

Report on the

**Meeting of the Technical Advisory Group on  
Poliomyelitis Eradication in  
Afghanistan and Pakistan**

Islamabad, Pakistan  
11–12 May 2010

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## **1. INTRODUCTION**

The Technical Advisory Group (TAG) on poliomyelitis eradication in Afghanistan and Pakistan held a meeting in Islamabad, Pakistan on 11 and 12 May 2010. The objectives of the meeting were to review progress towards poliomyelitis eradication in the two countries, particularly since last meeting of the TAG (1–2 June 2009), discuss planned activities for 2010 and make recommendations to address constraints facing the national programmes on their way to achieve the target.

Due to logistical challenges after adjustment of dates of the meeting to align it with the World Health Assembly meeting, the Chairman and a few other international members of the TAG could not attend the meeting. Members of the TAG decided by consensus that Professor Tariq Bhutta, National TAG Member, should chair the session on Pakistan and Dr Saleh Rehmani, National TAG Member, Afghanistan, should chair the session on Afghanistan. The programme and list of participants are attached as Annexes 1 and 2, respectively.

## **2. OPENING SESSION**

Professor Bhutta opened the meeting and welcomed the participants, especially new national members from Pakistan and Afghanistan. On behalf of Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, Dr Khalif Bile, WHO Representative in Pakistan welcomed the participants and expressed sincere thanks to the TAG members especially new members and to the delegations of Afghanistan and Pakistan and to representatives of the core partners of Rotary International, USAID, UNICEF, and Bill & Melinda Gates Foundation and thanked the Government of Pakistan for hosting this meeting. In his message, the Regional Director emphasized the close epidemiological relationship between the two countries and acknowledged the continuing coordinated efforts between them. He referred to the prevailing security situation in some parts of Pakistan and Afghanistan, which was seriously impeding progress by limiting access to children for vaccination. While acknowledging the significant efforts and various approaches adopted by the programme to reach the children in conflict affected areas, Dr Gezairy emphasized the need for maintaining a very high level of immunity among children in areas without poliovirus infection.

Professor Rashid Jooma, Director General, Federal Ministry of Health, Pakistan, in his welcome address to the TAG, termed the meeting as a gathering of the large polio eradication family to take stock of situation and highlighted that the group was in spotlight and under pressure to complete a major task on the global public health agenda, namely polio eradication. He highlighted challenge of insecurity in key transmission zones in 2009 as an important risk to efforts to stop polio in Pakistan. While acknowledging that Pakistan was in the spotlight, Professor Jooma reiterated commitment that the Federal Ministry of Health would do whatever was doable.

The meeting was then addressed by Dr Faiz Ullah Kakar, Adviser to the President of Afghanistan on Health and Education. Dr Kakar welcomed the participants and assured the TAG of the continued commitment of the Government of Afghanistan to the target of polio

eradication and the personal involvement of His Excellency Mr Hamid Karzai, President of Afghanistan, in ensuring that the programme achieved its objectives. He referred to the concerted efforts being made by the Government of Afghanistan to bring together all stakeholders in the country in support of polio eradication. He underscored the issue of insecurity in southern Afghanistan and informed the TAG of the recent expansion of areas having insecurity beyond southern region. Dr Kakar concluded by acknowledging the continued support of partners and close coordination among both country programmes.

Dr Bruce Aylward, Director, Global Polio Eradication Initiative, WHO HQ made a presentation on the global polio situation with the aim of setting context for the TAG meeting in advance of its deliberations. He highlighted timing of the TAG, just ahead of the World Health Assembly, which would pay considerable attention to the new strategic plan for 2010–2012 and would focus on data that underpin these plans and their impact to date as well as risk. Referring to the situation in the endemic countries, Dr Aylward highlighted remarkable success reinforced by steep decline in number of polio cases in 2010 to date in India due to increased resources and engagement of provincial leadership and in Nigeria due to engagement of the community and local level leadership. This brought Pakistan into the spotlight due to continued circulation of poliovirus, especially type 1, and thus became a real international concern. Dr Aylward referred to the recent outbreak of type-1 poliovirus in Tajikistan as new risk to the global efforts, and reinforced the fact that all areas remain at risk until global eradication of poliovirus. Another risk is the financial gap of US\$ 1.4 billion for the new plans and decreasing number of donors. The Director General of WHO and the Executive Director of the UNICEF had called for an urgent consultation on June 18 this year to launch the strategic plan 2010–2012. He emphasized the key role of the national TAGs in the new strategic plans particularly in relation to monitoring on the mid-course corrections. Dr Aylward acknowledged the district-specific planning for the 15 high-risk districts which was beginning to show positive results. He stressed need to give special focus on migratory and under-served populations in Pakistan and expressed disappointment over political interference in putting the right person in place.

Mr Khushnud Lashari, Secretary Health, Government of Pakistan, in his remarks before end of the inaugural session, said that the Government was cognizant of the fact that insecurity was impeding efforts towards eradication initiative, and a lot of efforts were being made to access children in insecure areas. He also highlighted efforts towards effective independent monitoring. The Secretary underscored importance of involvement of local community in achieving the desired results. He assured that milestones and strategic plans should be followed very diligently and nothing would be left behind to achieve the targets for the routine immunization and polio eradication programmes. He desired from the meeting to have a three year action plan which would be then taken forward in ensuring that Pakistan and Afghanistan achieve the global targets of polio eradication.

### **3. PAKISTAN**

#### **3.1 Epidemiological situation**

As at 10 May, Pakistan has reported 18 cases due to wild poliovirus with onset in 2010. Seven of these cases are due to wild poliovirus (WPV) type 1 and 11 due to type 3. Twelve districts have reported cases, with 4 of them reporting multiple cases. Large populous areas, including the whole of Punjab and Sindh province, except Karachi, remained polio-free in 2010.

The main active zones of transmission are: 1) central Federally Administered Tribal Areas (FATA) and Khyber Pakhtun Khaw (KPK), particularly in the Bajour/Mohmand/Khyber area with spillover into Charsada and Peshawar – in this area both WPV1 and WPV3 are circulating; and 2) the Quetta/Killa Abdullah/Pishin area of Baluchistan, with strong links to transmission in the southern region of Afghanistan.

In addition to these two major transmission zones, WPV1 transmission is continuing in southern KPK, with cases reported from North Waziristan and Lakki Marwat. Two WPV3 cases were reported from Baluchistan linked to separate transmission chains; one in neighbouring Helmand, in the southern region of Afghanistan, and the other to previous transmission in 2009 in Sindh.

Outside these areas, Karachi has reported only one case, but there is strong evidence from environmental sampling that Karachi continues to play a significant role as a recipient and amplifier of WPV from both active transmission zones. Evidence from 2009 also shows the role of Karachi in creating a “see-saw” effect for WPV transmission to and from transmission zones in other parts of the country, including southern Punjab.

There are some distinct characteristics of WPV cases: all cases are young, under 36 months of age, relatively under-immunized and from Pushtun-speaking communities. The districts at highest risk of persistent wild poliovirus transmission or regular re-infection have been identified, and district-specific plans have been developed and are in the process of being implemented; a review of progress against these plans in the three months since they were formulated was carried out on 10 May. The supplementary immunization rounds in 2010 have shown slow but steady improvement in quality, as indicated by post campaign monitoring and market surveys, in both Sindh and Baluchistan, in particular in the key high risk districts in Karachi and Quetta/Pishin/Killa Abdullah; this is the first real evidence of improvement in these areas.

Bivalent OPV has been introduced and used extensively, with all 15 high-risk districts and their wider transmission zones using bOPV at least 2 times between January and April 2010. In the supplementary immunization rounds between December 2009 and May 2010, the transmission zones used high efficacy vaccine (mOPV or bOPV) against WPV1 and WPV3 more frequently than at any equivalent period since the programme began. Case response has been carried out extremely rapidly following detection of WPV in 2009 and 2010 to date; on average the immunization response has been carried out only 11 days after case confirmation.

Innovative strategies such as the short interval additional dose approach have been implemented in Swat, where access had been a problem throughout 2009.

The communication agenda for polio eradication and immunization has been innovative in trying to build community demand for immunization, expanding intersectoral collaboration and focusing on high risk districts. In conflict affected areas with limited access, community-based surveillance and communication (CBSC) focal points offer the possibility of improving both surveillance and the capacity to reach children with immunization during campaigns. Major efforts to engage religious and community leaders in KPK and FATA are having a good impact on refusals in accessible areas and similar efforts in Quetta Block are being undertaken to address clusters of refusal.

Endemic transmission of WPV in Pakistan is restricted to known transmission zones, and known high risk districts within those zones; genetically, all the transmission being detected anywhere in the country can be traced back to these zones. Transmission persists in these zones for several reasons. One is the inability to access children for immunization due to conflict; this is particularly true for FATA and up until recently for central KPK. In 2010 to date, between 300 000 and 400 000 children in conflict-affected areas could not be reached in every supplementary immunization round. Another reason is continued problems with the quality of delivery of supplementary immunization activities. Despite recent improvements in high risk districts in Baluchistan and Sindh, there remain quality gaps and the improvements are too recent to have yet had a major impact on population immunity. Another reason is the high level of population movement into and out of the transmission zones, and the existence of large migrant and mobile populations in many areas. Migrant communities, whether temporarily or more permanently re-locating, retain close contacts with communities in the wild poliovirus transmission zones in Pakistan and neighbouring Afghanistan, and there is extensive movement backwards and forwards. By their nature, migrant and mobile communities tend to be underserved and more likely to be missed during immunization activities. Karachi plays a major role as a hub for receiving, amplifying and transmitting virus through population movement as it is a major destination for migrant and mobile populations, and up until recently has had significant quality problems in supplementary immunization activities.

Pakistan is in danger of becoming the last polio endemic country in the world. India and Nigeria are making significant progress in eradicating polio, and case numbers in both countries in 2010 are low. Although there has been progress in reaching more children with vaccine in the highest risk areas in Pakistan, the progress is too recent to have yet significantly impacted on wild poliovirus transmission. The improved political engagement and commitment, and the qualitative improvements at the level of the highest risk districts, will need to be strengthened and sustained throughout 2010 for any longer term impact to be achieved.

### **3.2 TAG discussions and conclusions**

The TAG acknowledges the progress that has been made in Pakistan recently. Some developments have been particularly significant. The Prime Minister's Action Plan on Polio

was released in February 2009, and the Inter-Provincial Committee on Polio, composed of the Federal Minister of Health and the Ministers of Health from each province, has begun meeting regularly, and has taken some strong actions to improve accountability and quality of polio eradication activities, including linking payment with performance. The IPCP has approved a workplan and milestones for the period 2010–2012. There has been substantial recent progress in engaging political parties and senior government in Sindh, Baluchistan, and KPK; the engagement of Provincial Chief Secretaries in particular means that administrative actions can now be taken to respond to under-performance at district level.

While very pleased with the progress outlined above, the TAG warns that it is recent, and remains fragile. Improvements in the quality of campaigns in the transmission zones, and particularly in the highest risk districts, must be sustained for multiple immunization rounds before any impact on population immunity can be expected.

Although access to children in KPK has improved significantly since the middle of 2009, the situation of access in FATA has deteriorated. This poses significant risks to polio eradication in Pakistan, as the population in these areas appears to be sufficient to maintain wild poliovirus circulation independently.

The tremendous mobility of populations in and out of the transmission zones carries with it the continued risk of spread of wild poliovirus; migrant communities outside their own area are frequently underserved and under-immunized, missing both routine immunization and being inadequately covered during supplementary immunization activities.

### **3.3 Recommendations**

#### *Supplementary immunization activity schedule and choice of vaccine*

The recommended schedule is designed to finally eradicate polio in the remaining transmission zones, while protecting populations throughout Pakistan against all poliovirus types.

1. The vaccine of choice for the May SNID is bivalent OPV. If adequate supplies of bivalent OPV are not available, priority for bOPV use should be given to the high risk districts/zones of Karachi, central KPK and FATA, and Quetta/Pishin/Killa Abdullah, with the appropriate mix of mOPV1 and mOPV3 in other districts in the transmission zones, as indicated by current epidemiology.
2. The supplementary immunization activity schedule for the second half of 2010 should be as follows:
  - NIDs in July 26 to 28 using bOPV
  - SNIDs in September using bOPV, at minimum in the highest risk districts, and in the surrounding high risk zone if epidemiologically appropriate
  - NIDs in November using tOPV
  - SNIDs in December using bOPV, at minimum in the highest risk districts, and in the surrounding high risk zone if epidemiologically appropriate.

In any of these rounds, if adequate supplies of the vaccine of choice are not available, tOPV/bOPV or the appropriate mOPV depending on epidemiology should be used.

3. Mop-up responses should continue to be carried out as rapidly as possible following the isolation of any wild poliovirus, using the appropriate monovalent OPV.
4. For 2011, the Government of Pakistan should plan to conduct up to four national immunization rounds each year, and up to four subnational rounds. If four NIDs are conducted, 2 should be with tOPV and 2 with bOPV. Vaccine of choice for the SNIDs should be decided based on epidemiology.

#### *Government and political oversight*

5. The IPCP should continue to meet quarterly to review progress in polio eradication, to identify obstacles, and to take actions to overcome them. In particular the IPCP should review progress against district plans in the 15 highest risk districts, and identify actions that need to be taken to support that progress.
6. Provincial chief secretaries are requested to take direct oversight of polio eradication activities, and to lead quarterly reviews of progress against district plans at the provincial level through the Provincial Steering Committees. In particular, action should continue to be taken to address sub-optimal performance during supplementary immunization activities.
7. The Prime Minister and Chief Ministers should be briefed every quarter on progress against the Prime Minister's Action Plan on Polio.

#### *Addressing ongoing transmission in the 15 highest risk districts*

8. Implementation of the district specific plans in all high risk districts must continue to be vigorously pursued; at district and provincial levels progress should continue to be reviewed every month; at national level, following the first quarterly review in May, the second quarterly review should be held in August 2010, with high level political involvement. The results of the May 2010 quarterly review should be presented to the next meeting of the IPCP.
9. The 15 highest risk districts should be prioritized by provincial and federal government and partners, to ensure that the best possible district leadership (DCO and EDO Health) is in place, that teams in these districts are fully up to strength, and that the full range of inputs included in district plans can be carried out.

#### *Communications and social mobilization*

10. The district-specific report card is an important new innovation and should be in use across all high-risk districts as soon as possible with an analysis of its use and impact prepared for the next TAG meeting.

11. Communication reviews should continue to be an aspect of the planning and monitoring components of the programme and small focused reviews should be held on an annual schedule. Reviews of communications should now take place at local level (i.e. desk review).
12. Provincial priorities should continue to be set (such as raising polio awareness in Baluchistan and engaging local leaders to reduce clusters of refusals in the Quetta Block) and coordinated with high risk district plans.
13. Continue to take advantage of the Prime Minister's Action Plan to expand intersectoral collaboration and increase the overall number of children immunized through such efforts.
14. The community-focused approach should be scheduling in the security-compromised areas of FATA following a review of the implementation in the agencies where the approach was piloted.
15. Nongovernmental organizations should be identified which can support community engagement to ensure issues are overcome (i.e. negotiate access, provide local teams, etc.).
16. Sustained social mobilization should be carried out between campaigns to also build demand for routine immunization.
17. Report card for the intervention districts should be produced quarterly to be used as an advocacy tool with district and provincial leadership. This is an important new innovation and should be used across all high-risk districts with an analysis of its use and impact prepared for the next TAG meeting.

*Migrant, mobile and underserved populations*

18. In all districts the identification and mapping of migrant, mobile, and minority underserved populations should be updated prior to every Supplementary Immunization Activity round. These groups must be included in microplans, immunization teams must be community appropriate, and the quality of activity must be monitored specifically in these communities.
19. Communications strategies tailored to migrant and mobile communities including Afghan refugees, nomads and IPDs continue to be developed and expanded.

*Accessing populations in security-compromised areas*

20. A joint federal provincial committee should be formed to urgently seek solutions to the serious issues of access in FATA and other security compromised areas.

21. In the context of district-specific plans, local solutions to achieving access for immunization and surveillance should continue to be explored in those areas affected by conflict. The impact of CPSC focal points should be evaluated and if indicated, their use should be expanded in conflict-affected areas.
22. In any area where access has been restricted, opportunistic immunization strategies should continue to be pursued. The use of SIADs (multiple rounds with short intervals) should become standard to rapidly deliver multiple doses of vaccine to children when windows of opportunity for access appear.
23. Permanent immunization posts should be established in transit points where populations move into and out of security-compromised areas to maximize the chances that children can be reached.

#### *Maintaining polio-free status in non-high risk areas*

24. All polio-free areas should concentrate on achieving and maintaining the highest possible level of population immunity through routine immunization coverage of infants and through achieving the highest possible coverage during Supplementary Immunization Activities; microplans should be regularly reviewed to ensure that all communities are included, in particular migrant and mobile communities.

#### *Detecting wild poliovirus transmission*

25. A national/international review of surveillance should be carried out before the end of 2010, focusing on the quality of surveillance in: 1) the transmission zones; 2) conflict affected areas; and 3) migrant and mobile communities.
26. Sub-national reviews should continue to be carried out by the national programme in any areas of potential concern, particularly following the detection of long-chain wild polioviruses suggesting that transmission may have been missed.
27. The plans to expand environmental surveillance to Peshawar, Quetta, Multan and Rawalpindi should be implemented before the end of 2010.

## **4. AFGHANISTAN**

### **4.1 Epidemiological situation**

As at May 10, Afghanistan has reported 8 cases due to wild poliovirus with onset in 2010. Seven of these cases are due to WPV3, and only one due to WPV1. Six cases have been reported from the southern region (five from Helmand Province alone), one from Farrah Province of western region (the only WPV1 case), and one from Nangahar Province in the eastern region. All, except one case, are 36 months of age or younger, and are relatively under-immunized, with only two cases having more than 4 doses of OPV.

The active transmission zone remains the southern region. The cases reported from other regions are sporadic. The eastern region reports cases nearly every year, usually associated with transmission in neighbouring areas of Pakistan, but circulation of WPV has never been re-established despite the high burden of transmission on the other side of the border.

Within the southern region, 13 districts have accounted for more than 90% of cases in the last 5 years. These districts tend to be relatively densely populated (with more than 50% of the target population of the whole Region), and several have been severely conflict affected. These 13 districts play the major role in maintaining endemic circulation of WPV in the southern region and in Afghanistan.

A number of steps have been taken to try to address accessibility to children in security compromised areas in the south. Negotiations for access were done through the medium of the ICRC. In addition nongovernmental organizations implementing the Basic Package of Health Services (BPHS), have now taken over responsibility for implementation of supplementary immunization activities in 10 districts in the southern region. The intention is to address both access and management issues in these districts. The initial impact of this change seems to have been improved access to children in parts of Helmand Province, although recent fighting has partly reversed that trend. The broader impact is not yet clear as the change is relatively recent. District specific plans are being developed for the 13 high-risk districts. The plans are not yet fully developed and require further work. In one of these high risk districts, Kandahar City, detailed work to improve microplanning and management has led to improved performance in supplementary immunization activities.

Since December 2009, bivalent OPV has been used in three supplementary immunization rounds in the southern region, and the two regions at risk of importation, the south eastern and eastern regions. The impact of these rounds is not yet clear because it is a very recent development, but despite the access and quality problems in the southern region, this concentrated use of highly immunogenic vaccines should have a solid effect on population immunity.

Based on survey findings and inputs from the field, mass media, especially local radio, was utilized to reach communities, particularly in inaccessible areas. A partnership was established with the BBC World Service to broadcast the soap opera “New Home New Life” (NHNL) three times a week with the key theme of getting every child immunized with OPV during every round and the importance of routine immunization. Polio public service announcements with the Afghanistan national cricket team players and polio true stories involving child-polio victims were produced and broadcast. UNICEF facilitated Afghan and Indian national teams to “Bowl Out Polio” in the ICC T20 tournament.

#### **4.2 TAG discussions and conclusions**

Afghanistan is succeeding in keeping transmission restricted only to the conflict-affected southern region; nearly 85% of the national population lives in areas that are free of endemic transmission of WPV. This must be considered as a significant achievement given

the extensive population movements within Afghanistan, and between Afghanistan and polio-endemic areas of Pakistan. Political commitment in Afghanistan remains strong, with a high level of interest from the Office of the President.

However, despite this achievement, the ongoing transmission in the southern region continues to threaten the rest of Afghanistan, and prevents the country from finally eradicating polio. Viruses from this endemic area move backwards and forwards between Afghanistan and Pakistan with mobile populations and therefore contribute to the continuation of transmission in the wider zone. Transmission is continuing in the southern region both because access to children is extremely limited in some areas due to conflict, but also because the quality of work even in accessible areas is not of the same quality as in other parts of the country.

Access and quality issues in the southern region remain the major risk for failing to finally stop transmission of WPV in Afghanistan. This region must remain the focus of programmatic attention for the government and partners. Ongoing military operations pose risks of further access problems and the situation will need to be carefully monitored in the coming months. There is an additional risk that insecurity will become a greater issue in other parts of Afghanistan.

The current WPV1 outbreak in neighbouring Tajikistan, following importation of WPV1 from India, does pose a risk of re-introduction to northern Afghanistan. Fortunately the northern provinces have good levels of population immunity, and travel across the border is more limited than in the south and east due to the presence of geographical barrier (river). However specific measures will be needed to reduce the risk.

### 4.3 Recommendations

#### *Supplementary immunization activity schedule and choice of vaccine*

The recommended schedule is designed to finally eradicate polio in the southern region, while protecting populations throughout Afghanistan against all poliovirus types.

1. The supplementary immunization activity schedule for the second half of 2010 should be as follows:
  - SNIDs in June in the southern, south-eastern and eastern regions using bOPV, and in provinces bordering Tajikistan using mOPV1
  - SNIDs in July in the southern, south-eastern and eastern regions using bOPV; NIDs in September using bOPV, at minimum in the highest risk districts, and in the surrounding high risk zone if epidemiologically appropriate
  - NIDs in November using tOPV
  - SNIDs in December in the southern, south-eastern and eastern regions using bOPV.

In any of these rounds, if adequate supplies of the vaccine of choice are not available, the appropriate mOPV depending on epidemiology should be used.

2. Mop-up responses should continue to be carried out as rapidly as possible following the isolation of any wild poliovirus, using the appropriate monovalent OPV.
3. For 2011, the Government of Afghanistan should plan to conduct up to four national immunization rounds each year, and up to four subnational rounds. If four NIDs are conducted, 2 should be with tOPV and 2 with bOPV. Vaccine of choice for the SNIDs should be decided based on epidemiology.

*Addressing ongoing transmission in the 13 highest risk districts*

4. District-specific plans for all 13 high risk districts should be reviewed and finalized by the end of May. At district, provincial, and regional levels, progress should be reviewed every month; at national level, progress should be reviewed quarterly, with the first review no later than the end of July, with high level political involvement. The results of the July 2010 quarterly review should be presented to the President.
5. The 13 highest risk districts should be prioritized by provincial and national government and partners, to ensure that teams in these districts are fully up to strength, and that the full range of inputs included in district plans can be carried out. In particular, all these districts should have appointed DHOs.

*Migrant, mobile and underserved populations*

6. In all districts, but particularly those bordering polio-infected areas (within Afghanistan, in Pakistan, and in Tajikistan) the identification and mapping of migrant, mobile, and minority underserved populations should be updated prior to every Supplementary Immunization Activity round. These groups must be included in microplans, immunization teams must be community appropriate, and the quality of activity must be monitored specifically in these communities.
7. Permanent cross-border vaccination posts should be established in districts bordering Tajikistan and Uzbekistan. NIDs and SNIDs should be synchronized with the two countries.

*Accessing populations in security-compromised areas*

8. The engagement of ICRC and other relevant agencies and government departments should continue to be sought to help negotiate access in conflict affected areas.
9. The programme should coordinate with government security forces, NATO/ISAF and anti-governemnt elements where necessary, to ensure the best possible access in each supplementary immunization activity.
10. Negotiations with nongovernmental organizations implementing the Basic Package of Health Services (BPHS) should continue to expand the number of districts in which they take responsibility for implementation of supplementary immunization activities.

11. In the context of district-specific plans, local solutions to achieving access for immunization and surveillance should continue to be explored in those areas affected by conflict. The impact of local initiatives to improve access should be evaluated and if indicated, their use should be expanded.
12. In any area where access has been restricted, opportunistic immunization strategies should continue to be pursued. The use of short-interval additional doses (multiple rounds with short intervals) should become standard to rapidly deliver multiple doses of vaccine to children when windows of opportunity for access appear.
13. The national network of animal health, including veterinary field units and a large number of community-based basic veterinary workers, should be taken into consideration to improve access in security-compromised and hard-to-reach areas

#### *Maintaining polio-free status in non-high risk areas*

14. All polio-free areas should concentrate on achieving the highest possible routine immunization coverage of infants. Microplans should be reviewed to ensure that all communities are included, in particular migrant and mobile communities.
15. Maximum effort should be put into achieving the highest possible coverage during Supplementary Immunization Activities, to ensure that high levels of population immunity are maintained. Provinces bordering Tajikistan should in particular ensure the highest possible coverage.

#### *Detecting wild poliovirus transmission*

16. The surveillance system in northern provinces should be in a state of high alert to ensure the rapid detection of any importation of wild poliovirus from the current large outbreak in Tajikistan.
17. Sub-national surveillance assessments should continue to be carried out by the national programme in any areas of potential concern, particularly if any long-chain wild polioviruses are detected, suggesting that transmission may have been missed.
18. The different communicable disease surveillance systems should share information and where possible coordinate to improve sensitivity.

#### *Communications and social mobilization*

19. There is an urgent need to fill polio communication posts immediately at Kabul level (the communication officer and data manager). These positions should be expedited and consultants recruited to fill the gap until staff are in place.
20. While Afghanistan cannot lose sight of maintaining a high quality programme across the country, it is clear that the priority is the south. It is therefore urgent to develop a

comprehensive integrated communication strategy for the southern region which includes the existing communication network, WHO, Ministry of Public Health, nongovernmental organizations and ICRC. A workshop should be held within the next two months to develop this strategy.

21. The CHIP training should be completed as soon as possible. Integrated training should be conducted prior to every supplementary immunization activity to improve IPC and social mobilization skills of volunteers, social mobilizers and access negotiators.
22. Communication reviews should continue to be an aspect of the planning and monitoring components of the programme and small focused reviews should be held on an annual schedule.
23. The courtyard women strategy should be reviewed to assess the impact and refine the objectives in order to target specific objectives based on the outcome of KAP, PCA and epidemiological data.
24. Further strengthen communication data collection, entry and reporting including communication indicators.

## **5. CROSS-CUTTING RECOMMENDATIONS**

1. Close coordination between the national programmes should be maintained, with regular meetings between the national teams to discuss progress, coordinate activities, and exchange ideas.
2. At local level, bordering provinces and districts should meet prior to each supplementary immunization round to re-assess arrangements for ensuring that all border and mobile communities are covered.
3. The performance of permanent cross-border immunization posts should be reviewed to ensure that they are performing optimally, particularly in those areas where children are moving in and out of conflict zones.
4. Given the current volatile situation for polio eradication, the TAG proposes to the Governments of Afghanistan and Pakistan to re-convene at the latest by October 2010.

## **6. CONCLUDING SESSION**

His Excellency the Federal Minister of Health of Pakistan, Secretary Health, Federal Director-General Health, Adviser to the President of Afghanistan on Health and Education, Director-General Health Punjab and Director-General Health KPK attended the concluding session. Representatives from the Rotary International, USAID, Melinda & Bill Gates Foundation, UNICEF and WHO were also present. Dr Bruce Aylward, Director, Global Polio Eradication Initiative, WHO HQ presented the conclusions and recommendations of the TAG. Representatives from the Rotary International, USAID, Melinda & Bill Gates Foundation,

UNICEF and WHO reaffirmed their commitment and support for the polio eradication in both the countries. The Adviser to the President of Afghanistan on Health and Education thanked the TAG for their deliberations and recommendations and assured the meeting of the Government of Afghanistan's continued commitment and support to polio eradication.

The Federal Minister of Health of Pakistan, in the concluding session, thanked WHO, UNICEF and partners in polio eradication for their generous support to Pakistan. He highlighted that Pakistan was going through a critical stage of polio eradication in the context of the greater provincial autonomy and a new health policy, although eradication remains a national and international responsibility. The Minister assured the meeting that efforts would continue to change the culture in health despite the challenge of continued population expansion. The Minister expressed his personal commitment to overseeing implementation of recommendations, in coordination with the national EPI manager.

**Annex 1****PROGRAMME****Tuesday, 11 May 2010**

08:00–08:30	Registration	
08:30–09:30	Opening session	
	Message from the Regional Director, WHO EMRO	Dr Khalif Bile Mohamud
	Address by representative of the federal Ministry of Health, Pakistan	Prof. Rashid Jooma
	Address by representative of the Ministry of Public Health, Afghanistan	Dr Fazullah Kakar
	Objectives and meeting agenda	Prof. Tariq Bhutta
	Global overview	Dr Bruce Aylward
	<b>Pakistan</b>	
09:30–09:50	Implementation status of June 2009 TAG recommendations	Dr Altaf Bosan
09:50–10:10	Epidemiological situation in Pakistan	Dr Nima Abid
10:10–11:00	Discussion and remarks from Federal Secretary of Health Pakistan	
11:20–12:40	New initiatives, plans, challenges and actions with particular reference to the Highest risk Districts/towns/agencies Khyber Pakhtunkhaw FATA Baluchistan Sindh Punjab	Dr Mujahid/Dr Salah Dr Khalid/Dr Salah Dr Ayub Kakar/Dr Yalahow Dr Rizwana/Dr Yehia Dr Arshad/Dr Darwish
12:40–13:30	Discussion	
14:40–15:00	Surveillance quality in Pakistan	Dr Obaid-ul-Islam
15:00–15:20	Campaign quality in Pakistan	Dr Tariq
15:20–15:40	Communication activities in Pakistan	Mr Mazhar/Ms Melissa
15:40–16:10	Discussion	
	<b>Afghanistan</b>	
16:30–16:50	Implementation status of June 2009 TAG recommendations	Dr Agha Gul Dost
16:50–17:30	Epidemiological situation in Afghanistan	Dr Arshad Quddus
17:30–17:50	Issues and initiatives in the southern region	Dr Javed Iqbal
17:50–18:30	Discussion	
18:30–19:30	Meeting of the TAG members (closed door meeting)	

**Wednesday, 12 May 2010**

- |             |   |
|-------------|---|
| 09:30–10:00 | Surveillance quality in Afghanistan             |
| 10:00–10:30 | Campaign quality/monitoring data in Afghanistan |
| 10:30–11:00 | Discussion                                      |
| 11:30–12:00 | Communication activities in Afghanistan         |
| 12:00–13:00 | Overall discussion                              |
| 13:00–15:00 | Closed TAG meeting                              |
|             | <b>Concluding session</b>                       |
| 15:00–16:00 | Presentation of TAG recommendations             |
| 16:00–16:30 | Closing remarks                                 |

**Annex 2**

**LIST OF PARTICIPANTS**

**MEMBERS OF THE TECHNICAL ADVISORY GROUP**

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Professor Abdul Din Muhammad Bari  
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\* Unable to attend

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