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World Health Organization

TECHNICAL ADVISORY GROUP ON POLIO ERADICATION FOR THE HORN OF AFRICA COUNTRIES

9th Meeting Report

30 April 2013 to 1 May 2013
Nairobi, Kenya

Executive Summary

The 9th meeting of the Technical Advisory Group on Polio eradication for the Horn of Africa (HOA TAG) was held from 30 April 2013 to 1 May 2013 in Nairobi, Kenya. The objectives of this meeting were to review the situation of polio eradication in selected priority countries of the Horn of Africa (Kenya, Somalia, South Sudan, Uganda and Yemen) and neighboring countries, to identify areas of concern that need to be addressed, in particular those that may affect more than one country in the area, and to make technical recommendations on appropriate strategies to ensure the interruption of wild and vaccine derived poliovirus transmission through improved population immunity and achievement and maintenance of certification level AFP surveillance.

The meeting took place in the context of a continuing outbreak of cVDPV2 in South Central Somalia which spread to North Eastern Kenya in 2012, and sub-optimal population immunity levels with a large pool of susceptible children unreached by any vaccination in the last 4 years. Though 400,000 of these children have recently been reached due to improvements in security, the remaining 500,000 inaccessible children under five represent the largest single group of under/un-immunized children in the world.

The TAG noted the achievements attained by the countries participating in the meeting and appreciated their efforts in following up and reporting on the status of implementation of the recommendations made during the 8th HOA TAG Meeting in September 2013. The TAG further noted that the results of quarterly risk analysis, using a standardized tool,enablingall countries to prepare six-month preventive supplementary immunization plans targeted at the highest risk areas. In addition, all 5 countries except Yemen conducted external AFP surveillance reviews, which revealed the existence of sub-national gaps and for Somalia, poor sensitivity in the South Central Zone. All the countries incorporated follow-up activities in their 6 month emergency plans.

The post TAG notification of 2 cases of WPV1 respectively from South Central Somalia and North Eastern Kenya is a reminder of the need to strengthen AFP surveillance in all of the HOA region and particularly Somalia neighboring countries including Yemen.

The TAG made the following key recommendations:

a. Representatives of the TAG should be facilitated to meet the regional directors of AFRO and EMRO to discuss the critical importance of high-level advocacy in the 3 key countries Uganda, Kenya and South Sudan.
b. Considering the unique situation in Somalia, where up to 500,000 children under 5 years old have not been reached during SIAs or EPI in the past four years, all mechanisms to ensure implementation of emergency procedures to pre-position vaccines and provide logistic support should be immediately activated to maximize all opportunities to vaccinate children and synchronize cross-border activities with neighboring countries.
c. All countries in the HOA should systematically and regularly document all immunization and surveillance activities conducted in refugee camps and among internally displaced persons. WHO and UNICEF should work, particularly at country level, with UNHCR, OIM and other humanitarian organizations to ensure that activities take place and are properly documented. Additionally, all returning children should have proof of an up-to-date immunizationschedule before departure.
d. When any vaccine derived virus (VDPV) is detected in any of the HOA countries, a thorough investigation should be conducted and a rapid response mounted depending

on the epidemiology and investigation. The scope of the response, age group to be targeted and interval between campaignsshould be based on the epidemiology of the outbreak.

e. All countries should provide, on a quarterly basis, documentation of impact of; implementation of surveillance review recommendations; cross-border collaborative activities; innovative strategies to reach children in difficult to access or security compromised areas; and, communication and social mobilization efforts to reaching children during SIAs and routine immunization activities.

The next meeting of the HOA TAG, with all countries of the sub-region, is proposed for 12 to 14 November 2013 in Nairobi, Kenya. In the interim, the TAG proposes to hold a conference call for the TAG in early September 2013.

I. Preamble

The 9th meeting of the Technical Advisory Group on Polio Eradication for the Horn of Africa Countries (HOA TAG) was held from 30 April 2013 to 1 May 2013 in Nairobi Kenya under the chairmanship of Dr Jean-Marc Olivé. This meeting was an interim TAG, recommended by the 8th TAG meeting of September 2013 and participation was limited to five countries (Kenya, Somalia, South Sudan, Somalia, and Yemen).

Since the last TAG meeting, there have been key global achievements. In 2013, only three countries (Afghanistan, Nigeria and Pakistan)have confirmed wild poliovirus cases (WPV) and wild polio virus type 3 has only been found in Nigeria. The last wild poliovirus type 3 in Asia was from Pakistan with onset of 18 April 2012. Niger was the only country in 2012 that experienced an outbreak with one case of WPV1, onset 15 November 2012. In 2013, four countries (Afghanistan, Pakistan, Chad and Somalia) have detected circulating vaccine derived viruses (cVDPV). The one case of cVDPV reported from Somalia in January 2013, is a continuation of the outbreak that began in 2008 and spread to North East Kenya in 2012.

The objectives of this meeting were to (a) review the situation of polio eradication in selected priority countries of the horn of Africa (Kenya, Somalia, South Sudan, Uganda and Yemen) and neighboring countries, (b) to identify areas of concern that need to be addressed, in particular those that may affect more than one country in the area, and (c) make technical recommendations on appropriate strategies to ensure the interruption of wild and vaccine derived poliovirus transmission, improve population immunity and maintain certification level AFP surveillance.

The last wild poliovirus in sub-region had onset of illness on 30 July 2011 in Rongo district, Nyanza Province, Kenya. This case was genetically linked to the 2010 WPV outbreak in Uganda and to the 2008 – 2009 outbreaks in Sudan and Kenya. As regards to cVDPVs, in 2012, the detection of an outbreak of cVDPV in Dadaab, North Eastern Kenya and the most recent identification of the cVDPV in Afgoi, South Central Somalia, indicates surveillance gaps in the sub-region and confirmation that the Somalia 2008 cVDPV outbreak remains uncontrolled.

Since the end of the TAG, two cases of WPV 1 were reported:

- One from a 32-month old girl (8 doses of OPV with last dose during March 2013 round) and 3 close contacts from HamarJabab, Banadir region of Somalia who developed paralysis on 18th April 2013;

- One case in Dadaab, Kenya close to theborder with Somalia in afour-month-old girl, with onset of paralysis on 30th April2013. This case hasbeen confirmed basedon 2 positive contactsamples.

The 9th HOA TAG meeting took place in the context of:

1. Gaps in sub-national AFP surveillance in countries of the Horn of Africa and a continuing outbreak of cVDPV2 in South Central Somalia which spread to North Eastern Kenya.
2. Sub-optimal population immunity levels with a large pool of susceptible children, especially in Somalia. At the time of the meeting, at least 400,000 children under five years old remain in inaccessible areas of South Central Somalia and have not been reached by any vaccination campaigns or childhood health interventions in the last 4 years.
3. Increasing immunizations opportunities in Somalia, due to improved security to reach and vaccinate children in areas that were previously inaccessible.

II: Country Updates

1. Kenya

The 8thHoA TAG made three specific recommendations for Kenya, and all were fully implemented. Update on implementation of Gap analysis conducted in 2012 was done of which 17 out of 22 recommendations had been fully implemented, 4 partially implemented and 1 not done(i.e., feasibility study to introduce environmental sampling).

Kenya conducted 3 rounds of SNIDs in the whole of North Eastern Province and in 11 districts in Coast Province in October, November and December 2012 in response to the cVDPV2 outbreak in Dadaab refugee camps. A total of 827,000 children were targeted (<15 years in the refugee camps and< 5 in the host community). Independent Monitoring coverage for the rounds was 92% and 91% for the October and December rounds, respectively. USD 1.5 million was raised for the 2 sub-NIDs in October and December 2012. The November round was done together with a measles NID and administrative coverage was 97%.

The country has improved both routine immunization and AFP surveillance at the national level. The national non-polio AFP detection rate was 3.96/100,000 in 2012, up from 3.23/100,000 in 2011; stool adequacy was 91% for 2012, up from 85% in 2011. In the first quarter of 2013 the AFP detection rate is 2.65/100,000 and stool adequacy is 95%.

OPV3 coverage at the national level was 82% in 2012, a slight drop from 86% in 2011. This was attributed to a strike by the doctors and nurses in 2012. Fifty four percent (54%) of the districts achieved > 80% OPV3 coverage in 2012. Rotary Kenya donated 40 motorcycles to support strengthening of active surveillance and routine immunization activities.

To address the refugee health issues, regular coordination meetings are being held with key stakeholders (UNHCR, MOH, UNICEF, WHO, CDC and various NGOs) both at the national and refugee camps level. Construction of a Level 5 hospital by Kenya Red Cross Society in Dadaab Refugee camp is almost complete and 50 out of the targeted 200 nurses are already working.

The main challenges include: unclear managerial structures following recent changes in the government structure, funding constraints for field operations, insecurity in the high-risk and border districts particularly in Northern Kenya, community based surveillance not fully established in all districts, weak cross-border surveillance systems, suboptimal population immunity in border areas associated with increased population movement, and inadequate staff to deliver routine immunization services. The recently completed general elections interfered with implementation of planned activities.

Planned activities for the next 6 months include:continue active case search for AFP in all districts; enhance community surveillance in high risk and hard to reach areas, conduct regular (monthly and quarterly) reviews of surveillance and routine immunization performance; provide logistical support for surveillance; plan and hold cross-border meetings with South Sudan, Somalia, Uganda and Ethiopia; carry out quarterly polio technical advisory group activities (NPCC and NPEC); provide supportive supervision by national, county and district levels, conduct and disseminate quarterly risk analysis for polio transmission; and, improve cold chain temperature monitoring and response system. Two SIAs are scheduled for August and Sept 2013 in high risk areas as well as adding OPV during the CHDs in May 2013. Also planned is training of health workers on immunization and continued advocacy for polio eradication including use of polio advocacy kits and social media, polio survivors/champions, and engagement with private sector and civil society organizations.

2. Somalia

The 8th HoA TAG made five country specific recommendations; all were implemented except one - synchronized SIAs could not be conducted with Kenya in October 2012 in response to the cVDPV outbreak in North Eastern Kenya and Southern Somalia, because it was not possible to pre-position vaccines on time along the Somalia/Kenya border area.

Since the last case of WPV1 in March 2007, Somalia has not reported a case of wild poliovirus. Nationally, surveillance indicators have been at maintained at certification level. The non-polio AFP rate in 2012 was 2.8/100,000 and the stool adequacy 98%. The annualized NP-AFP rate for 2013 (Week 11) is 2.1. At the sub-national level, three regions out of 18 were below the NP-AFP detection rate of 2/100,000. The proportion of zero-dose AFP cases (6 – 59 months) has worryingly increased from 8% in 2010 to 16% in 2012.

Routine immunization remains low in Somalia. Administrative coverage for OPV3, at the national level, was below 60% in 2012 with large sub national gaps and discrepancies. In March 2013, pentavalent vaccine was introduced and used as an opportunity to increase population demand for vaccines, to strengthen routine immunization in existing facilities, and to reestablish EPI in recently liberated areas.

In response to the ongoing outbreak of cVDPV, the Regional Director of WHO EMRO, in early December 2012, convened a high level joint mission with participants from UNICEF, CDC and WHO (EMRO/HQ). The outcome of this initiative was a 6-month Emergency Action Plan (EAP)-January to June 2013 -to stop the transmission of poliovirus, assess the field performance of AFP surveillance, and close the immunity gap in South and Central Somalia by the end of June 2013. The EAP recommended the implementation of polio SIAs within 4 weeks in any new area that becomesaccessible and to provide at least six doses of OPV to all children in newly accessible areas by June 2013. The emergency plan included the

implementation of at least 4 rounds of SIAs in Somaliland and Puntland in 2013. To support these activities Polio Control Rooms were established in Nairobi and Mogadishu, UNICEF and WHO staff was increasedin Nairobi and Mogadishu, and reverse cold chain monitoring for stool samples from South and Central Somalia was initiated.

An external field surveillance review conducted in late March 2013 revealed that AFP surveillance in Somaliland and Puntland is well developed and sensitive enough for timely detection of polioviruses; however, gaps in surveillance exist in Banadir (the only region external reviewers were able to visit in South-Central Somalia). The team found that not all suspected AFP cases notified by the community to District Polio Office (DPOs) were investigated and hence no stool samples were collected from them or their contacts. Furthermore, there was no active surveillance at the major hospitals or private clinics. This led the external team to conclude that in South Central Zone, surveillance was not sensitive enough, and WPV or VDPV circulation could have been missed. The recommendations of the external surveillance review were incorporated in the 6 month emergency plan.

Since the last meeting of the TAG in September 2012, the number of unvaccinated children in south Central Zone of Somalia was reduced from an estimated 1 million to about 500,000 in 2013due to improved access in South and Central Somalia and immediate expansion of immunization activities in these newly accessible areas.To date however, 26 out of 77 districts in South and Central Somalia remain completely inaccessible due to insecurity.

The comprehensive SIAs plans for 2013 follow the EAP schedule. The implementation of the recommendations of the AFP surveillance reviewremains a priority as the strengthening of routine EPI activities in security compromised areas maximizingall opportunities to provide vaccinations to children.

3. South Sudan

The 8th HOA-TAG made three specific country recommendations and one was not implemented - the recommended high level advocacy visit to Juba.Two rounds of SIAs targeting 3.3 million children were conducted in November and December 2012, and two rounds have been conducted in March and April 2013. Independent monitoring coverage for the November, December and March rounds was above 90% in all states except one (Jonglei).

South Sudan has been polio free since June 2009. In 2012, the national non-polio AFP detection rate was 3.9/100,000 and stool adequacy was 94%. For the first four months of 2013, the rate is 3.39 with a stool adequacy rate of 94%. Although all states had non-polio AFP rate above 2/100,000, there are sub-national gaps in surveillance in Jonglei and Unity States. These states both have areas with compromised security and difficult to reach populations. The programme however continues to increase the sensitivity of surveillance by collecting stool specimens from contacts of all AFP cases and from healthy children in silent counties.Cross-border meetings to strengthen collaboration with the Democratic Republic of Congo, Uganda and Sudan were conducted and South Sudan has been assisting in sending samples of AFP cases reported from inaccessible areas in South Kordofan, Sudan. The STOP Team programme continues to play a major role in sustaining AFP surveillance at certification level.

For activities to improve EPI coverage, catch-up campaign plans have been developed for May and June 2013. Outreach activities and defaulter tracing are ongoing, with

intensification of supportive supervision.DPT3 coverageis maintained above 70%.These activities were guided by risk assessments conducted during the first quarter of 2013.

The programme currently faces huge challenges of inadequatelyqualified staff, poor infrastructure, and insecurity. EPI and PEI programs still dependtoo heavily on external support from partners to carry out activities.

4. Uganda

During the 8th HOA TAG meeting, four specific recommendations to Uganda were made. All were partially implemented due to limited resources and competing public health priorities. The EPI and PEI communication plan was rolled out to 55 (49%) districts and village health teams (VHTs) have been trained in refugee hosting districts. Surveillance tools have been developed and high level advocacy visits were done by development partners including GAVI. Due to limited funding, only one round of sub-NIDs in 37 high risk districts was conducted in October 2012 vaccinating 2.4 million children. Independent monitoring indicated 89% coverage with 45% of the districts achieving a coverage of >94%.

A comprehensive two year EPI revitalization plan 2013-2014 is being implemented with support from partners focusing on service delivery, communication, implementation of family health days and supportive supervision components.In 2012, the EPI coverage reached 82%, while annualized coverage for 2013 is 88%. The RED approach has been scaled up to 60 districts and routine immunization performance was further boosted by PCV10 nationwide introduction on April 27, 2013 with participation of the President. One key challenge currently being faced by the programmeisvaccine and supplystock-outs due to the transition of vaccine supply and distribution from the EPI programme (UNEPI) to the National Medical Stores.

The national AFP detection rate in 2012 was 2.82 compared to 2.79 in 2011 with 56% and 54% of the districts achieving a rate of >2/100,000 in 2011 and 2012 respectively. The stool adequacy rate at the national level remained above 80% with over 60% of the districts achieving a rate of >79%. The annualized non-polio AFP rate as of week 16 in 2013 is 2.71. However, significant surveillance gaps still remain at the sub-national level. The programme incorporated the surveillance review recommendations into the three year surveillance strategic plan which is currently being implemented. The recommendation include, conducting regular focused technical supportive supervision by central surveillance teams, building capacity for all sub-national surveillance focal persons, replacing aging motorcycles and strengthening cross-border activities.

Plans for the remainder of 2013 are to implement two rounds of SNIDs in 37 high risk districts (35% of target population of under five children). The high-risk areas were selected based on the polio risk analysis conducted in January and April 2013.

5. Yemen

The 8th HOA-TAG made six country specific recommendations for Yemen. Five were fully implemented; only one was partially implemented - only one round of NIDs was conducted in January 2013.

Yemen has been polio-free since the WPV1 outbreak of 2005-2006, which resulted in 480 cases. An outbreak of cVDPV2 occurred in 2011 with 9 cases and an outbreak of cVDPV3

occurred in 2012 with 2 cases (The most recent case had onset on 24 August 2012). In June 2012, an international cVDPV Outbreak Response Assessment was conducted by independent reviewers.. An aVDPV2 and an aVDPV3 were isolated in 2012 with date of onset of paralysis on 2 February and 25 November respectively.

In 2012 two rounds of NIDs were conducted with tOPV in January and June. In addition, OPV was administered during a national measles campaign in March and April 2012. The NIDs targeted 4.43 million children. One round of NIDs was conducted in January 2013. All campaigns reported over 90% administrative coverage. Post campaign independent monitoring was implemented for the first time during the January 2013 NID.

The AFP surveillance performance indicators for 2010, 2011, 2012 and 2013 (to date) remain above certification level at both the national and sub-national levels. The 2012 annualized non-polio AFP rate is 3.9/100,000 and stool adequacy is 93%. All 22 governorates have non-polio detection rates above 2/100,000 except Al-Dhalea governorate (one of the most unstable governorate).

Routine immunization coverage for OPV3 was 82% in 2012. Yemen has sub-national immunity gaps, with 8 (36%) of 22 governorates reporting less than 80% OPV3 coverage in 2012. However, the increasing proportion of zero-dose AFP cases over time is alarming and demonstrates an increasing pool of susceptible children: 7% in 2008, 11% in 2009, 15% in 2010, 17% in 2011 and 13% in 2012.

The program is planningto implement an external AFP surveillance review in 11-16 May 2013 and to conduct three rounds of SNIDs in May, June and November 2103 and one round of NIDs in September 2013.

Yemen remains at high risk for WPV importation and sustained transmission due to civil unrest, large areas of insecurity, low and declining routine immunization coverage, and internally displaced persons and refugees.

III: Conclusions and Recommendations

1. General Conclusions

The Technical advisory Group noted the achievements attained by the countries participating in the meeting and appreciated the efforts of the countries in following up and reporting on the status of implementation of the recommendations made during the 8th HOA TAG Meeting in September 2013.The TAG also noted and welcomed the local initiative “Regional Forum for Polio Eradication” which brings together partners in the sub-region to support efforts on polio eradication. The TAG however noted that despite Improvements in security seen over the past 6 months in South Central Somalia that have led to about 400,000 children being reached at least once with vaccination for the first time since four years, the sub-region still hosts the largest single group of susceptible children in the world. The fact that, in Somalia,the proportion of 0-dose AFP cases doubled from 8% in 2010 to 16% in 2012 is a demonstration of this increasing susceptibility gap. The TAG further noted that countries were systematically conducting quarterly risk analysis using a common tool and that the results of the analysis were being used to guide the six-month plans for EPI and polio eradication activities including preventive supplementary immunization activities. In addition, all countries except Yemen had conducted external AFP surveillance reviews, which revealed sub national surveillance gaps, particularly in the South Central Zone of Somalia.All

the countries had however incorporated follow-up activities in their 6 month emergency plans.

The following are the key conclusions

a) **Advocacy and political commitment:** In view of the complex emergency situation and the low population immunity that is seen across all countries in the Horn of Africa, advocacy to maintain political commitment and commitment of local leadership should continue to remain a priority.
b) **Outbreak detection and response**: Although no wild polio viruses have been detected in the HOA countries since July 2011. The TAG remains concerned that there have been continued circulation of VDPVs with the most recent case reported from Afgoi in Somalia with date of onset 9th of January 2013. This case is part of the outbreak that had spread into north east Kenya in 2012. In addition, vaccine derived viruses have also been isolated from AFP cases in 2012 in Sudan, South Sudan, Yemen and Ethiopia. The detection of VDPVs in HOA reflects low population immunity, as does the increase in proportion of 0-dose AFP cases particularly in Somalia and Yemen.
c) **Risk Assessment**: The TAG noted that all the countries were systematically conducting risk assessments on a quarterly basis and all countries are updating their six-month action plans accordingly.
d) **Cross-border activities**: TAG noted that Kenya and Yemen reported collaboration with other UN Agencies and partners in implementing immunization activities in refugee camps and among internally displaced persons. DPs. The TAG was however concerned that cross-border activities were not being implemented in all countries, and where implemented they were limited and not adequately documented.
e) **Synchronization of supplementary immunization activities**: TAG noted that synchronization did not take place during the cVDPV outbreak response between Somalia and Kenya. This was considered a serious missed opportunity during an outbreak that spanned over two countries. The explanation was failure to preposition vaccines on the Somalia side because of lack of funds.
f) **Addressing surveillance gaps:** The TAG noted that surveillance reviews had now been completed in all the HOA countries except in Yemen and that the countries had made significant progress in incorporating the recommendations of the reviews into their six month activity plans. The TAG however expressed concern that surveillance gaps remain in all countries and as such, the risk of missing transmission or delays in identifying importation of wild virus or cVDPVs still exists.
g) **Improving sensitivity of AFP surveillance:** The TAG recognized the importance of strategies that the countries had adopted to improve the sensitivity of their surveillance systems. These strategies include collection of stool specimens from contacts of AFP cases in high risk areas, and the collection of stool specimens from healthy children in silent districts. In addition, the TAG noted that countries with difficult to access or security compromised areas were expanding community based surveillance/sensitization activities as an additional strategy.
h) Communications and social mobilization The TAG recognized the progress made in the area of communication and social mobilization and that country programmes have established robust indicators around general awareness. The TAG was concerned that the data collected arenot systematically reported or used to monitor impact on the number of children immunized. The TAG also noted that in order for progress to continue, there is a need to establish regional priorities for communication and social mobilization.

2. Recommendations

Cross Cutting Recommendations

a) The TAG has repeatedly stressed the importance of advocacy to the highest level in the HOA countries considering the urgency to complete the polio eradication. TAG recommends that representatives of the TAG should be facilitated to meet the regional directors of AFRO and EMRO to discuss issues of advocacy in the 3 key countries Uganda, Kenya and South Sudan.
b) When any VDPV is detected in the HOA countries a thorough investigation should be conducted and a rapid response should be mounted depending on the epidemiology and findings. The scope of the response, age group to be targeted and interval between rounds will be determined on case by case basis.
c) The TAG requested that risk assessment be included in the country weekly updates reflecting the activities conducted to mitigate the risks and to document the impact of the interventions. A joint HOA risk assessment showing the risks at sub-national level should to be presented to the TAG at the next meeting.
d) All countries in the HOA should systematically and regularly document all immunization and surveillance activities conducted in refugee camps and among IDPs. WHO and UNICEF should work, particularly at country level, with UNHCR, OIM and other humanitarian organizations to ensure that activities take place. Additionally all returning children should have a documented complete immunization schedule before departure.
e) The TAG re-emphasizes the importance of cross-border coordination and collaboration and requests that all activities be systematically documented and shared.
f) All efforts should be made to ensure complete implementation and documentation of the surveillance review recommendations and impact of the activities implemented. The TAG requests quarterly updates from all countries.
g) All HOA countries should follow the established guidelines for stool collection from contacts of AFP cases specifically from AFP cases with inadequate stools, and from 'hot' or highly suspected AFP cases where there is epidemiological evidence that the case has been in contact with or living in an area with possible or recent polio virus circulation. This includes being from a high risk group or being in a high risk areas or hard to reach districts even without reported virus isolation andwhen there is any suspicion by the program regarding the collection process or handling of the index AFP stool specimens. One stool specimen should be collected from 3 contacts for each index AFP case. ***(Guidelines for stool sampling from contact of AFP cases. WHO/EMRO, July 2012)***
h) Following the detection of imported wild poliovirus and or cVDPV, all countries should conduct a 3 and 6 month outbreak assessment following the standard WHO guidelines.
i) Considering the unique situation in Somalia, all mechanisms to ensure implementation of emergency procedures to preposition vaccines and provide other logistic support should be activated immediately to take advantage of opportunities to vaccinate children and synchronize activities with neighboring countries.
j) TAG reiterates the need to follow established guidelines for independent monitoring and to ensure timely analysis and reporting of SIA results.(***Guidelines for the Monitoring of supplementary immunization campaigns SIAs against Polio in the African Region. WHO/AFRO, 2010***)

k) TAG requests an assessment of the transport status for AFP surveillance activities in all HOA countries and plansforequipment replacement when needed.
l) The TAG reiterates its previous recommendation that all countries in the sub-region document the impact of communication and social mobilization efforts on reaching children during SIAs, through routine EPI and surveillance and that communication objectives and strategies particularly in reaching the chronically missed be based on these data.
m) The TAG recommends that countries should identify political challenges and barriers that impair, or could potentially impair polio eradication and routine immunization objectives. Based on this analysis, specific mitigation plans should be developed.

Country Specific Recommendations

1. Kenya

a) Conduct SIAs in the high risk districts as planned in the third/fourth quarter of 2013.
b) Update and document on a quarterly basis the impact of community-based surveillance activities that were introduced in difficult to access or security compromised areas. The documentation should include number of AFP cases and cost of activity.
c) TAG requests a quarterly update on advocacy activities undertaken with the Kenyan Government and leadership.

2. Somalia

a) TAG recommends that there should be timely pre-positioning of vaccines for newly accessible areas as well as for any opportunities for synchronization of activities with neighboring countries (Kenya, Ethiopia)
b) Provide a quarterly update on activities for providing OPV through existing fixed sites in security compromised areas and on routine EPI.
c) Provide an update on the reverse cold-chain monitoring of stool specimens and the implementation of the AFP surveillance review on non-screening of AFP cases and the introduction of active surveillance in the hospitals in Benadir.
d) Introduce independent monitoring using the established WHO standards in all SIAs to be implemented in Somalia.

3. Uganda

a) Joint technical assistance (WHO and UNICEF) should be provided to Uganda to address vaccine availability and logistics.
b) A quarterly report on the status of implementation of the external surveillance review recommendations.

4. South Sudan

a) The country should develop a long-term plan for the transitioning of key technical support from external partners to national staff, including the STOP Team initiative which is the main technical support for AFP surveillance.
b) The programme should immediately move to using an external group for independent monitoring during SIAs as per standard WHO guidelines.
c) Continue collecting stool specimens from contacts of all AFP cases as well from children in silent counties.

5. Yemen

a) Encourage the national government to make available financial resources for SIAs
b) Conduct independent monitoring as per WHO guidelines.
c) WHO should provide technical support for SIA data management as well as routine and administrative data.
d) Documentation of data on refugee camps and IDPs should be instituted.

IV. Next meeting of the TAG

The next meeting of the HOA TAG, including all countries of the sub-region, is proposed to take place from 12 to 14 November 2013 in Nairobi, Kenya.

Annex 1.

List of participants

Technical Advisory Group members

1. Dr Jean-Marc Olivé, France (Chairman),
2. DrYagobYousef Al-Mazrou; Saudi Arabia
3. Dr H. El Zein Elmousaad, Virginia, USA
4. Professor Francis Nkhrumah, Legon Ghana
5. Dr Robert Linkins, CDC, USA
6. Professor Redda Teklahaimanot; Addis Ababa, Ethiopia
7. Mr Carl Tinstman, Boulder, Colorado, USA
8. Dr Rafah Aziz, London, United Kingdom (Unable to attend)

UNICEF and WHO Country Representatives

9. Dr Olivia Yambi. UNICEF Representative, Kenya
10. Dr CustodiaMandlhate WHO Representative, Kenya
11. Dr MartheEverard, WHO Representative, Somalia

Technical Advisors

12. Steve Rosenthal, UNICEF/HQ
13. Jeffrey Bates, UNICEF/HQ
14. Mbaye Salla, WHO/AFRO
15. Samuel Okiror WHO/AFRO
16. Nestor Shivute WHO/AFRO
17. Dr Tahir Mir , WHO/EMRO
18. HalaSafwat, WHO/EMRO
19. Tahir Mir, WHO/EMRO
20. Derek Ehrhardt, CDC/USA
21. Benjamin Nkowane WHO/HQ

National (MOH) Representatives and participants

22. Juliet Muigai, MOH, Kenya
23. Ian Njeru, MOH, Kenya
24. Collins Tabu, MOH, Kenya
25. Abib Aden Nur, MOH, Somaliland, Somalia
26. Yassin Mohamed Nur, MOH, Mogadishu, Somalia
27. Ahmed MoalimHirsi, MOH Puntland, Somalia
28. Anthony Laku, MOH, South Sudan
29. Jacinta Sabiiti, MOH, Uganda
30. Ali Bin Break, MOH, Yemen

Partner Representatives (International/Regional)

31. Sam Ouko, Polio Plus, Rotary International, Nairobi
32. Tim Petersen, Bill and Melinda Gates Foundation
33. Sue Gerber, Bill and Melinda Gates Foundation
34. Gene Bartley, Bill and Melinda Gates Foundation
35. Niall Fry, Independent Monitoring Board, UK
36. EndaleBeyene, USAID/Washington DC.
37. Frank Conlon, CORE Group Polio Project, Washington DC

38. Lee Losey, CORE Group Polio Project, Chicago, Illinois
39. Anthony Kisanga, Core Group Polio Project, South Sudan
40. Subroto Mukherjee from USAID/Nairobi
41. Julia Henn, USAID/Nairobi
42. Barbara Hughes, USAID/Nairobi
43. Sheila Macharia USAID/Nairobi
44. LilianMutea USAID/Nairobi
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49. Daniel Ngemera, UNICEF/ South Sudan
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54. AnnetKisakye, WHO, Uganda
55. Osama Mere, WHO, Yemen
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