Summary report on the

Meeting of the Technical Advisory Group on Polio Eradication in Pakistan

WHO-EM/POL/406/E

Islamabad, Pakistan
27–28 November 2013

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1. Introduction

The Technical Advisory Group (TAG) on Poliomyelitis Eradication in Pakistan met in Islamabad on 27 and 28 November 2013. The objectives of the meeting were to review progress towards poliomyelitis eradication in Pakistan since the last TAG meeting in December 2012, discuss activities planned for 2014, particularly planning for the forthcoming low transmission season, and make recommendations to address the constraints facing Pakistan on the way to achieving the goal of eradication.

The meeting took place at a critical time for the Pakistan polio eradication initiative. In the past 4 months, Pakistan has recorded the highest number of new wild poliovirus cases of any infected country in the world, and is the only endemic country to register an increase in cases from 2013. Wild poliovirus is spreading within Pakistan and into Afghanistan and the WHO Eastern Mediterranean Region; and there is an imminent risk of further spread. Pakistan is currently the single most significant endemic reservoir of wild poliovirus in the world.

The national programme recognizes three specific challenges that threaten the completion of the eradication of polio from Pakistan. First, inaccessibility in parts of the Federally Administered Tribal Areas (FATA) and insecurity in Peshawar, surrounding districts and Karachi are creating barriers between vaccinators and children that lead to children being missed in vaccination campaigns, a growing immunity gap in key areas and very rapid virus transmission. Second, management, oversight and accountability issues continue to hamper campaign efficiency in critical high risk areas, creating the necessary conditions for large reservoirs in which virus circulation can be maintained and amplified. Third, the constant risk of virus spreading

from these reservoirs threatens the maintenance of progress in polio-free areas.

The findings, conclusions and recommendations of the TAG presented below are oriented around those three key challenges.

2. Summary of discussions

The polio eradication programme in Pakistan has had a very difficult year. The number of cases in 2013 is higher than the total number of cases reported in 2012, making Pakistan the only one of the three remaining endemic countries to experience an increase of cases in 2013. In 2013 Pakistan accounts for more than 50% of all cases reported from endemic countries; all viruses detected in Afghanistan in 2013 is of Pakistan origin and virus from Pakistan has spread to the west where it has circulated in several countries and is currently causing an outbreak in the Syrian Arab Republic.

Violence against vaccinators and their security escorts has created a climate of threat and uncertainty and has understandably affected the quality of activities in key areas of Khyber Pakhtunkhwa (KP) (Peshawar and surrounding districts), parts of FATA, and Karachi. The ban on polio immunization campaigns in North Waziristan and South Waziristan has continued and more than a quarter of a million children in these agencies have had no access to vaccination against polio for nearly two years. In Khyber agency, ongoing conflict continues to restrict opportunities for vaccination for children in Barra.

Genetic evidence shows that the poliovirus transmission occurring in North Waziristan and Khyber agencies is sustained and amplified in densely populated areas primarily the Greater Peshawar area. From

this area, the virus spreads to other parts of Pakistan and eventually on to other countries. With extensive population movement to and from areas of intense circulation in KP and FATA, the multi-district greater Peshawar region is now the primary poliovirus reservoir in Pakistan. The compromised security in this area further complicates efforts to close off this part of the transmission cycle. Eighty-five per cent of polio cases reported in Pakistan in 2013 are either from areas where children cannot be accessed, or from areas that are affected by compromised security.

As the high season has progressed, poliovirus has moved out of the remaining areas of intense circulation and has begun to re-infect polio-free areas in other parts of the country, and in neighbouring countries, as it has in previous years. There remains a significant risk that poliovirus will continue to move into polio-free areas within Pakistan and beyond.

However there is also much that is positive in polio eradication in Pakistan in 2013. The annual national emergency action plans, which were first introduced in 2011 have demonstrated an overall strong impact on the oversight of the programme and ultimately on the quality of immunization activities in most districts. In 2013 several areas that used to have intense poliovirus circulation are polio-free, or have seen only very sporadic cases (including Quetta block in Baluchistan, Northern Sindh and Southern Punjab).

Environmental surveillance data has largely supported the evidence of case surveillance data that the geographic range of circulation has shrunk in 2013 and that most of the country is polio-free. Short interval immunization rounds (the SIAD strategy) have been successfully incorporated as an accepted part of the programme and

there is good evidence of their impact. Poliovirus from reservoir areas that has been exported into polio-free areas of the country has been responded to rapidly and effectively.

The recent developments required a shift in communication strategy. Previously a high visibility approach focused on public information about polio through media and door-to-door social mobilization, the communications approach moved to indirect methods, focusing on raising awareness about vaccine-preventable diseases, and promoting polio vaccination within a wider context of immunization. Local ownership for vaccination is now more critical than ever.

With over 80% of polio cases originating from only four Pashtun tribes, the communications effort in 2014 must focus more intensively on building trust for immunization services among these highest risk groups. The programme must ensure adequate representation of these groups in as vaccinators, social mobilizers and community influencers, and in mass media messaging.

Despite an environment that is hostile to vaccination in some areas of Pakistan, the communication programme has made advances in creating an enabling environment. A highly engaged media generated over 6400 national articles focusing on polio in 2013; the highest market share globally. Among these, less than 5% of Urdu and English press portrayed the programme negatively. Caregiver refusal rates were reduced by over 40% in one year, and the proportion of these due to religious reasons reduced particularly in KP, where there was a large focus on religious advocacy. Acceptance of polio immunization in the general community is higher than it has ever been, with less than 0.5% of caregivers refusing the vaccine. Political, social, and

religious leaders and groups have become more active and visible supporters of the eradication goal.

Therefore the TAG reaffirms its belief that poliovirus can be eradicated from Pakistan provided solutions are found for immunizing children in currently inaccessible areas. Eradication will require the national programme to systematically implement the national emergency action plan, to learn from experience and innovations to improve the quality and impact of activities, and to identify new ways of helping communities to immunize their children in areas of compromised access. The recommendations below are intended to support the national programme to achieve this.

3. Recommendations

Governance: implementation of the national emergency action plan

1. The federal and provincial governments should fully implement the national emergency action plan for 2013 and ensure oversight by national and provincial task forces.
2. National and provincial task forces should meet in December 2013 to oversee preparations for the intensified activities in the low transmission season.
3. The national emergency action plan for 2014 should be drafted and finalized by the end of January 2014.
4. Steps should be identified to strengthen AFP and environmental surveillance for implementation in the second half of 2014.

Reducing barriers

5. The national programme should explore practical options for allowing parents and leaders in North Waziristan and South Waziristan to protect their children in the current setting and context, through identifying locally acceptable solutions such as:
   – through self-vaccination by communities
   – non-campaign strategies
   – utilizing existing infrastructure and providers
   – locally developed emergency plans for North Waziristan and South Waziristan.

Transit strategy

6. The transit strategy should be reviewed immediately and an updated strategy incorporated into the national emergency action plan for 2014.
7. The performance of cross-border immunization points, particularly Torkham, and internal transit points should be reviewed by the end of January 2014 and action taken to improve performance.
8. The number of permanent transit teams should be increased and social mobilizers included at key strategic points.

Immunizing children from FATA in settled districts

9. The districts of southern KP should be regarded as Priority 1 areas until May 2014.
10. There should be up-to-date mapping and specific plans for immunizing children from infected areas residing in these districts during the low season.

11. The Khyber Pakhtunkhwa Provincial Task Force should maintain oversight in these districts and specifically evaluate the impact of supplementary immunization activities in reaching children from FATA in each activity during the low season until May 2014.

Improving quality and safety in Peshawar and Karachi

12. Peshawar and Karachi Gadap should continue to be regarded as Priority 1 until poliovirus transmission in Pakistan is interrupted.
13. Access to all children in UC4 Gadap and Peshawar for low transmission season supplementary immunization activities must be ensured by the relevant authorities.
14. Special task teams for Peshawar and Karachi chaired by provincial secretaries should meet every two weeks until April.
    - The special task teams should receive constant support from provincial task forces to ensure specific actions are taken on quality and access problems
    - The focus of the task teams should in particular be underperforming union councils.
15. Special task teams must incorporate senior security personnel to ensure coordination of security for immunization activities; information on security issues and risks, and the provision of security, should be closely coordinated between the security agencies, the provincial and local governments, and the partners involved in supporting implementation to ensure optimum security for teams.
16. Emergency response teams from the Prime Minister's Polio Monitoring and Coordination Cell should be deployed to support local teams.

17. Specific transit strategies in Peshawar and Karachi should be reviewed and an updated by the end of January 2014 and should form part of the plans developed by special task teams.
18. High-risk populations from heavily infected areas should be mapped and specific plans developed to ensure they are reached and immunized during the low transmission season.

Reducing risks in polio-free areas

19. Quetta Block and Hyderabad should continue to be regarded as high risk; specific supplementary immunization strategies tailored to these areas should aim to ensure the maximum impact on population immunity in the coming low season.
20. The recent detection of ongoing local transmission in northern Sindh should be investigated through a special review of surveillance and immunization activities.
21. Provincial task forces should maintain a high level of oversight for these high risk areas and ensure the highest possible quality of immunization activities, particularly in supplementary immunization activities during the low season until May 2014.
22. Any single case outside the endemic transmission zones should be regarded as an outbreak and a programme emergency until transmission is stopped.
23. Response to outbreaks should be in accordance with national and international guidelines; within 2 weeks of case detection; large (multi-district); and utilize short interval immunization rounds.

Supplementary immunization strategy and schedule

24. The TAG endorses an amended schedule of supplementary immunization activities and suggests a review of the

supplementary immunization strategy and schedule based on epidemiology during the second quarter of 2014.

25. The TAG endorses the general principle of short interval rounds in Priority 1 areas and in response to outbreaks in polio-free areas.
26. Monovalent OPV1 should be used as rapidly as it becomes available in Priority 1 areas.
27. Trivalent oral polio vaccine (OPV) should be used at least twice in Priority 1 areas from December 2013 to June 2014 due to the risk of circulating vaccine-derived polioviruses.

Engaging communities and building demand

28. A strategic, consistent campaign to profile vaccinators and frontline workers as protectors of children should be developed and launched as soon as possible.
29. A civil society coalition that creates a participatory and independent social movement for polio eradication should be built, with particular emphasis on the private sector, private practitioners and potential alternative service providers.
30. Pashtun voices should be amplified in the national and local media discourse to increase local ownership for immunization.
31. Concrete steps should be taken to expand COMNet's capacity to reach unavailable children; and the proportion of children converted from missed due to child not available to vaccinated, should be added as a key performance indicator of vaccination teams where COMNet staff are working. The programme should also find ways to effectively address refusals and 'not available' children in areas where COMNet is not present.
32. In areas that remain inaccessible to polio teams, the social mobilization network should utilize its local staff to map potential opportunities to reach children through alternative mechanisms:

through stocking health facilities with vaccine and promoting routine services, mapping of midwives or other trusted health workers that have access to children, and more robust strategies to reach children during migration.

33. Global polio eradication initiative protocols for joint micro-planning should be implemented and monitored at union council level to ensure high-risk children are consistently included in micro-plans.
34. A communication strategy and localized plans should be established to:
    - reach children in inaccessible areas and support activities should access be achieved
    - support short interval immunization rounds
    - support the introduction of in activated polio vaccine (IPV).

Using monitoring data to reach missed children

35. Consistent with protocols of the national emergency action plan, analysis of all reasons for missed children and conversion rates within 15 days should be reviewed as a key performance indicator at all levels, following each campaign.
36. Monitoring forms should disaggregate the reasons why children are unavailable for immunization in order to understand this issue better and to allow the development of better strategies to reach these children.

Synergies with routine immunization

37. The TAG endorses the national programme plan for optimizing the contribution of polio eradication to broader immunization

goals in selected districts, in particular the strengthening of routine immunization, and requests 6 monthly reports on progress.

38. Indicators for monitoring the implementation of the national programme plan for optimizing the contribution of the polio infrastructure for strengthening routine immunization should be reflected in the 2014 national emergency action plan.
39. The programme should explore the feasibility of using IPV together with OPV as an additional strategy for special situations:

– In selected transit points with a high volume of traffic from inaccessible areas, potentially as part of a full EPI package
– In conjunction with measles campaigns in selected high risk areas with concentrations of under immunized children.

40. An assessment of feasibility and the advantages and disadvantages of such an intervention should be prepared by the end of March 2014.

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