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Report on the

Meeting of the Technical Advisory Group on Poliomyelitis Eradication in Pakistan

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1. INTRODUCTION

The Pakistan Technical Advisory Group (TAG) on Poliomyelitis Eradication met in Islamabad on 21–22 March at a time when polio eradication has been declared a "programmatic emergency for global public health" and 3 countries, Afghanistan, Nigeria and Pakistan, are driving global transmission of polioviruses. The objectives of the meeting were to review progress towards poliomyelitis eradication in the first quarter after the launch of the augmented national emergency action plan. This was the first meeting of the Pakistan-specific TAG, as previously it was combined for Afghanistan and Pakistan. The objective of separate TAGs is to provide more focus and in-depth review of the country programmes.

Pakistan is the only one of the three remaining endemic countries that has reported an increased incidence of poliomyelitis in the past three consecutive years. In addition, Pakistan has reported 50% of global cases to date in 2012. The main reason for that is a deterioration of immunization status in key high-risk areas in this country.

The meeting was opened by Professor David M. Salisbury, Chairman of the TAG, who highlighted with concern the critical situation of Pakistan for polio eradication and the threat posed by the country for global polio eradication efforts. Dr Guido Sabatinelli, WHO Representative in Pakistan, welcomed the participants and acknowledged the continued support of polio partners, namely Rotary International, United States Agency for International Development (USAID), UNICEF, Centers for Disease Control and Prevention (CDC), Bill and Melinda Gates Foundation, Japan International Cooperation Agency (JICA) and World Bank. He delivered a message from Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, who acknowledged the efforts made by the Government of Pakistan to achieve the target of polio eradication and referred, specifically, to the augmentation of the national emergency action plan for polio eradication and the efforts being made to ensure its implementation at all levels. He expressed hope for the urgent and effective implementation of the plan.

The meeting was then addressed by the Federal Secretary Ministry for Inter-provincial Coordination (Cabinet Division), who welcomed the participants and acknowledged the timeliness of the TAG meeting. He reiterated the strong commitment of the Government of Pakistan to succeed in achieving the goal of polio eradication.

The programme and list of participants are attached as Annexes 1 and 2.

2. TECHNICAL PRESENTATIONS

2.1 Global developments in polio eradication

The elimination of India from the list of the polio endemic countries marks a major step towards global polio eradication. The profound drop in wild poliovirus type 3 (WPV3) shows that it may be on its way to being eradicated. Pakistan is one of only two countries globally which reported type 3 polio cases during the past 6 months. The exportation of WPV1 from Pakistan to China reinforces the fact that no part of the globe is free from risk until global eradication is achieved. Upcoming important timelines include finalizing the national emergency plan by end of March 2012, review of the consolidated plan by the Strategic

Advisory Group of Experts in April and the World Health Assembly in May 2012. Two points for consideration of the TAG in the current meeting were whether the augmented national emergency action plan addressed all issues required to reach the coverage levels for oral poliovaccine (OPV) needed to stop transmission in Pakistan, and what changes were needed to optimize implementation of the plan in each province.

2.2 Augmented national emergency action plan

In Pakistan, Balochistan, Sindh and Federally Administered Tribal Areas (FATA) contributed a substantial proportion of upsurge of polio cases reported during 2011. The augmented national emergency action plan (A-NEAP) was endorsed by the National Task Force on Polio Eradication, and the Assistant to the Prime Minister on the Social Sector has been appointed as the national focal person for polio eradication. The A-NEAP authorizes the government district managers to lead supplementary immunization activities and holds them accountable for their quality. It also focuses involving the public representatives and stresses adequate preparations for supplementary immunization activities at the union council (UC) level. Key recent steps in the light of the A-NEAP include abolishment of the zonal supervisors, nomination of the UC medical officers, strict actions against the suboptimal performers at all levels and deferment of supplementary immunization activities in case of inadequate preparations. Moreover well-known religious leaders, political figures and social workers have also been taken onboard. The A-NEAP has provided momentum to the programme which needs to be carried forward and the government is fully committed to this

2.3 Implementation status of the recommendations of the last TAG meeting

All supplementary immunization activities were conducted as per the advice of the TAG using the appropriate type of OPV. Case response activities using bivalent OPV were carried out in response to detection of all WPV1 cases outside the known persistent transmission zones in 2011. In addition, large scale, intensive mop-ups were carried out in central southern Sindh, North Sindh, southern Punjab and southern Khyber Pakhtunkhwa. Khyber agency reported two P3 cases; short interval additional dose campaigns were conducted in Khyber agency using bivalent OPV only in the accessible areas; inaccessible areas could not be reached.

2.4 Epidemiological situation

In 2011, Pakistan reported 198 cases (196 WPV1 and 2 WPV3) from 60 infected districts, which was the largest number of cases reported since 2000. The majority of cases during the past 3 years were reported from the known transmission zones of FATA and associated areas of the central Khyber Pakhtunkhwa (KP) province, Quetta block (Quetta, Pishin and Killa Abdullah) in Baluchistan province and Karachi. Following the explosive outbreak in 2011, the 15 cases in 2012 may represent the tail end of this outbreak except in FATA, which continues reporting polio cases of both serotypes.

The key epidemiological characteristics of polio cases are that the majority are among children under 2 years of age with predominance in males, 77% are from Pashto-speaking

families, 23% belong to refusal families and 88% live in multiple family dwellings. More than half the cases are inadequately immunized, with some having not received any doses of OPV. Among the polio cases, Pashto-speaking children accounted for a larger proportion of un-immunized and under-immunized children in 2010 and 2011 as compared to other ethnicities, and 63% of the polio cases reported from FATA belonged to areas which could not be visited by the vaccination teams for a long time due to insecurity. Nearly 30% of the non-polio AFP cases reported from both FATA and Balochistan were reportedly either un-immunized or under-immunized against polio. This calls for urgent attention to address these children. In fact, more than 70% of polio cases were either reported from or genetically linked to the three transmission zones.

It is important to highlight that the results of lot quality assurance sampling (LQAS) indicate marginally better performance at this point in time as compared to last year, which may be the result of the recent thrust provided by the A-NEAP. The TAG was asked for guidance on the scale of the subnational immunization day campaigns (sub-NIDs).

2.5 Balochistan

Districts with persistent transmission include Kila Abdullah, Pishin and Quetta with 22, 16 and 15 cases respectively, while Nasirabad/Jaffarbad block escaped infection due to satisfactory vaccination coverage. Most of the cases are in localized *tehsils*; all the 15 cases in Quetta are in Quetta city. Out of the 22 confirmed cases in Kila Abdulah district, 13 are in Chamman, and out of the 16 confirmed polio cases in Pishin 15 are from Pishin *tehsil*.

AFP surveillance in Balochistan showed that 30% of the confirmed P1 cases had zero OPV doses and 48% had 7+ doses. LQAs in Pishin was rejected at 80% in the last 2 supplementary immunization activities and according to the January supplementary market survey, only Quetta reached 90%.

Reasons for failure include inadequate preparations for quality campaigns, deficient micro-plans, inappropriate area-in-charge and team selection and training, lack of accountability, misuse of resources, political interference, and pockets of refusals.

The Government of Balochistan has shown a high level of commitment. Four meetings are conducted in the Chief Minister’s office, out of which 2 are chaired by the Minister. At the level of management, a highly committed additional secretary for health has been assigned as the provincial polio focal persons, four non performing district health officers have been replaced, and the old tier of zonal supervisors replaced by medical officers as UC in charge.

The province has restructured the programme and is implementing a new strategy of conducting supplementary immunization activities in two phases to ensure quality in Quetta block. At the UC level in high-risk districts, WHO has deployed 57 UC polio workers providing technical support for supplementary immunization activities. UNICEF has established ComNet and 8 DHSOs, 31 UCOs and 192 social mobilizers have been deployed in field to support social mobilization and media activities. All mobile (nomadic and seasonal) and cross-border populations have been considered in micro-planning. A media orientation

workshop was arranged for the prominent health journalists in the last quarter of 2011. Meetings were held with parliamentarians from high-risk districts who exhibited active support in the form of district and union council level inaugurations

Seminars involving religious leaders and conferences for the leadership of all prominent political parties were held in Pishin and Killa Abdullah. In the January–February campaigns 344 community meetings, 127 madrassa/school sessions, 435 mosque announcements and 53 UC level inaugurations were held by communications staff in the UCs of high-risk districts. Two high-risk UCs in Quetta block are being outsourced to a nongovernmental organization from the next round.

A plan has been developed to increase the number of technical support staff in high-risk districts to improve the campaign preparations, pilot outsourcing of immunization campaigns to local nongovernmental organizations in 4 UCs in high-risk districts, complete the establishment of polio control rooms at provincial and district level, enhance media engagement and involve more parliamentarians and religious and political leaders.

2.6 Federally Administrative Tribal Areas

FATA has reported 59 polio cases with a large number from Khyber Agency, followed by North Waziristan, frontier region Kohat and Lakkimarwat. Major challenges are insecurity and management in the accessible areas. The state of inaccessibility at the end of December 2011 reached 8%, with major inaccessibility in Khyber Agency followed by Orakzai Agency. Management issues and lack of accountability persist in the areas such as Landikotal and Jamrud Tehsil of Khyber Agency and Miranshah of North Waziristan. Lack of ownership by the agency health team is quiet evident. None of the Agencies achieved the target level of 95% coverage; coverage ranges from 82% in Kurram Agency to 54% in frontier region Bannu. All these factors contributed to the polio outbreak in 2011.

NEAP indicators in 2012 as compared to 2011 are improving. Civil Military Coordination Committee meetings are held in each Agency 12 days before campaign. Activities in the field are monitored. Accountability started with transfer of Agency Surgeons in Mohmand Agency and Kurram Agency due to poor performance. As well, parliamentarians were involved and a wide range of social mobilization activities were conducted including school and college health sessions, local *jirga* of the tribal elders and community representatives, games and local polio walks.

To strengthen implementation of the A-NEAP in FATA, particularly to improve the access and quality of campaigns, the Health Directorate is considering actions that include deployment of “transit teams” (Bara, Bajour, Mohmand) for mobile and internally displaced populations of Orakzai and South Waziristan, involvement of religious organizations, addressing refusals, enhancement of routine vaccination by conducting child health days, holding medical camps, further strengthening cross-border vaccination points, engaging polio ambassadors, further involvement of teachers in union council polio eradication committees (UPECs) and in teams during campaigns – especially female teachers, and transparency in making payments to field staff.

2.7 Khyber Pakhtunkhwa

At the advocacy level, new steps include the decision of the Standing Committee on Health of Provincial Assembly to have polio eradication and immunization programme on its permanent agenda and inclusion of the Chairman of Committee in the Task Force at the provincial level and Chairman of the District Development Advisory Committee (DDAC) as member of the district polio eradication committees. The mechanism of establishing a polio control room at the provincial level with close coordination with the district health teams has been in place since May 2011 and a deferment mechanism since June last year. In June 2011, seven districts had their supplementary immunization activities delayed due to insufficient number of quality teams.

As a result of these steps, there has been a remarkable change in the indicators for process and outcome. The proportion of union councils having meetings within the time-line has increased from 61% in March 2011 to 100% in January 2012 (both months had NIDs); and percentage of union councils failing to achieve target (95%+ children vaccinated among those checked by independent monitors with proof of finger-mark) dropped from 51% to 17% in the same period in the persistent transmission districts. Partner support at the UC level in the highest risk UCs was acknowledged.

The province and FATA have close collaborative mechanisms for coordinated operations. For instance, in response to the first type 3 wild poliovirus in 2011, short interval additional dose campaigns were conducted in 4 districts. Ahead of the recent crisis of exodus from Bara, district commissioners alerted local teams to intensify transit point team strategies and district teams to focus on the areas having internally displaced populations. A WHO consultant found 11 missed children in a sample of 104 children checked at household level, all of them were new arrivals (not missed by teams) but reflecting high volume of population movement. There has been no isolation of wild poliovirus type 3 from AFP cases or sewage sampling in 2011 and 2012 so far.

Security factors are an important consideration for the province. In 2011, the highest number of casualties due to terrorist activities was in Khyber Pakhtunkhwa: 820 deaths and 1684 injuries in 512 different terrorist attacks.