TECHNICAL ADVISORY GROUP ON POLIO ERADICATION IN ANGOLA, DRC, NAMIBIA AND ZAMBIA

FINAL REPORT OF THE 6TH MEETING
LUANDA, MARCH 3-5, 2010

1. PREAMBLE

The 6th TAG meeting for Angola, DR Congo, Namibia and Zambia was held from 3rd to 5th of March 2010 in Luanda. Teams led by high ranking officials from all four countries participated in the meeting.

His Excellency the Minister of Health, Angola, Dr. José Van Dunem opened the meeting with a clear message of government commitment to interrupting wild poliovirus transmission in Angola once and for all. The chairperson of the TAG, Dr. Ciro de Quadros outlined the objectives and agenda of the meeting. Participants included members of the TAG, senior staff of the Ministry of Health in Angola, the Chairperson of the Angolan Medical Association, and Partners including UNICEF, WHO, CORE, and USAID. The meeting was closed by the Honourable Vice Minister of Health.

This meeting was held with the following objectives:

- leview the current situation of polio eradication in the four countries
- Identify obstacles that are hampering the interruption of transmission of wild poliovirus (WPV) in Angola and DR Congo
- Recommend activities aimed at interrupting transmission in 2010 in Angola and DR Congo.
- Recommend activities to maintain Namibia and Zambia polio free.

The agenda included Global and Regional updates and detailed analysis of the national Polio Eradication and EPI activities in the four countries. The TAG met in closed session to review progress and make recommendations. The participating countries met separately to discuss and agree on collaboration areas as well as coordination and implementation of cross-border activities.

The 6th TAG meeting took place in the context of renewed urgency to achieve interruption of wild poliovirus transmission following an independent external evaluation of the Global Poliomyelitis Eradication Initiative (GPEI) requested by the Director General, Dr. Margaret Chan. This evaluation carried out in 2009 focused on identifying the remaining technical, operational and financial challenges to interrupting wild poliovirus transmission globally after the "intensified eradication effort" launched in February 2007. The independent evaluation team expressed confidence "***that if the managerial, security and technical issues can be addressed polio eradication can be achieved."***

Further more; recently new milestones in polio eradication to be achieved globally have been set as follows:

- Interrupting wild poliovirus transmission in all importation countries by 30th June 2010

- Interrupting wild poliovirus transmission in countries with re-established WPV transmission (Angola, Chad and DR Congo) by 30th December 2010
- Interrupting wild poliovirus transmission in at least two endemic transmission countries (Including Nigeria) by end of December 2011

It is critical to note that Angola and DR Congo need to conform to one of the milestones by the end of this year. Accordingly, all efforts should be made by Governments and Partners to address any outstanding operational and financial issues before the implementation of activities starting in May 2010. The opportunity to interrupt wild poliovirus once and for all with reduced risk of further wild poliovirus importations is at hand with the progress made both in India and Nigeria in 2009.

2. CURRENT SITUATION

Angola and DR Congo are two of the four countries, with Chad and Sudan, considered to have re-established transmission of WPV, i.e. internal circulation of WPV for over 12 months. Furthermore, out of the only 4 cities in the world today still infected with WPV, 3 are located in Angola (Luanda, Benguela and Lobito), the fourth one being Karachi in Pakistan.

Angola reported its most recent WPV type 3 in November 2008 but is experiencing an outbreak of WPV type 1 that has been circulating in the country for over 2 years. In 2009, Angola reported 29 WPV type 1 cases.

DR Congo reported its most recent WPV type 1 case in August 2008. However, the September 2009 outbreak of WPV type 1 that Burundi experienced was shown to be linked to DR Congo viruses, pointing to the fact that the virus lineage has been missed for over 1 year, most likely in Eastern/North-Eastern DR Congo. The country reported 3 cases of WPV type 3 from 2 regions in the first semester of 2009, the result of 2 distinct importations from Angola, and has not reported any case due to WPV type 3 since.

The GPEI Strategic Plan milestone targeted at countries with re-established transmission states that WPV circulation should have been interrupted by the end 2010. **In order for this objective to be achieved, the current two key issues of sub-optimal SIA quality in Angola and DR Congo and sub-optimal AFP surveillance performance at sub-national level in priority provinces of Luanda and Benguela in Angola as well as Equateur, North Kivu and South Kivu in Dr Congo need to be addressed as a matter of urgency by mid 2010**

Two key recommendations of the independent evaluation were that international technical support to persistently re-infected areas / countries with re-established transmission should be at par with that provided to endemic areas and that the GPEI should support more actively routine immunization systems strengthening.

Angola

Seven (54%) of the 13 recommendations from the 2009 TAG were fully implemented, five (38%) partly implemented or in process and one (7%) was not implemented.

The recommendation not implemented was the full implementation of the RED strategy in key provinces, especially Luanda and Benguela. Recommendations not fully implemented are (1) Implement a mop up in April, in Luanda and Benguela, (2) MOH and Partners should utilize the time available before the NID to conduct an enhanced extensive country-wide media and advocacy campaign, (3) the expansion of the number of sites offering immunization services on a regular basis, (4) the prioritization of support to those identified districts where large numbers of children remain unimmunized, (5) both Government and Partners should ensure adequate technical human resources are available at national level to manage, supervise and monitor surveillance activities.

In 2009, Angola reported 29 WPV cases, all of them type 1, in 4 provinces (Luanda, Benguela, Kwanza Sul and Kwanza Norte). The most recent WPV1 viruses were detected in Benguela and Luanda (in September). The most recent WPV3 was detected in Namibe in November 2008. All WPV so far have been covered by 3 rounds of SIAs.

In 2009, Angola conducted 3 NIDs and 3 SNIDs, using tOPV and mOPV1. Two NIDs were conducted using fixed post strategy. Although independent monitoring shows continued sub-optimal performance in key areas, innovations took place since the last TAG that have contributed to improved quality. Of note were the participation of the Armed Forces and the Police in the planning, implementation and monitoring, as well as the involvement of local authorities (Governors, Municipal Administrators, traditional leaders) at the planning stages, including advocacy.

In the second half of 2009, independent monitoring capacity and efficacy were strengthened with an increased number of monitors that helped to maximize chances of finding insufficiently vaccinated areas and with immediate feed-back provided through standardized forms after the rounds. Corrective actions were taken jointly with the municipalities and the implementation of these actions verified the next day by the direct supervisor of the monitoring teams. Documentation of these corrective activities especially their impact was not clear but needs to be done in the subsequent SIAs rounds.

OPV status did not improved significantly from its 2008 level with more than 60% of non polio AFP cases aged 6-59 months receiving fewer than 4 doses of OPV.

Surveillance quality has dropped since 2008, with non-polio AFP rate standing at 3.5 at the national level in 2008 and 3.2, in 2009. Stool adequacy rate dropped slightly too, from 93% in 2008 to 91% in 2009. All provinces report a

non-polio AFP rate greater than 2. In 2009 the 5 provinces with the lowest detection rates are Luanda (2.3), Benguela (2.7), Cunene (2.5) and Huila (2.9).

Of the 21 districts with an under 15 population >100 000, 4 have a non-polio AFP rate below 2 (2 districts; Cazenga and Sambizanga in Luanda province and 1 district; Ganda in Benguela Province). Despite the improvements in surveillance, further work on basic concepts such as monitoring active surveillance visits and conducting risk assessments based on data collected needs to be done with provincial focal points.

There has been a slight decrease in routine immunization coverage with preliminary data on national DPT-Penta3 coverage for 2009 of 72% compared to coverage of 81% in 2008. Three out of the four polio infected provinces (Luanda, Kwanza Sul and Kwanza Norte) reported an increase in the proportion of unimmunized children with DPT3 from their 2008 levels. Luanda however saw an improvement, with a reduction of the proportion of unimmunized children from 22% to 15% in 2008 and 2009 respectively. The majority of children in Angola who are either not immunized or partly immunized, are concentrated in 10 districts located in the provinces of Luanda, Benguela, Moxico, Huila, Bie and Kwanza Sul. A high proportion; (38%) are concentrated in just 5 districts in Luanda and Benguela.

DR Congo

Three out of the seven recommendations from the 5th TAG were fully implemented three partly implemented, and one not implemented related to conducting national surveillance review.

Since the last TAG meeting, DR Congo has experienced two importations of WPV type 3 cases from Angola resulting in a total of three wild polioviruses in 2009 (2 in Bas-Congo and 1 in Kasai Occidental provinces). The first case was reported in Kamonia district, Kasai Occidental province and the last case in Tshela district Bas-Congo province with date of onset on 10th February 2009, and 24 June 2009 respectively. The last type 1 WPV case was confirmed in Kamonia district, Kasai Occidental province with date of onset on 18th October 2008.

In response to the type 3 cases outbreak in 2009, DR Congo has carried out 11 SNID rounds, five rounds using mOPV3, two rounds with mOPV1 and 4 rounds with tOPV, covering a total of 18,158,395 children under 5 years old. However the two rounds carried out in Nord Kivu were sub-optimal with a large number of unreached areas because of security reasons. In addition the independent monitoring conducted during SIA has identified significant number of missed children based on finger marking.

The non-polio AFP rate at national level has remained above 4.0 per 100,000 children under 15 year old since the past two years and above 2.0 at provincial levels. The stool adequacy rate at national level is 85%, with 3 provinces below 80% (Equateur, Kasai Occidental and Kasai Oriental).

Overall, the national detection rate of non-polio enteroviruses has been maintained at highest level in 2009 (above 10%).

Despite the progress, the TAG was informed about the steady decline in the total number of AFP cases detected in country since 2007. This is particularly attributable to the re-profiling and downsizing of WHO staff in charge of surveillance as well as inadequate involvement of their national counterpart in active case search activities.

The detection of an orphan virus in Cibitoke district, Burundi in September 2009, closely linked to Miti Muresha, Sud Kivu virus of June 2008 confirmed significant gaps in surveillance in the Eastern provinces of the country with possible missed wild poliovirus transmission. Additionally the declining number of AFP cases detected in the last two years compared to 2007 combined with reducing proportion of AFP cases validated by qualified surveillance personnel needs to be addressed.

The TAG noted the efforts made to increase the routine immunization coverage with a DPT3 coverage of 86.3% and 92.2% in 2008 and 2009 respectively. Routine performance remained sub-optimal in 2 provinces during the past 2 years, Orientale and Bandundu.

Issues were raised including the inadequate funding to cover the operational costs for vaccines and supplies distribution, supervision, monitoring and evaluation of performance at operational levels.

Actions initiated at national level to fill the gaps include; (i) involvement of private sectors, religious and NGOs to support operational cost pertaining to routine immunization activities, (ii) advocacy with national and local authorities, (iii) active search of unimmunized children in the big cities with involvement of community, and (iv) re-orientation of staff at local operational level.

Namibia

Of the 5 recommendations from the 2009 TAG, Namibia implemented only one recommendation fully, two partially and the other two were not implemented at all. The outstanding recommendations include (1) adoption of the surveillance generic guide to a simpler version for sub-national level and (2) the updating and finalization of the EPI policy.

Although there is still a threat of importation of wild poliovirus into Namibia from Angola, no new wild poliovirus has been reported since April 2006.
As in 2008, Namibia conducted 2 rounds of SIAs' in 2009 fully funded by the government using tOPV achieving coverage of over 95% in each of the rounds.
Independent monitoring implemented showed less than 5% missed children overall but with just more than 5% in 2 provinces; Kunene and Khomas.

Child Health Days (CHD) that included tOPV were also conducted in 4 out of the 13 regions (Oshana, Ohangwena, Omusati and Omaheke) towards the end of 2009 targeting 110,045 children representing about 36.6% of the total population of under fives. Data on the number of children vaccinated is yet to reach National level.

Surveillance performance for the past 3 years has been sustained achieving certification standard surveillance indicators for AFP at National level with only 1 region not detecting any case in 2008. In 2009, all 13 regions detected cases, stool adequacy was suboptimal is 4 of the regions (Kavanga, Khomas, Omaheke and Otjozondjupa). Only Khomas region a non-polio AFP detection rate of less than 1/100,000 children below 15 years of age.

The country also did a risk analysis which has enabled the identification of 4 high risk provinces namely Khomas, Kunene, Ohangwena and Otjojandjupa.

Since 2000, routine immunization has been maintained at more than 80% with some sub-national variations. The areas with low routine immunization have been identified and are targeted for strengthening through the RED implementation process.

Zambia

All three 2009 TAG recommendations were fully implemented.

The last SIAs in Zambia were conducted in 2002, when the last WPV was reported, but the country carries out Child Health Weeks twice every year and includes tOPV.

The country has maintained surveillance performance at the highest level ; the non polio AFP rate at national level has been maintained above 2.0 and the stool adequacy rate above 80% for the past two years.

Efforts were made to sustain routine coverage consistently above 90% since 2002. In 2009, only 22,919 children remain unvaccinated in spite of financial constraints.

Cross border coordination meeting

One cross border coordination meeting has been carried out since the last TAG meeting in July 2008, involving Angola and Namibia. Local cross border meetings are also held between Zambia and DRC, and Namibia and Angola. However there remain gaps in coordination between the infected and neighbouring countries.

4. CONCLUSIONS AND RECOMMENDATIONS

Cross-cutting recommendations

The TAG recognizes that there is still significant risk of transmission across the borders of the participating countries and urges all countries and Partners to:

- Immediately heighten activities to exploit the narrow window of opportunity between May and August before the rainy season, to implement high quality SIAs, to achieve the end 2010 goal.
- Reinforce the SIA and AFP surveillance performance as well as supervisory capacities from Central to the lower levels, document findings and provide feedback (especially in polio infected areas of Angola and DR Congo)
- Adhere to global outbreak response guidelines; in particular, ensuring response within 4 weeks using the appropriate vaccine and targeting an appropriate area and population
- Ensure that during the coming SIAs cross-border activities are coordinated and facilitated with clear documentation of children vaccinated. In particular mobile populations and routes of movement between countries should be identified and targeted.
- Share surveillance data and ensure that border areas are effectively covered by surveillance activities
- Ensure that all countries have a three-year consolidated EPI/Polio plan and programme of work with specific milestones to guide the work of both the Government and its Partners in immunization.
- **Finally all recommendations not implemented and partially implemented should be addressed in 2010 and reported on at the next TAG.**

Countries with re-established wild poliovirus transmission

DR Congo and Angola along with Chad and Sudan constitute the only areas in the world with re-established WPV transmission following importation. It is crucial for both Angola and DR Congo to stop all transmission of wild poliovirus as per milestones established, by the end of December 2010.

Both countries have previously interrupted WPV transmission more than once. TAG is convinced that if the two countries immediately address all issues related to implementing high quality supplementary immunization activities and sensitive AFP surveillance system particularly at sub-national level, achieving interruption of WPV circulation by end of 2010 is feasible.

In 2009, the two countries made substantial progress, demonstrating ability to effectively identify districts and areas of sub-optimal coverage during independent monitoring. There is therefore a need to develop area specific plans to ensure high quality supplementary immunization activities to rapidly reduce the proportion of missed children to less then 5%, guided by independent monitoring data. Immediate corrective actions for poor performing areas should be taken and documented and these areas revisited.

Angola

The TAG has noted interruption of WPV type 3, with no circulation since November 2008 and further noted that all the type 1 WPV cases confirmed in 2009 occurred in 4 provinces: Luanda, Benguela, Kwanza Sul and Kwanza Norte. WPV transmission has continued because children in these key areas (particularly Luanda and Benguela) have been consistently missed by both supplementary and routine immunization activities.

The TAG commends the coordination efforts of the country through the ICC which meets monthly under the chairpersonship of Honourable Vice Minister of Health.

The TAG further commends the continued support by the Governors and the involvement, most recently, of the Armed Forces in the independent monitoring of the SIAs as well as implementation of polio campaigns in key areas. Such innovations could hold the key to completing eradication and should be consolidated.
The TAG was provided with credible information with regards to independent monitoring results that can be used to direct the programme activities in the coming months.

In order to further boost population immunity, mandatory repeat immunization activities should be implemented in areas identified to have high number of missed children (>5%). The results of these activities should be documented and their impact monitored.

Recommendations

- **SIA schedule:**
  In order to interrupt WPV transmission in Angola by end of December 2010 as per set milestone, TAG recommends the following SIA rounds:
  - May: SNIDs in 3 provinces of Luanda, Benguela and Kwanza Sul using bOPV. These provinces constitute areas with the highest population density and consistently reporting confirmed WPV.
  - June: NIDs using tOPV to guard against any outbreak of cVDPV and possible undetected circulation of WPV type 3
  - July: SNIDs in 3 provinces of Luanda, Benguela and Kwanza Sul using bOPV.
  - August: NIDs using tOPV.

  Should there be any confirmed WPV, mop ups should be carried out consistent with global outbreak response recommendations.
- **Quality of SIAs:**
  The TAG believes that the target of interrupting WPV by the end of the year is feasible provided that:
  - Political leadership: Political leadership gets fully involved at national, provincial and municipal levels. It is particularly critical that the Governors take it upon themselves to ensure that the Municipal Administrators are accountable and are held responsible for the quality of the SIAs in their areas of jurisdiction.
  - Municipal level micro planning: The process of micro-planning that has hitherto been carried out at Central level and passed on to Provinces

for implementation should be initiated at Municipal level. Plans developed should be shared with the Provinces and National level well ahead of the campaign. The emphasis is to take into account all the SIA-quality related issues clearly outlined in the guidelines provided. Specific attention should be given to the provinces of Luanda and Benguela.

- Social mobilization: The TAG noted with satisfaction the efforts that have been made in developing an integrated strategy for social mobilization in the country. However the use of TV and radio is not sufficient to adequately mobilize communities. TAG recommends these plans be completed with the immediate development of specific social mobilization plans for Luanda and Benguela with a strong inter-personal communication component.
- Independent monitoring: Independent monitoring remains a gold standard for determining the quality of SIAs and must include in-house and outside/street monitoring.
  - The involvement of the Armed Forces and other non-governmental organizations that has already produced credible monitoring data should be rolled out, particularly in highest risk provinces of Luanda and Benguela.
  - Where independent monitoring indicates sub-optimal coverage (<95%) immediate repeat immunisations should be carried out and the actions and results clearly documented.
  - Furthermore, lessons learned should be used to improve subsequent rounds of SIAs.

- **Surveillance:**
  - Both Government and Partners should ensure that adequate technical human resources are available at national level to manage, supervise, and monitor surveillance activities. As a matter of urgency, within 2 month, WHO should fill the surveillance officer position that has been vacant for more than 2 years.
  - The TAG commends the Government on the efforts made to improve surveillance since the last surveillance review in 2007 but notes that active surveillance is not being implemented but rather cases are picked passively from the main hospitals, clearly documented in Luanda province. Therefore the TAG urges Government with the support of Partners, particularly WHO, to
    - Revitalize active surveillance starting with the 4 high priority provinces through building capacity of all new surveillance focal points, conducting active case search as per plans developed and provide evidence of the visits carried out.
    - The current lists of active surveillance sites should be reviewed and updated and the active surveillance visits monitored and reported at the ICC.
    - Validate at least one third of all AFP cases detected.
  - The TAG strongly recommends that an in-depth surveillance review be conducted in the last quarter of 2010.
- **RED strategy:**
  The TAG reiterates its previous recommendation of strengthening routine immunization particularly continuing the expansion of vaccination sites and

aggressively implementing the RED strategy in the highest risk areas of Luanda and Benguela, before the May 2010 rounds. This should be documented and discussed at the ICC meetings. The opportunity should be used to include other interventions to address prevailing conditions such as cholera and rabies, as well as other high impact child survival interventions.

DR Congo

The epidemiological situation of the country since 2006 can be summarized into three categories: 1) areas prone to repeated importations arising from Angola (Bas Congo and Kasai Occidental provinces), 2) areas with possible missed transmission (Orientale province and Nord and Sud Kivu), 3) the rest of the country. These categorisations can be used to guide the scope and prioritization of SIAs.

Despite problems with the quality of SIAs in some areas, the last type 1 WPV was reported in August 2008 and the most recent type 3 WPV was reported in June 2009. The confirmation of the orphan virus in Burundi in September 2009 linked to the June 2008 Sud Kivu virus and a 2007 Equateur type 1 virus casts doubt on the quality of surveillance in this part of the country. While there has been significant progress in the national coverage for routine immunization (DPT3: 92%), the prospects of sustaining this achievement is bleak in the context of limited financial resources.

Recommendations:

The TAG believes that the target of interrupting WPV by the end of the year is feasible. It therefore recommends the following:

- **SIA schedule:**
  - In the context of the ongoing decentralization process, the political leadership at all levels should get fully involved and take ownership of the implementation of high quality SIAs.
  - 2 SNIDs in June and July 2010 focused on the importation route (particularly border districts of Bas Congo and Kasai Occidental) and missed transmission areas (especially Orientale province, Nord and Sud Kivu). The first and second rounds should use bOPV and tOPV, respectively.
  - The TAG remains deeply concerned that there have been no national rounds implemented in DR Congo since 2002 and recommends that the country and Partners do everything possible to conduct 2 NIDs immediate after the 2 SNIDs.
  - If any new WPV is confirmed, response activities should be carried out consistent with the global recommendations.
- **SIA quality:**
  The main mechanism for assessing SIA quality should continue to be the systematic checking of finger marking by trained independent monitors. During SIAs, any area where monitors find sub-optimal coverage (>5% unimmunized), the immunization activity should be immediately repeated.

A specific report on the results of monitoring, and the result of repeat vaccination, should be prepared after each SIA round and used to improve quality in subsequent rounds.

- **Surveillance:**
  Given the uncertainty of transmission of WPV in the Equateur, Orientale, Nord and Sud Kivu areas, as evidenced by the confirmed WPV in Burundi linked to these areas, an urgent, immediate international risk assessment should be carried out in the above-mentioned provinces before the end of April 2010. It should include a detailed active search in all prioritized active surveillance sites. The findings should be used to guide subsequent SIA interventions as well as the scaling up of the RED approach.

The TAG was informed by the Government Representative at the meeting that surveillance performance declined following the re-profiling and downsizing of WHO surveillance staff, at a time when the national capacity is still inadequate. The TAG therefore urges Government with the support of Partners, particularly WHO, to:

  - Ensure WHO polio-funded provincial staff are fully accountable for AFP performance with alternate funding sources identified for other functions.
  - Ensure that the provincial surveillance officers prioritize supervision of active surveillance in the lower levels and report of their activities consolidated at national level for the attention of ICC.
  - Revitalize active surveillance through conducting active case search and provide evidence of the visits carried out. Provincial focal points should closely monitor these activities.
  - Ensure capacity building of local surveillance officers.
  - Validate at least one third of all AFP cases detected.
  - Monitor progress in low performing areas and discuss findings at the ICC.
  - The TAG also recommends that an in-depth surveillance review be conducted in the last quarter of 2010.

- Sustaining population immunity: The TAG received encouraging reports on improved routine immunization over the past three years. However TAG is concerned about the discrepancies between the reported routine immunization coverage and the immune status of the non-polio AFP cases. TAG therefore supports any plans to conduct additional activities to address the sub-national routine immunization gaps. It further recommends that Government and Partners mobilize the necessary resources for operational costs as well as provision of cold chain equipment.
- **High level Advocacy visits: Given the urgency to meet the established milestones of interrupting transmission before the end of 2010, and in the light of dwindling external resources, TAG recommends a high level advocacy visit be conducted before June 2010 with the aim of discussing with Government and identifying internal resources to support planned activities, specifically SIAs and routine immunization.**

Polio-free countries

Namibia

The TAG commends the efforts of the Namibian Government to maintaining high population immunity through the self-financed annual polio campaigns. The TAG still notes the persistent surveillance gaps, particularly in the areas bordering with Angola.

The TAG recommends that the country:

- Fully implements the remaining recommendations of the 5th TAG meeting.
- Updates the SNID plan presented to the TAG to cover all high risk areas identified.
- Addresses the identified sub-national surveillance gaps through conducting active surveillance and providing evidence of the visits carried out. Special attention should be given to areas bordering Angola.
- Regularly updates polio importation preparedness and response plans.

Zambia

The TAG commends the efforts of the Zambian Government to address the recommendations of the 5th TAG meeting. The TAG concurs with the country plan to implement Child Health Days including OPV in 2010 as a means of boosting population immunity in the identified high risk areas.

The TAG notes with concern the decline in funding for immunization 2009 due to economic situation and the direct impact it has had on the coverage.

The TAG recommends that the country with support of partners to:

- Strengthen surveillance performance in the identified high risk areas along the border with Angola and DR Congo.
- Regularly updates polio importation preparedness and response plans.
- Prioritize financing of immunization activities in 2010 to ensure that this fundamental aspect of primary health care is protected.

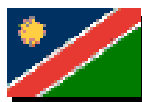
Finally, the TAG again urges the Governments and all the PEI Partners to provide the needed resources to support country activities, which if properly implemented will result in the interruption of transmission of the wild poliovirus in this area of Africa.

Next Meeting

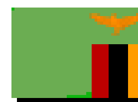
It is recommended that the TAG meets again in the first quarter of 2011.

Annex 1: COORDINATION MEETING 4th MARCH 2010, LUANDA, ANGOLA:

Angola


Namibia

D. R. Congo


Zambia

Annex 1:

During the 6th Meeting of Technical Advisory Group for Poliomyelitis Eradication, a coordination meeting was held on 4th March, 2010 between Angola, Democratic Republic of Congo, Namibia and Zambia delegations, as well as WHO, UNICEF and CORE Group professional staff.

The meeting that facilitated by Dr. Adelaide de Carvalho, National Director of Public Health of MoH Angola had the following agenda:

- Status of implementation of the February 2009 coordination meeting recommendations.
- Discussion on outline of joint activities for 2010:

(1) Implementation status of February 2009 coordination meeting recommendations:

Recommendation 1: *To conduct 1 coordination meeting between the 4 bordering countries in Windhoek – Namibia from 27th to 29th October, 2009.*

This activity was not done due the overlapping tasks in the host country. It was proposed to hold this meeting in the same country during the second half of October 2010.

Recommendation 2: *Conduct local cross-border coordination and information sharing meetings quarterly and/or whenever necessary.*

South border: Angola - Namibia;

Two meetings were held the first was between Kuando Kubango (Angola) and Kavango (Namibia) and the other was between Cunene (Angola), Omusati and Ohangwena (Namibia). These meetings were consistent with the local plan developed.

East border: Angola – DR Congo - Zambia:

This meeting was not conduct due to communication constraints. Country delegations agree on optimizing communication between the three countries, to better plan future local cross-border meetings.

Recommendation 3: *Take every opportunity to synchronize polio SIA's between any implementing countries.*

Polio SIA's between Angola and Namibia were successfully synchronized in June 2009 as agreed.

On the other hand, the cross-border synchronized activities between Angola, D.R. Congo and Zambia, did not happen due the coordination gaps among the countries.

(2.) Discussion on outline of joint activities for 2010:

- Country should proceed with the preparations to synchronize the polio SIAs planned for June to October 210. Social mobilization materials should be developed a head of time.
- AFRO should facilitate one cross-border coordination meeting between Angola, Namibia, DR Congo and Zambia during the second half of April 2010, to discuss preparation and synchronization SIA's planned for June to October 2010
- Countries to propose dates to implement the synchronized SIA's activities and share with each other, ISTs and AFRO through WHO Country Offices by the end of March 2010.
- By the end of March 2010, the countries should share the proposed social mobilization material, to be used in cross-border SIA's activities (Polio, Vitamin A and deworming); in preparation for finalization at the coordination meeting to be held in April 2010.
- Countries delegates request WHO/AFRO to support and facilitate a cross-border meeting with senior staff from Angola, Namibia, DR Congo and Zambia, in Windhoek – Namibia, in second half of October 2010.

Dr. Adelaide de Carvalho, National Public Health Director, closed the meeting.

Annex 2: List of participants:

Nº.	Name	Oganization Country
	TAG MEMBERS	
1	Mr Ciro De Quadros, President of TAG	Sabin Institute/USA
2	Dr Bruce Aylward, Global Polio Eradication	WHO/HQ/Geneva
3	Dr Sam Okiror, Regional Polio Focal Point	WHO/AFRO/Congo
4	Dr Maritel Costales	UNICEF/NewYork
5	Dr Ahmadu Yakubu	UNICEF/ESARO
6	Dr Carl Tinstman	Former UNICEF Off.
7	Dr. Luis Bernardino, National Certification Committee	Pediatric Hosp.Angola
8	Dr. Raul Feio, National Expert Committee	EU Officer/Angola
	PARTICIPANTS FROM COUNTRIES	
11	Mr Tony Musinde Sangwa,Directeur du Cabinet du MoH	MoH/DRCongo
12	Dr Andre Kasogo Mulamba,EPI Manager	MoH/DRCongo
13	Dr Koffi Tsogbe,IVD Focal Point	WHO/DRCongo
14	Dr Andre Yameogo	UNICEF/DRCongo
15	Ms Martina Allies	MoH/Namibia
16	Mr Primus Shilunga	MoH/Namibia
17	Ms Roselina de Wee, IVD Focal Point	WHO/Namibia
18	Dr Penelope Kalesha-Masumba, EPI Manager	MoH/Zambia
19	Dr Albert Sitali,Provincial Medical Officer	MoH/Zambia

20	Dr Helen Mutambo, EPI Focal Point	WHO/Zambia
21	Dr Adelaide de Carvalho	DNSP/MoH/Angola
22	Dr Alda Morais Pedro	DNSP/MoH/Angola
23	Dr Filomena Wilson	DNSP/MoH/Angola
24	Dr Helga Freitas	DNSP/MoH/Angola
25	Ms Isabel L. Severino	DNSP/SI/MoH/Angola
26	Ms Rosa Maria Geovetty	DNSP/SI/MoH/Angola
27	Maria António Gregório	DNSP/SI/MoH/Angola
28	Mr. David Campos	DNSP/SI/MoH/Angola
29	Ms Joana Maria M. Admiro	DNSP/SNN/Angola
30	Dr- Abou Beckr Gaye	WHO Team Leader /EPI/ Angola
31	Ms Sandra Regina da Silva	WHO/Angola
32	Mr Henrique Dalva	WHO/Angola
33	Dr Maria de Lourdes Neto	WHO/Angola
34	Mr Dalton Agostino	WHO/Angola
35	Dr Brandão Co	UNICEF/Angola
36	Dr Titus Angi	UNICEF/Angola
37	Dr Isilda Neves	MoH/ Luanda/Angola
38	Dr Catarina Oatanha	MoH/ Luanda/Angola
39	Dr Regina Antonio	MoH/ Luanda/Angola
40	Dr Kabeya Mukelenge Didi	MoH/ Luanda/Angola
41	Dr Valentino Aurelio	MoH/ Benguela/Angola
42	Mr Daniel Luciano	MoH/ Benguela/Angola
43	Dr Adão Castelo	MoH/ Kuanza Sul/Angola
44	Ms Teresa Joaquim	MoH/ Kuanza Sul/Angola
45	Dr Duarte Varela	MoH/ Kuanza Nortel/Angola
OTHER PARTICIPANTS		
46	Dr Jean-Marie Yameogo, Regional Surveillance Officer	WHO/AFRO/Congo
47	Mrs Christine Lamoureux	WHO/HQ
48	Dr Tesfaye Shiferaw	UNICEF/ESARO
49	Dr Samson Oboche Agbo	UNICEF/Angola
50	Dr Diego Garcia	Consultant WHO Angola
51	Dr Cesar Javier Calderon	Consultant WHO Angola
52	Dr Almaz Gebresenbet	Consultant WHO Angola
53	Dr Yameogo K. Robert	Consultant WHO Angola
AUTHORITIES AND REPRESENTATIVES OF AGENCIES		
54	Dr José Vieira Dias Van-Dúnem	Minister of Health Angola
55	Dr Evelize Fresta	Vice Minister of Health Angola
56	Mr Mateus Alves de Brito	Vice Governor Kuanza Sul Angola
57	Dr Diosdado Nsue Milang	Representative WHO Angola
58	Dr Koenraad Vanormelingen	Representative UNICEF Angola
59	Mr Randal Peterson	Director USAID Angola
60	Dr Pinto de Sousa	Bastionario Orden dos Médicos Angola
61	Ms Marcelina Gregorio	Representative ai CORE