MEETING ON THE COORDINATION OF CROSS-BORDER ACTIVITIES IN THE FRAMEWORK OF OPERATION MECACAR

Report on a WHO Meeting

Ashgabat, Turkmenistan
26–27 July 2000
ABSTRACT

The meeting was convened by WHO in collaboration with UNICEF to address poliomyelitis eradication issues facing Afghanistan, Tajikistan, Turkmenistan and Uzbekistan. The global poliomyelitis eradication programme is making remarkable progress at present despite all the impediments, and the aim is interruption of all transmission of wild poliovirus by 2002 and certification of eradication by the end of 2005. Tajikistan, Turkmenistan and Uzbekistan have maintained free of reported cases of poliomyelitis, have sustained high routine immunization coverage and have continued supplementary immunization activities with high coverage. The sensitivity and quality of surveillance for acute flaccid paralysis in these countries has improved to meet WHO performance criteria. At least nationally, Afghanistan has accelerated its activities towards the target of interrupting wild virus transmission, with a reduction in wild poliovirus isolation despite expansion of surveillance sentinel sites covering a higher proportion of the population over the last year. Nevertheless, further intensive efforts are necessary to meet the goal of eradication. Despite the limited population movement across the borders of Afghanistan with the other participating countries in recent years, there remains continued risk of importation and cross-border transmission in some areas. For this reason, further coordination should continue. For all countries, continued progress is needed in the prompt collection, transportation and analysis of faecal specimens, and in the identification of priority cases for transfer and analysis.

Keywords

POLIOMYELITIS - prevention and control
EPIDEMIOLOGIC SURVEILLANCE
IMMUNIZATION PROGRAMMES
NATIONAL HEALTH PROGRAMMES
TRANSIENTS AND MIGRANTS
AFGHANISTAN
TAJIKISTAN
TURKMENISTAN
UZBEKISTAN
EASTERN MEDITERRANEAN
EUROPE
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Introduction

This cross-border meeting was convened in Ashgabat on 26–27 July 2000 by WHO in collaboration with UNICEF to address polio eradication issues facing Afghanistan, Tajikistan, Turkmenistan and Uzbekistan. The meeting was chaired each day by Drs Ataeva and Niyazmatov, respectively; the Secretary was Dr Wassilak and Dr Deshevoi was Rapporteur. The scope and purpose, provisional programme, and list of participants are attached.

Global status of poliomyelitis eradication

At this time, the global polio eradication programme is making incredible progress despite all the impediments. Although the year 2000 target date set in 1988 for the eradication of poliomyelitis will pass before the objective is met, this was also the case for the successful smallpox eradication programme. Already in 2000, with improved surveillance, the number of cases of poliomyelitis has decreased to historically low levels, 678 cases provisionally reported as of 19 July. The next year’s aim to interrupt all transmission of wild poliovirus by 2002 and reach certification of eradication by the end of 2005. The emphasis will be on the reservoir and conflict countries in west and central Africa, the horn of Africa, and Afghanistan-Indian subcontinent, with intensified, child-to-child supplemental immunization. Past experience and the global shortage in oral polio vaccine means that the quality of supplemental immunization is more important than the number of rounds to be conducted. Synchronization of NIDs, days of tranquility for conflict areas, and effective planning for reaching previously unimmunized children will be critical. The progress in India serves as an example of the possibilities (in Orissa state) and remaining hurdles (in the densely populated northern states with low routine immunization coverage) in polio eradication efforts. Complacency in immunization and surveillance efforts – exhibited recently in Iraq, which experienced an increase in polio cases in 1999 while the public health system experienced severe strains during the international sanctions – must be avoided as we approach the final steps towards global eradication. The particular emphasis at this meeting is how to ensure progress in the central Asian republics and Afghanistan given ongoing poliovirus circulation in Afghanistan, and Pakistan which is part of the same epidemiologic block.

European Region status

Extraordinary progress has been made in the European Region since 1989 towards polio eradication. For the first time in history no wild poliovirus circulation has been detected for over one year since the last case was reported in Turkey on 26 November 1998. Four well-known strategies have been implemented in the region to eradicate the disease: achieving and sustaining high routine immunization coverage; carrying out mass vaccination campaigns (NIDs); establishing sensitive surveillance for acute flaccid paralysis (AFP) and for polioviruses; and conducting “mopping-up” operations targeting high-risk territories. Coordinated Supplementary Immunization activities (NIDs, SNIDs or Mop-Up) were carried out in ten countries during spring 2000 (Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, Kyrgyzstan, Russian Federation, Tajikistan, Turkey, Turkmenistan, and Uzbekistan). The average immunization coverage that has been achieved in the Region is as high as 96%. This means that over 11 million children received two additional doses of Oral Polio Vaccine.

The quality of AFP/wild poliovirus surveillance has been improving, particularly in recently endemic countries. Twelve of the 17 recently endemic countries have a provisional non-polio
AFP rate of ≥ 1 per 100,000 of children under 15 years of age and 15 countries have ≥ 80% of two stools collection rate. Nevertheless, the NPAFP rate in non-endemic countries is lower. Despite the progress made, however, subnational performance indicators of AFP surveillance in some countries are still not consistently sufficient, with some areas particularly in need of further improvement. The regional polio laboratory network is thoroughly established and also demonstrated improved performance in 1999–2000. Actions to ensure the laboratory containment of wild poliovirus have been initiated in the Region.

The risk of importation of wild polioviruses remains very high, since the Region shares common borders with Afghanistan and Iraq where endemic transmission of wild poliovirus is still continuing, as well as possible distant importations from other reservoirs.

Certain challenges need to be tackled at this stage in order to achieve requirements for certification in each country, such as improving or maintaining high quality AFP surveillance, maintaining high level immunization coverage to minimize the risk from importation of wild poliovirus, and appropriate actions to ensure laboratory containment of wild poliovirus.

**Eastern Mediterranean Region status**

Regional achievements in poliomyelitis eradication have been reflected in all the critical eradication strategies and in almost all the countries of the EMR. In 1999, the regional reported coverage with at least three doses of oral polio vaccine (OPV3) by one year of age was 83% (range: 18%–100%). OPV3 coverage of ≥90% was reported from 14 countries. During 1999 full NIDs continued to be conducted in 20 of the 23 countries of the region. Iran and Tunisia conducted targeted subnational campaigns in provinces at risk of poliovirus importation and/or with sub-optimal immunization coverage, and NIDs have not been considered necessary in Cyprus. During 1999 and 2000, NIDs and other supplementary immunization activities have been intensified in countries with persistent poliovirus circulation (Afghanistan, Egypt, Iraq, Pakistan, Somalia, and Sudan). In 1999 each of these countries either conducted two pairs (4 rounds) of NIDs (Afghanistan, Egypt, Iraq) or one pair of NIDs and one pair of large-scale subnational campaigns (Pakistan, Somalia, Sudan). During 2000, each of these 6 countries will conduct 2 pairs of NIDs and additional mopping up or subnational campaigns. The quality of campaigns in remaining endemic countries has been improved substantially through using predominantly the house-to-house vaccination strategy, greater focus on high-risk areas, improved planning and supervision, allocation of additional financial resources and increased technical input by international experts.

Campaigns are coordinated among groups of contiguous countries within EMR. Successful coordination with the European Region has led to elimination of the poliovirus reservoir in the border areas of Iran, Iraq, Syria and Turkey. Cross-border coordination will continue between Afghanistan, Pakistan and Iran. Increasing attention is being focused on collaboration with the Regional Office of WHO for Africa to coordinate eradication activities among countries of the Horn of Africa (Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan and Uganda) and countries that border western and southern states of Sudan (Chad, Central African Republic and DR Congo).

All member countries have established acute flaccid paralysis (AFP) surveillance. Fifteen countries (Bahrain, Egypt, Iran, Iraq, Jordan, Lebanon, Libya, Oman, Pakistan, Palestine in Self-Rule Areas, Qatar, Saudi Arabia, Syria, Tunisia, Yemen) achieved or exceeded the WHO
established minimum AFP reporting rate indicative of a sensitive surveillance system (≥ 1 non-polio AFP case per 100,000 children aged <15 years) during 1999. Among the eight remaining countries, the annualized non-polio AFP reporting rates during 2000 have exceeded 1 in Afghanistan, Kuwait, Somalia and Sudan. The regional average reporting rates for non-polio AFP in 1999 and 2000 to date are 1.1 and 1.3, respectively. During 1999 and 2000, two adequate stool samples have been collected from 67% and 71% of the reported AFP cases in EMR, respectively. During 1999 nine countries, Bahrain, Cyprus, Iraq, Jordan, Kuwait, Oman, Palestine, Syria and Tunisia achieved the WHO recommended target of collecting two adequate stool specimens from at least 80% of AFP cases. During 2000, an additional 4 countries, Egypt, Lebanon, Libya, and Saudi Arabia collected adequate stool specimens from ≥80% of reported AFP cases. The most remarkable improvements in the sensitivity and quality of AFP surveillance have occurred during 1999–2000 in Iraq, Lebanon, Pakistan, Sudan and Yemen. The EMR laboratory network consists of 12 laboratories (eight national and four regional reference laboratories). All network laboratories have been fully or provisionally accredited by WHO.

From 1988 through to the end of 1999, the number of confirmed cases of poliomyelitis reported in the EMR countries decreased from 2342 to 915, despite substantial improvement in disease reporting. Only 246 polio cases were reported up to end June 2000. Compared with 13 EMR countries in 1999, 16 have reported zero cases during 2000. However, since 1996 only 6 countries, Afghanistan, Egypt, Iraq, Pakistan, Sudan and Somalia have reported cases with indigenous strains of wild poliovirus. In 1999, Iran and Syria reported cases associated with imported poliovirus strains. Intensive control measures comprised of multiple NID rounds and mopping up campaigns have led to cessation of the poliomyelitis outbreak in Iraq. The substantially improved AFP surveillance has confirmed the cessation of the outbreak; the last virologically-confirmed case had paralysis onset in January 2000. Wild poliovirus has not been isolated in Yemen despite improving AFP surveillance during 1999 and 2000; Wild poliovirus transmission has been localized to a few districts in four governorates of Upper Egypt. The latest virologically-confirmed case of poliomyelitis in Egypt had onset in late May 2000. Geographic expansion of surveillance to parts of south and central Somalia has led to identification of an outbreak of poliomyelitis caused by wild poliovirus types I and III in Mogadishu. Pakistan has continued to report the largest number of cases and has contributed more than 60% of the total number of virologically-confirmed cases in the region followed by Afghanistan. Wild poliovirus type 2 has not been isolated in the Region since 1997.

The Regional Commission for Certification of Poliomyelitis Eradication has reviewed reports with national documentation of polio-free status from countries with high quality AFP surveillance, which have not reported cases of poliomyelitis for several years. The commission has favourably reviewed reports from Bahrain, Iran, Jordan, Kuwait, Oman, Saudi Arabia, Syria and Tunisia.

Although the progress towards polio eradication in EMR is on track for interruption of virus transmission within the next 18 months and certification of the region as polio-free by end 2004, significant challenges remain that must be surmounted to reach the final eradication goal. Stronger high-level political commitment that translates into multisectoral involvement of the government, accountability of performance at each level and mobilization of all communities is needed in some of the remaining endemic countries. In countries affected by conflict and areas without government control and insecurity, access must be secured through a strong partnership of all UN agencies and nongovernmental organizations under the joint leadership of WHO and UNICEF. This partnership must further increase the involvement of governments and local
authorities in areas of conflict to ensure corridors of peace, access to communities and active engagement and logistic support for field operations. Finally, deployment of large numbers of personnel, logistics and accelerated program operations (particularly, multiple house-to-house NID rounds and strengthening and expansion of AFP surveillance) require continued support from national governments and substantial additional financial resources from all partner agencies. To successfully reach the goal of elimination in EMR, the global coalition of partners should ensure that the human and financial resources needed are provided on time by the concerned governments and partner agencies.

**Country presentations**

**Afghanistan**

Afghanistan is one of the polio endemic countries sharing a long border with three Member States of the WHO European region: Tajikistan, Uzbekistan and Turkmenistan. Because of difficult terrain, lack of security, insufficient communication and infrastructure the overall routine immunization for all EPI vaccines in Afghanistan is less than 40%. Supplementary immunization is the main strategy for eradication of polio in the country. Since 1995, the quality and coverage of NIDs have been improved to the extent that in the spring 2000 NIDs over 96 percent of districts were covered and the overall coverage for under 5 children exceeded 96%. Two sub NIDs in the border districts have so far been implemented in coordination with Iran and Pakistan in 1997 and 1998. In 1999 and 2000 the NIDs have been coordinated with NIDs in Pakistan and cross-border immunization with Iran. There has been less coordination with the countries sharing the border in northern Afghanistan. There is a plan to implement another 2 rounds of NIDs in autumn 2000 and 5 rounds of NIDs in 2001. It is expected that these numbers of quality NIDs and house-to-house strategy will bring the country to zero reported polio by the end of 2001. There are a number of operational problems, particularly in border areas, that can be solved and operations can be facilitated with cross-border coordination and collaboration.

AFP surveillance was established in Afghanistan in September 1997. The detection rate of non-polio AFP cases has been increased from 9% of minimum expected cases in 1997 to 80% in 1999. The AFP surveillance proved the existence of indigenous poliovirus in Afghanistan. There is a plan to expand the AFP surveillance in Afghanistan to detect all annual non-polio AFP cases (100+ expected) in 2000. The plan is aiming at establishing at least one sentinel site in 200 districts out of the total 330 districts by the end of 2000. There are already indications that the annual non-polio AFP cases rate would be >1.0 during 2000. The other indicators, for instance, the rate of adequate specimens that is presently at 46%, need to be improved. A plan is envisaged and being implemented to increase this and other indicators by the end of 2000.

**Tajikistan**

The Republic of Tajikistan has contributed to polio eradication by conducting successful national immunization days (NIDs) and other supplementary immunization activities since 1995, and by improving the quality of surveillance for acute flaccid paralysis and wild poliovirus. Annual supplementary immunization activities have reportedly reached more than 95% of all target children. Reported routine coverage with 3 doses of OPV among infants 1 year of age has been improved from 77% to 98% in most of the country over the last five years. Wild poliovirus was last isolated in 1994 and the last clinically confirmed case was reported in 1997.
The achievement and maintenance of polio-free status is particularly important for Tajikistan, because of its geographical location in direct proximity to the largest remaining global reservoirs of wild poliovirus – Afghanistan and the Indian subcontinent.

The quality of AFP surveillance has improved between 1997 and 1999 and is now achieving the level needed for certification of polio-free status. The non-polio AFP rate increased from 0.67 in 1997 to 1.55 in 1999. In 2000 the provisional AFP rate is 1.36 (28 weeks) The proportion of adequate stool specimens collected of AFP cases has increased from 63% to 74%, and 100 respectively. Mobile surveillance teams have been operating since April 2000 in several high-risk areas, using vehicles recently supplied by WHO. These teams are designated for performing supervision, sensitizing field personnel and filling personnel gaps for case finding. The initial experience with mobile teams to improve surveillance in relatively low performing areas is promising.

However, while progress in AFP surveillance is visible at all levels, reporting of AFP cases has not reached the expected performance indicators in several areas. Transport of stool specimens to the regional reference polio laboratory in Moscow is still affected by a number of logistical problems and feedback from the laboratory is not frequent enough.

**Turkmenistan**

The country had made progress in its polio eradication efforts since the last case of virologically confirmed polio was detected in 1996 by improving routine immunization coverage (over 99% since 1997), conducting national immunization days and other supplementary immunization activities with overall reported coverage > 99%. NIDs have been conducted since 1995 in the spring as a part of Operation MECACAR/MECACAR Plus, and mopping-up operations have been conducted since 1997 in the autumn.

AFP surveillance has also improved. The non-polio AFP rate is over 1/100,000 children < 15 years of age since 1998 (1.3–2.1), and 1.72 provisionally in 2000. The proportion of AFP cases from which two adequate stool specimens were obtained improved substantially from 54% in 1998 to 79% in 1999, and 100% in 2000 (28 weeks). All the stool specimens from AFP cases detected in 2000 have been sent for virological investigation to regional reference laboratory in Moscow against 78% in 1997. In January–June 2000, all the reported AFP cases were detected within 7 days after onset of the paralysis and appropriately investigated within 24 hour after notification, and 94% of the cases were followed up in 60 days after paralysis.

Because of border with existing poliovirus reservoir in Afghanistan, Turkmenistan plans to conduct two rounds of sub NIDs in border districts in the autumn 2000 and needs to continue both NIDs and mopping-up operations in 2001 and possibly 2002.

Having a target to sustain polio-free status and submit documentation for European Certification Commission in 2001, Turkmenistan plans to maintain high quality virological surveillance for AFP/polio, develop a plan for earlier warning and response to wild poliovirus importation. In the order to maintain high level of immunization coverage, there is a plan to use mobile teams of vaccinators to cover hard-to-reach and remote areas during supplementary immunization campaigns. There is also a plan to establish a center of advance training of health workers to improve their knowledge and immunization practice.
Uzbekistan

Considerable progress has been made towards polio eradication in Uzbekistan. There were no confirmed polio cases in the country since earlier 1995. Reported routine OPV3 immunization coverage is high in all country provinces, reaching over 95% nationally and in virtually all districts. NIDs were introduced in 1994. Since then, the reported levels of coverage during each round of NID have exceeded 99%. Subnational NIDs has also been conducted since 1997 every autumn.

AFP surveillance was established in September 1996. Since then the system has made impressive progress and achieved the required level of sensitivity in 1999, reporting non-polio AFP rate of 1.21 per 100,000 children under 15 years of age. There were 77% of AFP cases reported within 7 days after onset of paralysis and 96% of cases have had two adequate stool samples collected within 14 days of onset. Challenges for 2000 – 2001 include maintaining high level of AFP surveillance performance, accreditation of national virological laboratory, and preparation of documentation for certification of polio-free status in 2001. In the order to achieve targets set, the country is planning to establish mobile teams for strengthening monitoring and supervising of AFP surveillance, improving stool delivery to the National Polio laboratory, and supporting supplemental immunization activities in the areas of concern. Two rounds of mopping-up immunizations are planned for autumn 2000 and to be synchronized with those in Tajikistan, Turkmenistan, and Afghanistan. The area targeted for these mop-ups will be restricted to districts or provinces bordering with above-mentioned countries.

Conclusions

Considerable progress has been made towards polio eradication in participating countries. Uzbekistan, Tajikistan and Turkmenistan have maintained their status as free of reported cases of poliomyelitis, sustained high routine immunization coverage and continued supplementary immunization activities with high coverage. Overall improvement in the sensitivity and quality of surveillance for acute flaccid paralysis was also noted in these countries. Subnational performance indicators of AFP surveillance in all participating countries are still not consistently sufficient, with some areas particularly in need of further improvement. Afghanistan has accelerated its activities towards the target of interrupting wild virus transmission with a reduction in wild poliovirus isolation despite expansion of surveillance sentinel sites covering a higher proportion of the population over the last year. However, further intensive efforts are necessary to meet the polio eradication goal.

Despite the limited population movement across the borders of Afghanistan with the other participating countries in recent years, there remains continued risk of importation and cross-border transmission in some areas. In addition, there is the potential for the introduction of poliovirus from India, Pakistan or other endemic countries.

Synchronization of dates of supplemental immunization activities was not achieved in the past due to higher priority given to the coordination between Afghanistan and Pakistan. However, with advance planning and better communication this would be possible. There is also potential to support vaccine delivery in some hard to reach northern areas in Afghanistan through Tajikistan.

With the institution of national interagency immunization coordinating committees, there is increased potential for improved coordination of polio eradication efforts.
Recommendations

The following recommendations supplement the recommendations made during the previous Coordination meeting on prevention of cross-border transmission of wild poliovirus and malaria between selected countries of the Eastern Mediterranean and the European Regional Offices of WHO that was held in Baku, 23–25 August 1999.

**Immunization activities:**

1. Coordinated NIDs should continue each spring in Afghanistan and in the European Region countries adjoining Afghanistan (Tajikistan, Turkmenistan, and Uzbekistan) at least through 2002, and mopping-up activities each autumn in those countries should be done in coordination with immunization activities in Afghanistan.

2. Four rounds of NIDs should be conducted in Afghanistan each year until transmission becomes more focal and mopping-up activities can be applied to replace two rounds of NIDs.

3. WHO and UNICEF in Afghanistan and Tajikistan need to identify focal points in order to facilitate vaccine delivery to hard to reach areas in Northern Afghanistan through Tajikistan with the coordination of the WHO Field Office, Almaty.

4. House-to-house immunization by trained vaccination teams should be the main strategy used in intensified supplementary immunization in Afghanistan also it should be used to reach populations of the highest risk areas in the other participating countries.

5. In view of the current global OPV shortage and the need for acceleration of immunization activities, countries are requested to plan the supplementary immunization activities and forecast vaccine need in addition to their routine requirements as far in advance as possible. WHO, UNICEF and other partners should ensure timely availability of vaccine for implementation of planned activities.

6. Special attention should be given to ensure that migrants and cross-border population are immunized at both sides during the coordinated supplementary immunization activities with establishment of immunization sites at the crossing points.

7. High quality of intensive supplemental immunization activities should be ensured through advanced preparation, detailed micro-planning, addressing local challenges and extensive supervision and evaluation.

**Improving AFP surveillance:**

1. Surveillance performance should be monitored and improved at each administrative level with special attention given to border areas and areas resided by high-risk populations. Peripheral staff should be alerted to the potentially increased risk of importation of poliovirus.

2. Complete and prompt clinical and epidemiological and virological investigation of all AFP cases should be done as part of routine AFP surveillance. National programs should ensure safe specimen handling and rapid transport under appropriate reverse cold chain conditions. However, particular priority should be paid to whenever an AFP case is discovered in any child with fewer than 3 doses of OPV, with clinical signs highly suggestive of poliomyelitis (e.g., fever at onset, asymmetry, rapid progression of paralysis) or in a child who recently travelled from a polio-endemic country, or belonging to high-
risk population. When such a priority AFP case is discovered, arrangements should be made for the immediate transportation of specimens, and the laboratory alerted to test the specimens as a priority, immediately upon arrival in order to shorten the time from onset to test results.

3. WHO EURO should address and resolve the current problems in transport of specimens to the Regional Reference Laboratory (or other appropriate accredited laboratory, as designated) and to ensure the timely receipt of laboratory results by national programmes.

4. All district level epidemiological staff, particularly in border areas, should be trained in proper epidemiological investigation of AFP cases. The investigation form should contain areas for history of recent travel of the child and household contacts and on the evaluation of the area where the onset of paralysis occurred.

5. Countries should ensure prompt cross-border notification of any AFP case with exposure in the originating country and any confirmed polio cases through the most efficient and direct route. If direct communication is not possible, then it should be done through the respective WHO and UNICEF country and regional offices.

6. The reasons for the delay in detection and notification of AFP cases in Afghanistan should be thoroughly investigated particularly as it relates to delays in the collection of faecal specimens. The findings of this review should be used to develop appropriate sensitization material that would inform parents to seek health care and encourage peripheral health care providers to report AFP cases immediately. It may also be useful to revisit the selection of sentinel sites.

7. A national plan of action for preparedness to respond to any importation should be prepared and updated on regular basis in each country. The plan should address for implementation at all levels:
   - early detection of importation through high quality AFP surveillance,
   - rapid epidemiological investigation,
   - enhancement of AFP surveillance,
   - immediate and appropriate immunization response,
   - activities to document interruption of transmission.
Annex I

SCOPE AND PURPOSE

The scope and purpose of the meeting is

- To review the poliomyelitis situation in the participating countries;
- To share experiences on surveillance of AFP;
- Focusing on high-risk bordering areas, to discuss and coordinate national plans for mopping-up operations to be implemented during October and November 2000, in order to assure high quality action;
- To further enhance coordination between Afghanistan and Tajikistan, Turkmenistan, and Uzbekistan, in order to minimize the risk of cross-border transmission of wild poliovirus;

Цели совещания

- Обзор положения с полиомиелитом в странах, участвующих в совещании;
- Обмен опытом по вопросам надзора за ОВП;
- С особым упором на положении в провинциях высокого риска будут обсуждены и скоординированы национальные планы, включая «операцию подчистки», которая должна быть проведена в октябре и ноябре 2000 г., а также, как обеспечить высокое качество проведения этой акции;
- Усиление координации между Афганистаном, Таджикистаном, Туркменistanом и Узбекистаном с целью сведению к минимуму риска завоза дикого полиовируса из одной страны в другую.
Annex 2

PROGRAMME

Wednesday, 26 July 2000

08.30 – 09.00  Registration of participants
09.00 – 09.30  Opening session:
               WHO/EURO
               WHO/EMRO
               The Ministry of Health, Turkmenistan
09.30 – 10.30  Situation analysis/Progress and Acceleration:
               European Region
               Global overview
               Eastern Mediterranean Region
               Discussion
10.30 – 11.00  Coffee break
11.00 – 11.30  Vaccine supply and UNICEF initiatives in poliomyelitis eradication
               Discussion
11.30 – 12.00  Situation in the key endemic countries:
               Afghanistan
               Tajikistan
               Turkmenistan
               Uzbekistan
               Discussion
12.00 – 13.30  Lunch break
13.30 – 15.00  Situation in the key endemic countries (continued)
15.00 – 15.30  Coffee break
15.30 – 17.00 Round table discussion on coordination:
Afghanistan, Tajikistan, Turkmenistan, Uzbekistan
Timing:
Round 1 October
Round 2 November
Target age groups
Target areas
OPV needs
Social mobilization
Time for micro-planning
Mobile teams
Logistics
Supervision
Evaluation
Reporting (format to be agreed based/previous experience)
Available resources (national/international) and required resources

Thursday, 27 July 2000

08.30 – 10.00 Experience of countries in solving operational problems
Conclusions and recommendations

10.00 – 10.30 Coffee break

10.30 – 12.00 Round table discussion on improvement of the quality of surveillance for AFP in participating countries

12.00 Closure of the meeting
Annex 3

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