipitating outbreaks in the Horn of Africa and the Middle East. Increased instability in parts of Pakistan also played a role in limiting access to children, allowing continued transmission of polio virus. While insecurity was not the sole contributor to these outbreaks, the disruption of immunization activities led to areas of low population immunity and ongoing insecurity hampered outbreak response [2].

Many innovative partnership strategies have been utilized in different countries to address challenges of the same nature. The collaboration of military institutions in the implementation of massive health activities has been an important strategy for ensuring coverage not only in times of armed conflict but also in times of peace. Several examples can be found in the response of epidemics. The most recent example is found in the global response to the Ebola outbreak experienced in Sierra Leone, Guinea, and Liberia [3,4].

In Angola, the early post-conflict situation was characterized by the presence of many inaccessible zones and districts due to insecurity and poor infrastructure. There are still challenges of reaching those areas through immunization and other child survival strategies. In 1999, Angola experienced the biggest poliomyelitis

* Corresponding author.
E-mail address: okeibunorj@who.int (J. Okeibunor).

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epidemic ever recorded in the African Region; with 1117 cases and 113 deaths caused by wild poliovirus type 1 and 3 [5,6].

Partnership with the Angolan Army Health Service (AAHS) is one of the innovative partnerships that the Polio Eradication Initiative (PEI) introduced into the country to support the polio vaccination campaigns in insecure and hard to reach zones which were later scaled up to routine immunization and other child survival interventions.

The partnership with AAHS was initiated in 1999 with the involvement of the military in polio Supplementary Immunization Activities (SIAs) targeting to reach children in insecure and hard to reach areas. These children were otherwise would always be missed by both the routine and supplementary immunization activities.

This paper describes the AAHS partnership in polio eradication activities and their contribution to national polio vaccination campaign.

2. Methods

Before embarking on creating a partnership with Angolan military it was essential to make high-level advocacy with top military decision makers to engage the leadership in the process for better and sustainable support to the strategy. The Director of AAHS is a member of the Inter-Agency Coordination Committee (ICC) for polio and vaccine preventable diseases. The Minister of Health chairs the ICC and it is composed of top public health officers and the representatives of United Nations partner agencies [World Health Organization (WHO) and United Nations Children's Fund (UNICEF)], CORE Group (a USAID-funded nongovernmental organization), Rotary, Angolan Red Cross, Social Society, and AAHS.

The principal supports provided by the AAHS were the administration of oral polio vaccine, vitamin A, deworming agents, social mobilization, monitoring campaign quality, and surveillance. Distribution of logistics using military vehicles and helicopters to hard to reach and insecure zones was also part of the support.

3. Planning

Joint planning with the military team was an integral part of the strategy which determines the effectiveness and efficiency of the partnership. Mapping and updating of the hard to reach and insecure zones was accompanied by micro planning for logistics, materials, and personnel.

The military vaccination teams were composed of two persons as any other vaccination team. Indications for the use of military vaccinators were: (a) hard-to-reach villages located uphill or in some mountains, (b) insecure areas, and (c) filling the gap in the situation of under-recruitment of vaccinators.

During the planning care was taken not to underestimate the target population in each zone in order to avoid any potential logistic and material stock out during the implementation phase of the strategy. Clear chronogram of the preparation and implementation phase was also part of the planning.

4. Materials

Leaflets were prepared and provided to the military vaccinators to guide them on the target population, the importance of the vaccine, the dose to be administered, the route of administration and other important technical issues. The leaflets also addressed social mobilization issues and community case definitions for immediately reportable diseases.

Though military vaccinators had to use their uniform when acting as vaccinators, during deployment in the field, they received polio campaign T-shirts and caps (usually white in color with the campaign logo) to help the community identify them as vaccinators.

5. Training

Military vaccinators were trained by municipal level officers supported by provincial level supervisors at least 1 day before the implementation of the campaign in their local quarters. The training included a practical demonstration using recording and reporting formats, vaccines and leaflets elaborated to guide civil vaccinators. The leaflets covered several topics as the target population, the importance of the vaccine, the dose to be administered, the route of administration and other important technical issues. The leaflets also included social mobilization issues and community case definitions for immediately reportable diseases.

6. Implementation

The military teams vaccinated children by house to house visits and conducted active case search at the same time by asking the families for the presence of any affected person with immediately notifiable diseases like Acute Flaccid Paralysis (AFP), suspected measles cases and others. By the end of the daily vaccination activities, they received snacks and drinks for refreshment. In some cases, military teams brought their own meals that also represented a contribution to the implementation of the polio campaign.

7. Coordination and supervision

Each military group deployed had an officer in charge to supervise and coordinate support with the municipal technical team. At the local level, coordination was done with the health facility in charge of the vaccination area.

The coordination site for the military team was usually at military health facilities or posts. In the case of absence of military health facility or post, a nearby civil health facility or any vaccination campaign coordination site will serve as a coordination center.

8. Monitoring the quality of the campaign

One more field of the collaboration of the military partnership is their involvement in the implementation of independent monitoring of the polio campaign coverage.

Administrative data of the number of vaccinated children came from daily tally sheets filled in by vaccination teams and summarized sequentially by villages, coordination areas, and communes. Though this was the main information to assess vaccination results and assess the coverage of target population for each area, it was also assumed that there is a concern for the quality of this data due to poor recording, consolidation, and transcription of data. In several cases, some data on the number of vaccination children submitted by volunteer vaccination teams did not correspond to the number of vaccine doses received. There were also reports of unmotivated vaccination volunteers that that reported an exaggerated number of children vaccinated in their assigned area.

As a complementary monitoring and evaluation mechanism, an independent monitoring (IM) survey of unvaccinated children was carried out in each province by CORE group through visits to a certain number of houses in selected villages to determine the proportion of children missed during the campaign. If the proportion of the cumulative number of missed children was <10%, the campaign was considered of high quality, AAHS provided personnel to assist in IM.