NATIONAL EMERGENCY ACTION PLAN

For Polio Eradication

2015–2016

The Prime Minister of Pakistan / Chairman of the National Task Force for Polio Eradication endorsed the National Emergenc Action Plan for Polio Eradication in a meeting held on 11 June 2015, Prime Minister's House, Islamabad

Mian Muhammad Nawaz Sharif
Prime Minister, Islamic Republic of Pakistan
(Chairperson, National Task Force for Polio Eradication)

NATIONAL EMERGENCY ACTION PLAN

For Polio Eradication

2015–2016

The Prime Minister of Pakistan / Chairman of the National Task Force for Polio Eradication endorsed the National Emergenc Action Plan for Polio Eradication in a meeting held on 11 June 2015, Prime Minister's House, Islamabad

Mian Muhammad Nawaz Sharif
Prime Minister, Islamic Republic of Pakistan
(Chairperson, National Task Force for Polio Eradication)

CONTENTS

FORWARD

While the year 2014 has been of trials and tribulations for Pakistan's fight against Polio, it has also been a year of opportunities and breakthroughs. The year saw enhanced ownership and political commitment at all levels of the Government. The formation of the Prime Minister's Focus Group on Polio Eradication reflects strong political commitment of the highest leadership. Based on the decision of the Prime Minister's Focus Group a cabinet committee on Immunizations was formed. The establishment of Emergency Operations Centres (EOCs) at the federal and provincial levels was a key step, which highlighted government ownership of the eradication initiative, and significantly improved planning, monitoring and coordination of the Program.

With a view to focus on resolving the security issues confronting the Program, the newly formed Cabinet committee on immunization comprising of the Ministers' for Defence, Interior and National Health Services was tasked exclusively to ensure security for Polio teams across Pakistan in support of the Provincial Governments. The Ministry of Interior, upon the request of the Program, assigned the Director General National Crisis Management Cell as the National Focal Person for Polio security. This step has had a major impact in coordinating security efforts with the Provinces and in improving the overall security planning of the Program. Access to children significantly enhanced. Following military operations in North Waziristan, the exodus of population from the area provided the Program with the opportunity to reach over 260,000 children through Permanent Transit Points established on the route of their outward journey. A robust campaign was subsequently launched in areas that hosted these Temporarily Displaced Persons. Following the recent military operations, children in previously inaccessible areas of Khyber agency are also being reached after many years. A major stride forward was the resumption of house-to-house and hujra vaccinations in both North and South Waziristan during the last quarter of 2014. Under the UAE PAP Project, with the support of the Army, immunization activity continued all over FATA and 12 districts of Khyber Pakhtunkhwa contiguous to FATA.

The year was a good one for reaching out to the communities and mobilizing them through influencers. The successful International Ulema Conference held in mid-2014 issued a consensus edict in favour of Polio vaccinations. A major effort was made in engaging Ulema, from all schools of thought, and Religious Support Persons for high risk Union Councils to engage with the communities and convert refusals. Due to a comprehensive strategy to deal with refusals, the year 2014 saw a consistent drop in refusal proportion dropping from 0.30 percent to 0.15 percent.

The Program also successfully introduced IPV in a phased manner to boost the immunity of the population against Polio in high-risk areas.

The beginning of 2015 has been a good one with high quality campaigns and a focus on missed children, as recommended during the Technical Advisory Group Meeting held on February 14 and 15, 2015. Security during the Polio campaigns has significantly improved with the cordoning off strategy, deployment of more security personnel and community-based protection for health workers. In 2015, the program will capitalize on the enhancements made in 2014, and focus on three key areas: ownership and accountability at all levels of government for high-quality campaigns; identification and systematic tracking and access of missed children; focus on the vaccinators for appropriate selection, training and supportive supervision; and new strategies to enhance community acceptance and trust.

All of these endeavours hinge on proper management and accountability at all levels, as prescribed by the National Emergency Action Plan. Let us make every effort to make it happen and stop Poliovirus transmission in Pakistan.

Ayesha Raza Farooq
Prime Minister's Focal Person for Polio Eradication

EXECUTIVE SUMMARY

Pakistan accounted for 86% of the global wild poliovirus (WPV) case count in 2014. Pakistan is the only country to have reported a dramatic increase in cases last year. In 2014, polio affected forty-four districts (23 in 2013) from three provinces/areas. There was some spill over in all provinces with no or minimal viral establishment. Environmental samples tested positive for WPV in Peshawar and DI Khan (KP), Lahore and Rawalpindi (Punjab), Quetta block (Balochistan), Sukker, Larkana, Hyderabad and Karachi (Sindh), and most recently Islamabad. To date in 2015, there are 21 confirmed WPV cases. The majority of WPV cases continue to appear in the known reservoir areas. Although reported cases have risen, access breakthroughs in North and South Waziristan give some cause for optimism. The large-scale displacement of populations afforded opportunities to vaccinate at transit points and in host communities.

Against this background, the Government of Pakistan and its partners began intense preparations for the low transmission season in September 2014, resulting in national and provincial low seasons strategic plans. In November 2014, during a three-day consultative workshop in Bhurban, details for the reservoir areas expanded upon these plans. The plans provided milestones for the low season, focusing on key issues, such as, improving the quality of vaccination campaigns, improving the performance and morale of frontline workers, increasing the security measures for protecting health workers, developing special strategies for reaching mobile populations, expanding innovations, and using inactivated polio vaccine (IPV) in areas with difficult or irregular access.

Polio eradication continues to be a national emergency with the renewed commitment of the Government at all levels. The Polio Eradication Initiative (PEI) recognizes that quality and coverage of polio campaigns are too low, with significant pockets of continuously missed children. Furthermore, the PEI recognizes inefficient selection, payment, training and supportive supervision of front line workershas negatively affectedthe quality of polio activities. In addition, the level of independent monitoring is too low to assure adequate program performance management and accountability. Finally, routine polio vaccination coverage is too low.

The goal of the NEAP 2015-16 remains to interrupt transmission of wild poliovirus in Pakistan. Key elements and strategies of the plan are in this document, in detail, which includes both refinements of existing strategies and the incorporation of innovative approaches. The underlying assumption of the 2015 Pakistan NEAP is that “all children anywhere in the country can be reached”

The strategic approach will be to stop poliovirus transmission in all reservoirs in Pakistan by the end of 2015; in addition, to detect, contain and eliminate poliovirus from newly-infected areas, as well as to maintain and increase population immunity against polio throughout Pakistan through vaccination campaigns and routine vaccinations. The NEAP details specific objectives, targets, milestones and indicators that will guide and drive the program to its goal.

The NEAP 2015-16 will have a strategic focus on:

- Increasing quality of all polio eradication activities; including campaigns, AFP Surveillance and routine immunization
- Increasing programmatic access and reach, with a focus on tracking and vaccinating continuously missed children
- Placing frontline workers at the centre of the polio eradication initiative
- Expanding continuous community-protected vaccinations
- Ensuing integration of planning and implementation of Operations, Security and Communications through Federal and Provincial ECCs and District Polio Control Rooms/Teams
- Monitoring of performance and increased accountability at all levels
- Reviewing and enhancing AFP Surveillance sensitivity and quality
- Enhancing seroconversion through targeted IPV introduction and expansion
- Implementing the outbreak response strategy

The oversight and review of program implementation, as per the emergency plan, will continue through:

the Prime Minister’s Task Force and the Prime Minister’s Focus Group for Polio Eradication, as well as the National Steering Committee headed by the Prime Minister’s Focal Person for Polio Eradication at the national level

the Provincial Task Forces headed by the Chief Secretaries and Security Coordination Committees at the provincial level

- the District Polio Eradication Committees headed by the Deputy Commissioners (Civil Military Coordination Committee headed by Political Agent in FATA).

BACKGROUND

Overall Polio Situation

Pakistan reported 306 wild poliovirus (WPV) cases in 2014 (compared to 93 in 2013), which accounts for 86% of the global case count. This is in stark contrast to the situation in the other two remaining endemic countries. In Afghanistan, the total case count for 2014 was 28, while Nigeria has not reported any cases since July 2014.

Forty-four districts in four major provinces, Khyber Pakhtunkhwa (KP), Balochistan, Punjab, Sindh and Federally Administered Tribal Areas (FATA), experienced cases in 2014. This compares to 23 affected districts in 2013 and 12 districts from the first three months of 2015. The total number of WPV cases for 2015 to 22 with the most recent case had onset of paralysis on 29 March 2015 from Peshawar (Figure 1 and 2).

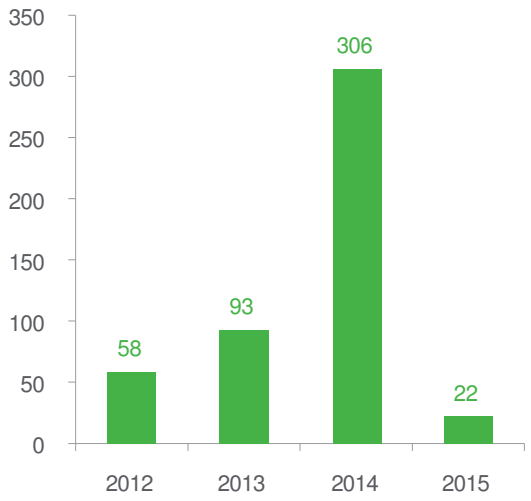


Figure 1: Epidemic curve of polio cases, 2012– 2015

Among the confirmed polio cases in 2014, more than 84% were children under 2 years of age, 62% had not received any OPV dose during their life and 22% had only received 1 to 3 doses based on parent recall. Out of the total polio affected children, 94% were from mobile Pashto-speaking families.

The majority of the 2014 WPV cases were from areas with barriers to immunization. The dominant epidemiological feature remains the ongoing transmission of WPV in FATA, particularly in the Khyber Agency. Due to both intense transmission and extensive population movements (due to conflicts), the virus spread to other areas, including the main population centres in KP, Sindh and Punjab. However, the Program was also able to take advantage of these population movements enabling the program to vaccinate large numbers of previously unreached children on the move.

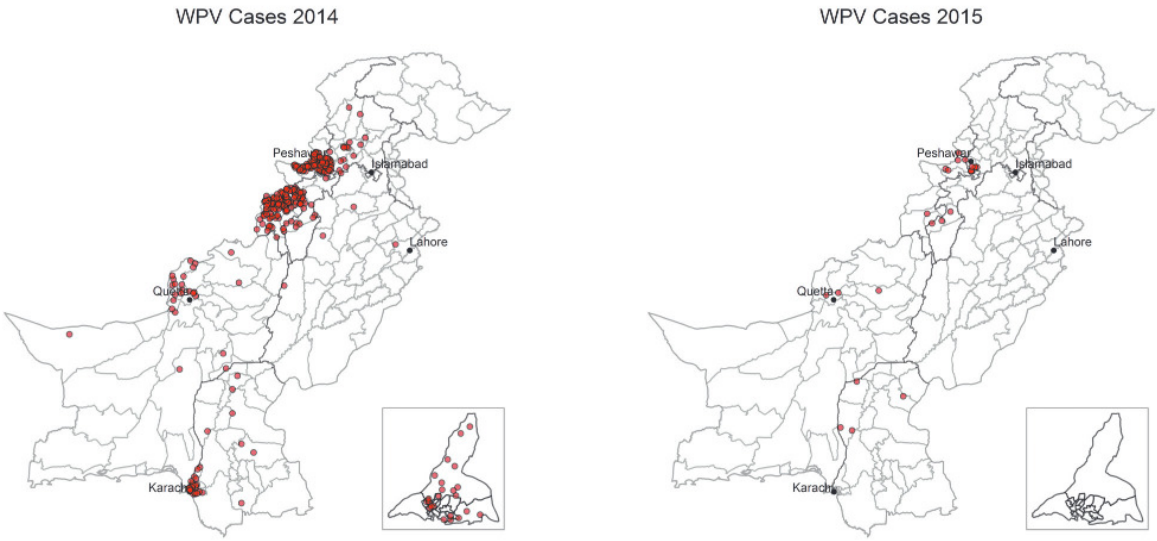


Figure 2: Distribution of WPV cases in 2014 and 2015

Other areas inaccessible for years (e.g. South Waziristan) opened up in June 2014 and became largely accessible to this day. The vast majority of children in Pakistan are now accessible to the programme. For example in the Federally Administered Tribal Areas (FATA), the number of inaccessible children has dropped from 250,000 to 48,000 primarily limited to defined pockets of Khyber and North Waziristan agencies as of 23 March 2015

Endemic/ Resevoirs

Since the majority of WPV cases continue being detected from the known reservoir areas, the success of global polio eradication depends on clearing the remaining core reservoirs by vaccinating all children with multiple and repeated doses of OPV (Table 1).

Table 1: List of Pakistan's remaining reservoir districts

No.	Province	District
1	SINDH	BALDIA
2	SINDH	GADAP
3	SINDH	IGIQBAL
4	KP	PESHAWAR
5	KP	BANNU
6	BALOCHISTAN	QUETTA
7	BALOCHISTAN	PISHIN
8	BALOCHISTAN	KABDULAH
9	FATA	KHyBER
10	FATA	WAZIR-N
11	FATA	WAZIR-S

Virus spread/ Outbreaks

Low population immunity coupled with high mobility of at-risk populations from key reservoirs, particularly FATA, is facilitating transmission of WPV in multiple districts that were not previously infected. Although there was minimal viral establishment in the majority districts infected in 2014, districts in northern Sindh continued to detect WPV cases and positive environmental samples. Transmission in low-risk districts points to a worrying population immunity gap attributed to poor campaign performance and accumulation of susceptible chronically missed children.

Environmental surveillance/ Sampling

Since its inception, environmental surveillance (ES) has increased the resolving power of AFP surveillance; reinforcing the point of sustained WPV1 circulation in the known reservoirs, especially Karachi. Environmental sampling detected WPV in Peshawar and DI Khan (KP), Lahore and Rawalpindi (Punjab), Quetta block (Balochistan), Sukkur, Larkana, Hyderabad and Karachi (Sindh), and most recently Islamabad. To date in 2015, KP (Peshawar, Lakki Marwat, Nowshera and Tank), FATA (South Waziristan and Khyber Agency) and Kambar in Sindh have reported seven WPV1 positive environmental samples. Out of 372 environmental samples tested, 131 (35%) were WPV detected from the environmental samples collected from Peshawar and DI Khan (KP 43% positive), Lahore and Rawalpindi (Punjab 23% positive), Quetta block (Balochistan 48% positive), Sukkur, Jacobabad, Hyderabad and Karachi (Sindh 47% positive), and most recently from Islamabad.

VDPV

The polio laboratory network also confirmed 26 circulating vaccine-derived poliovirus type 2 (cVDPV2) cases in 2014; 21 from FATA, three from KP and one each from Punjab and Sindh.

Progress in 2014

The Polio Programme in Pakistan carried out 5 NIDs, 4 SNIDs and 9 SIADs in 2014. In addition there were 5 case responses and 15 special weekly vaccination campaigns in Peshawar and Karachi (Table 2).

Table 2: Administrative coverage, LQAS and market survey result of the SIAs conducted in 2014, Pakistan

SIAs	Target Children below 5 years	Reported Coverage		LQAS Results			Market Survey Results (%)
				No. of Lots taken	Lots Passed		
		n	%		No.	%	
Jan, 6-8, SIADS	7,927,473	5,000,206	63%	55	39	71%	92%
Jan, 20-22, NIDs	34,175,758	32,680,069	96%	179	121	68%	95%
Feb, 10-12, SIADS	7,405,372	5,878,841	79%	126	71	56%	92%
Feb, 24-26, NIDs	33,406,370	33,457,460	100%	131	92	70%	97%
Mar, 10-12, SIADS	8,131,605	6,964,809	86%	107	64	60%	94%
Mar, 24-26, NIDs	34,160,753	32,964,577	96%	141	89	63%	96%
Apr, 14-16, SNIDs	9,687,463	8,634,405	89%	88	48	55%	94%
Apr, 28-30, SIADS	2,297,492	1,854,237	81%	30	2	7%	93%
May, 5-7, SNIDs	11,289,008	10,943,254	97%	121	72	60%	94%
May, 19-21, SIADS	2,532,440	1,883,202	74%	76	34	45%	97%
Aug, 18-20 SIADS	11,232,961	9,889,237	88%	118	48	41%	91%
Sep, 01-03 SIADS	10,388,337	9,192,513	88%	128	54	42%	92%
Sep/Oct, 29-01 NIDs	34,160,753	35,435,716	104%	186	112	60%	95%
Oct, SIADS	6,982,989	5,866,375	84%	73	54	74%	93%
Nov, 10-12 SNIDs	13,863,971	13,133,801	95%	135	79	59%	94%
Nov, 24-26 SIADS	5,622,604	4,170,897	74%	106	54	51%	94%
Dec, 08-10 NIDs	34,160,753	35,817,637	105%	208	121	58%	95%
Dec, 22-24 SNIDs	15,673,763	13,981,031	89%	141	86	61%	93%

A large number of children previously not accessible were accessed and vaccinated through protected campaigns and transit vaccination. Despite these efforts the virus continued to circulate within known endemic reservoirs and spread outside these areas resulting in cases/outbreaks.

There was significant progress in accessing previously unreached children in security-compromised areas. Improved communication and joint planning with security agencies at all levels supported this endeavour.

- Nine million children reached with OPV at Permanent Transit Point
- Resumption of house-to house vaccination in both North and South Waziristan
- Continued immunization activities in FATA and 12 districts of KP contiguous to FATA

The Government of Pakistan established the Emergency Operations Centres (EOCs) in late 2014 at national and provincial levels to provide a solid platform to strengthen the “one-team” concept at all levels towards better program oversight and

accountabilit□ Since its establishment, the ECCs pla□ed a vital role in bringing together senior government o□ cial and GPEI partners under one roof, hence enhancing timel□ joint decision making, sharing data, and regular program reviews□

The □ear 2014 marked a renewed government commitment to polio eradication and a series of innovations, including:

- Renewed government commitment and oversight
  - PM's Focus Group
  - National Task Force
  - Minister and Prime Minister's Focal Person
  - District prioritization and high-risk Union Council (HRUC) approach
- Enhanced coordination, command and control
  - National ECC and appointment of National ECC Coordinator
  - Provincial ECCs
  - Joint operational and securit□ planning (e□g□ Peshawar and Karachi)
- Improved Campaign Quality
  - Major surge of polio sta□ especiall□ at □eld level supported b□ GPEI partners□
  - Improvements to the pa□ments s□stem□
  - S□stematic review of microplans in HRUCs instituted
- Protection of Campaigns and Front Line workers (FLWs)
  - Joint planning with securit□ forces in FATA, KP and Sindh (Karachi)
  - A strateg□ to deliver "protected" campaigns put in place with increased campaign protection
  - Strateg□ for communit□-based protection using Communit□ Volunteers piloted successfull□ in Karachi and now being scaled up
- Mobile Populations
  - Enhanced transit strateg□ with more PTP teams reaching appro□imatel□ nine million child children in transit
- Communications
  - Low pro□le communication campaigns and the presentation of polio as part of a larger child health package
- Enhanced cross border cooperation
- Intense preparation and implementation of low season plan (Bhurban Plan, surge, etc□)
- Ulema Conference/ Religious SupportPersons placed at UC level

Lessons Learnt in 2014

The program has looked carefull□ at the reasons for continued polio transmission utilizing anal□ses from administrative data, tall□ sheets, campaign monitoring, LQAS, AFP surveillance and inputs from the Technical Advisor□ Group (TAG)□

The consensus that has emerged is:

- Qualit□ and coverage of polio campaigns are too low
- Routine OPV coverage remains too low
- AFP Surveillance is not optimal
- Signi□cant pockets of missed children remain
- Pa□ment mechanism are still not e□ cient
- Monitoring and supervision is weak
- Front Line Workers (FLWs) are often poorl□ selected, trained, supervised and supported

The program will proceed b□:

- Focusing on missed children
- Using protected campaigns
- Implementing an enhanced transit strateg□
- Implementing low pro□le communication campaigns and the presentation of polio as part of a larger child health package
- Combining polio vaccination with other interventions, such as measles vaccination or other routine immunizations

The more recent lessons learnt for conducting SIAs in securit□-compromised areas are the following:

- Most casualties were incurred during door-to-door campaigns
- Securit□ escorts have been speci□call□ targeted, particularl□ where the□ directl□ escorted polio workers

- Security escorts have been specifically targeted while travelling to/from polio escort duties
- Securing an area by creating cordons and/or patrols resulted in fewer security incidents
- Security arrangements are markedly improved when police and other law enforcement agencies are given sufficient time to develop their security plans in advance of campaigns
- Involvement of community influencers in the discussion of appropriate security arrangements helps with successful implementation
- All areas are potentially insecure (eg recent fatalities in a supposedly secure area of Karachi) and require a systematic and thorough security assessment before each campaign

Challenges for 2015-16 2015-16

The program initially set the target of interrupting WPV transmission by the end of 2015, however; the target was reviewed taking into consideration the epidemiology of WPV during the 2015 low season and operation and security gaps in reaching the continuously missed children.

The program must now:

- Reach continuously missed children
- Significantly improve the quality of polio campaigns
- Ensure adequate protection for all polio activities
- Increase efforts to vaccinate children in inaccessible, underserved or mobile populations
- Address community fatigue and build and sustain trust, demand and community ownership for polio vaccination
- Increase sensitivity and quality of AFP surveillance
- Strengthen routine immunization and systematically improve synergies between PEI and EPI
- Improve the Vaccine Management System
- Ensure close communication, situational awareness, coordination and integration at all levels through PCRs and Provincial and National ECCs
- Implement IPV strategy in reservoirs and plan for implementation of IPV into EPI
- Interrupt ongoing outbreak in central Pakistan and other recently re-infected districts

THE NATIONAL EMERGENCY ACTION PLAN 2015–16

Goal

The overall goal of the National Emergenc□Action Plan for Polio Eradication is to stop Wild Poliovirus (WPV) transmission and cVDPV b□Ma□2016□

Strategic Approach

The strategic approach will be to:

1) Maintain and increase population immunity against polio throughout Pakistan by implementing high quality campaigns
2) Stop poliovirus transmission in all reservoirs and prevent establishment of poliovirus circulation in the rest of the country
3) Detect, contain and eliminate poliovirus from newly-infected areas
4) Sustain polio interruption through increased routine immunization coverage

Guiding Principles

1) Increased quality of all polio eradication activities; including campaigns, AFP Surveillance and routine immunization
2) Increased programmatic access and reach with a focus on continuously missed children
3) Integration and coordinated planning and implementation of Operations, Securit□and Communications through Federal and Provincial ECCs and District Polio Control Rooms/Teams
4) Enhanced/real time monitoring of performance and increased accountability at all levels

Specific objectives and targets

Reservoirs (endemic zone): Although it is signi□cant to achieve high population immunit□throughout Pakistan, the success of global polio eradication depends on clearing the 11 remaining core reservoirs through □nding and vaccinating the chronicall□ missed subpopulations with multiple and repeated doses of OPV□

- In addition to the 5 NIDs, an e□tra 4 rounds of SNIDs will be conducted b□□ear, reaching 90% coverage validation b□third part□independent monitoring or a minimum 80% of all LQAS lots assessed accepted at greater than 90% coverage
- Monthl□communit□-based/protected continuous vaccination; LQAS pass of 95% coverage b□third part□ independent monitoring

- Annualized AFP Rate of ≥2/100,000 and ≥80% of AFP cases with adequate stool specimens across all reservoirs districts
- Reduce the number of children missed from all sources to ZERO by December 2015
- Implement IPV campaigns in all HRUCs in areas with intermittent access and in core reservoirs, reaching 90% coverage validation by third party independent monitoring
- Decrease the number of children unimmunized with DTP3 by 10% by December 2015 compared to January 2015

National (Maintenance): The failure to reach all children, especially in high-risk areas, with sufficient doses of vaccine is leading to continued transmission of poliovirus in Pakistan. To maintain and increase population immunity against polio throughout Pakistan, the program will:

- Implement at least 5 rounds of NIDs by year reaching 90% coverage, by third party post-campaign monitoring or a minimum 80% of all LQAS lots assessed nationally in every SIA accepted at greater than 90% coverage
- Achieve annualized AFP rate of ≥2/100,000 and ≥80% of AFP cases with adequate stool specimens across all districts in Pakistan
- Reduce the percentage of zero-dose NPAFP children by 75% by December 2015 compared to January 2015
  - Increase the percentage of children with more than four doses OPV by 50% by December 2015 compared to January 2015

Non-Reservoir (outbreak zone) and high risk districts: Detect, contain and eliminate poliovirus from newly infected areas

- Annualized AFP Rate of≥2/100,000 and ≥80% of AFP cases with adequate stool specimens across all non-reservoirs districts
- In any newly infected districts (WPV and/or cVDPV), conduct three large-scale case response campaigns (in conjunction with the scheduled rounds, i.e. NIDs, SNIDs). Before conducting case response, the district team should conduct thorough review of microplans and having them independently validated by third-party monitors. The target for each case response is 90% coverage validated by third party independent monitoring or a minimum 80% of all LQAS lots assessed accepted at greater than 90% coverage
- In districts with persistent transmission after 3-case case responses will be treated as "emerging reservoir" and additional 5 rounds of SNIDs will be conducted by year, reaching 90% coverage validation by third party independent monitoring or a minimum 80% of all LQAS lots assessed accepted at greater than 90% coverage
- Reduction in the percentage of zero-dose NPAFP children by 75% by December 2015, compared to January 2015
- Clear currently infected districts (WPV, cVDPV, environmental samples) by December 2015 and prevent re-infection

Milestones and Key Programmatic Activities

- By the end of Q2 2015
  - Conduct AFP surveillance review
  - Review implementation of the Low Season Plan
  - Implement independent monitoring all phases of campaign (pre-campaign, intra-campaign, and post-campaign)
- By the end of Q3 2015
  - Finalize joint operational, security and communication plan for Q4
  - All HRUCs and reservoir districts microplans are updated and validated
  - Front-line workers and Community Health Volunteers are selected and trained
  - Effective timely payment is in place
- By the end of Q4 2015
  - Report on progress against objectives and targets
  - Finalize joint operational, security and communication plan for the Jan-Mar 2016 plan

KEY STRATEGIC PRIORITIES FOR 2015–16

Reach and Vaccinate Continuously Missed Children

The SIAs data analysis indicates that a substantial number of children remain unvaccinated at the end of SIAs and even after the 4th day of catch-up. The proportion of these children among the total target children for SIAs may be small but the numbers are high enough to sustain virus circulation. It is important to make sure that all of the children missed during the SIAs are effectively tracked and vaccinated. In practice, this translates to reaching all of the estimated 35.3 million children living in Pakistan, in particular the children living in HRUCs.

The implementation of a paradigm shift away from 'covered children' towards 'continuously missed children' is now required for reaching 100% of an estimated number of children. The current proportion of the covered children among targeted is not delivering the expected results as the number of still missed children is enough to sustain viral transmission. This shift will occur by implementing the following:

- Updating UC level mircoplans with a view to cover each dwelling and the household
- Consolidating a list of missed children based on child / household locations across Pakistan with particular focus on HRUCs and reservoir districts
- Accurate completion of tally sheets compiled by the vaccinator; a critical starting point for the tracking of missed children
- Supportive supervision starting with Areas in Charge and intra- and post-campaign monitoring with a focus on verifying who is missed and where
- At the end of each campaign, a consolidated list of missed children is prepared which becomes the focus of priority follow-up in mop-up activities and subsequent campaigns.
- The mop activities of missed children will be carried out by UC-level staff (UCMO, UCPW, AIC, UCCO), where applicable "team B" will be used to track and vaccinate missed children
- Data on children through AFP and WPV case investigations and participation at health camps will further supplement the missed children list on an ongoing basis
- The patterns and trends across campaigns will be tracked over time with the view to reduce the list to zero

Enhance campaign quality

To ensure that high quality polio campaigns reach all missed children, the program will implement:

- Developing integrated UC microplans
- Intensifying intra-campaign supportive supervision
- Enforcing accountability at all levels
- Systematically monitoring all phases of the polio campaign

Integrated micro-planning at Union Council Level

Integrated micro-planning at the UC level is the cornerstone of a successful SIA implementation. The micro-plans ensure all components of activities are covered, including mapping of the areas of high-risk and with migrant populations, starting and ending points of each team's daily activity, and key landmarks, such as schools, mosques, churches, transit points and any other important sites.

The micro-plan must include the details of each polio team member and their assigned supervisor, plus the necessary logistics. Micro-plans need to be regularly reviewed, field validated, and then altered based on past campaign monitoring and field validation. All identified missed areas from past rounds must be included in the following micro-plans.

Micro-planning must be a collaborative e□ort between all departments in the UC, calling on the revenue department, education, local law enforcement, religious leaders, civil societ□organizations, the health department and others□ With justi□cation and inclusion in the micro-plans, the program can consider requests for additional polio teams, for either house-to-house, street vaccination or transit team activit□□ If additional resources are needed to reach ever□child ever□ time, then the program will most likel□provide it if the revised plan submitted b□the district and province dul□justi□es the requirement□An acceptable micro-plan must have the following:

a) Human Resources
b) Vaccine and Logistics Map of refusal clusters and high risk and migrant populations
c) Securit□Plan
d) Supervision Plan
e) Social Pro□le of the area
f) Social mobilization plan
g) List of religious leaders and ke□communit□in□uencers in the area
h) Identi□cation of all nurser□schools and madrassas in the area (This also means contacting and informing these institutions before the campaign)
i) Mapping of Transit Points and Transit Team deplo□ment and supervision plans
j) Mapping of □□ed vaccination and team vaccine collection points; these must include routine immunization □□ed and outreach sites in the area of the Polio team members' training plan

There should be joint veri□cation of inclusion of an□high-risk groups into micro plans prior to each campaign□Integration of operational, communication, training and securit□components into micro-plans for all high risk and securit□compromised UCs shall be a joint responsibilit□of the UC team (Polio Eradication O□cer, WHO district level sta□and the DHCSOs, under the guidance of the UCMO)□

Intensified Supportive Supervision

The DCO/DC/PA/TMO and EDOH will ensure the qualit□of campaign implementation□In addition to Department of Health, ke□line departments, particularl□Education and Revenue, must be engaged to support and supervise implementation□ High qualit□supervision during polio campaigns is vital to the success of the Pakistan polio eradication program□ The program will strengthen and e□pand the e□isting supportive supervision s□stem to promote continuous improvements of campaign qualit□, b□providing the necessar□leadership and b□ emphasizing mentorship, joint problem solving and two-wa□ communication between supervisors and vaccination teams□ To meet these e□pectations, the following must be adhered:

- A su□cient number of supervisors, correct and adequate training, appropriate tools and means of transport
- Supervisors help to plan and oversee the deliver□of OPV, review dail□plans with the teams, ensure plans are implemented, take corrective action when necessar□, and solve problems for teams
- Conduct the evening meeting with the team leaders as a group at the end of the da□to review the work completed, solve problems that arose and compile lists of missed children
- Take actions based on □ndings discussed during the evening meeting
- Ensure the catch-up plans have been prepared and implemented properl□
- Ensure the presence and qualit□of supervision b□the AICs in the □eld through screening their check lists and supervisor□plans

Enhanced Monitoring

It is important to s□stematicall□monitor essential campaign elements at all levels and improve monitoring mechanisms pre-, intra- and post- campaign□The following actions are required as per the NEAP:

- Strengthening and streamlining reporting of pre-campaign preparedness indicators and process through reporting from multiple sources directl□to provincial ECCs
- Enhancing supportive supervision b□all tiers (Commissioner, DC, EDO-Health, UCMO, AIC)
- Introducing s□stematic intra-campaign monitoring through independent monitors from partner agencies and third part□institutions
- E□panding standard LQAS to cover all HRUCs
- Strengthening third-part□post-campaign monitoring

Enforced Accountability at all levels

To ensure high-qualit□performance, the provincial and national ECCs will start implementing rewards based on the accomplishments of revised and updated microplans, tracking and vaccinating missed children□Based on independent investigations of poor performing governments and partners' sta□, necessar□action will be undertaken within two weeks of the investigation□

Place Frontline workers at the centre of the eradication initiative

Regardless of which scenario – polio reservoir, case outbreak or maintenance, every vaccination campaign comes down to a single, critical touch-point, which is a short, personal interaction with a front-line worker. When the front-line workers succeed, the overall eradication campaign succeeds. When it comes to their success, the truth is simple: community acceptance and trust is everything.

Up to 200,000 front-line workers are involved in national vaccination campaigns across Pakistan with high team turnover, a notable feature of the current intensive campaign schedule. To achieve the success collectively desired, frontline workers must be empowered and motivated at the centre of the polio eradication effort through the creation of a more enabling and supportive environment, in high-risk areas in particular. Major actions towards this end will include:

- Prioritise the employment of more fixed term community front line workers in the very HRUCs and reservoir districts
- Each frontline worker is recruited at community level with a profile appropriate to the social norms and standards acceptable to the community in which he or she will serve
- Enhance the quality and duration of training provided to frontline supervisors, Areas in Charge, and their staff in very HRUCs and priority one districts which develops motivation and supportive supervision techniques, increases knowledge about the essentials of good campaign performance and fosters more effective interpersonal communication at the door step
- Enhance operational communications with frontline workers to provide more guidance and support before each vaccination campaign and more detailed feedback on operational performance and related monitoring feedback to focus area team evaluation and inform future planning and preparations
- Ensure that frontline workers are paid within a week of campaign completion through the effective and efficient payment mechanism with independent monitoring to identify where problems exist so that problems may be effectively and swiftly dealt with
- Recognise and incentivise outstanding team performance at the union council level and provide additional guidance and support to those union councils that struggle to achieve the minimum performance benchmarks

CONTINUOUS COMMUNITY PROTECTED VACCINATION (CCPV)

Building on the success achieved in Karachi, northern Nigeria, and Afghanistan, the program will implement Continuous Communit□Protected Vaccination (CCPV) to the rest of core reservoir districts in areas with securit□challenges□Sindh successfull□implemented communit□protected vaccination in parts of eight super-high risk UC in Karachi□

The c□cle of CCPV is as follow:

- First week of the month: Training, micro-planning and logistics distribution
- Second week: Administer OPV house to House –HH (1st SIAD passage) and polio plus kits
- Third week: Cover missed children [open refusal, silent refusal (ever□0/0 house to be considered as silent refusal until proven otherwise), NR, NT, NA], new-borns, newcomers and create demands on OPV and RI□
- Fourth week: Orientation, update on micro-planning based on gaps in previous passes, logistics distribution and implementation of Passage and HH polio plus (CCVs kits)□

Communit□Support Teams (CST) will provide securit□for CCVs under supervision of the respective DC in coordination with LEAs□

Surveillance

A sensitive AFP surveillance s□stem aims at □nding all of the cases of acute □accid paral□sis (AFP), investigate them and collect stool specimens for testing in a WHO-accredited laborator□to con□rm the presence or absence of polioviruses□ There are si□main strategies to improve the e□ectiveness of current AFP surveillance:

a) Enhanced supervision and monitoring of the e□isting reporting sites with supervision visits that include active case reviews

b) E□pand the e□isting AFP surveillance network b□better identi□cation of new private health facilities and ke□ informal sites such as traditional healers or other non-certi□ed practitioners

c) E□pand the number of environmental sampling sites to better verif□the e□isting circulation of polioviruses and eventuall□ to document the absence of poliovirus circulation

d) Conduct active surveillance during polio campaigns and other SIAs□This means polio workers will ask the communit□ about suspected AFP cases, while working in SIAs, then report these suspected cases to appropriate district surveillance team

e) Ensure that the designated District Surveillance Coordinators make all e□orts to achieve the highest level of AFP surveillance and are made responsible for ensuring that all tehsils and districts have surveillance indicators meeting the Certi□cation Standards

f) Ensure adequate focus is given to improving AFP surveillance b□conducting detailed and speci□c anal□sis of AFP data for the 11 known reservoirs; strengthening active surveillance and zero-reporting in priorit□one districts and including high risk areas, like Town 4 which contributed to most of the polio cases in Peshawar, in the environmental surveillance sites

IPV

Despite repeated oral polio vaccine SIAs, wild poliovirus transmission remains persistent in the polio reservoir areas of FATA, KPK, Balochistan and Sindh. In some of these areas, children have developed polio after 7+ doses of OPV. This suggests a need to enhance sero-conversion in these areas. Evidence from scientific studies (India 2012, Ivory Coast 1993, etc.) shows that IPV administered to persons who have previously received OPV significantly boosts gut immunity to polioviruses and consequently can lead to faster interruption of community transmission. IPV given to OPV vaccinated persons also helps close gaps in serological immunity faster and more effectively than another dose of OPV and/or attempts to improve vaccination coverage. In addition, recent studies have proven that, especially in settings where OPV is less immunogenic, a supplemental dose of IPV provided to children who have been previously exposed to some OPV, closes remaining immunity gaps in blood and gut immunity more effectively than a supplemental dose of OPV. According to WHO's Strategic Advisory Group of Experts on immunization (SAGE), IPV as an additional dose for optimizing seroconversion should be administered after 4 months of age.

The provision of IPV in selected polio reservoirs in 2015 is an immediate supplementary activity to the longer-term introduction of IPV into the routine immunization program through GAVI support; expected in Pakistan in 2015.

The objective of the IPV-SIA campaigns is to provide one dose of IPV (concurrently with one dose of mOPV/bOPV to accelerate interruption of community transmission of WPV1 & cVDPV2 in selected polio reservoir areas.

The areas selected for the initial campaigns are Quetta block, Peshawar, plus southern districts of Khyber Pakhtunkhwa, FATA and high-risk areas of Karachi. Additionally, temporarily displaced persons from FATA and health camps in high-risk areas of Karachi and Khyber Pakhtunkhwa are targets. The program decided, due to the emerging outbreak in central Pakistan, especially in the riverine areas, to target areas that may have inaccessible children due to operational failures.

While the situation is very concerning in the reservoir regions of FATA, central Khyber Pakhtunkhwa and Karachi, the risk of polio cases and outbreaks outside these reservoirs remains high due to ongoing population movement. The program needs to ensure high immunity levels in areas outside reservoirs while at the same time be able to respond aggressively to any wild poliovirus isolates, when detected.

Emergency Response Team

The National Emergency Operations Centre will continue to spearhead an Emergency Response Team (ERT), to expedite the processes of responding to the polio cases/outbreaks and environmental wild poliovirus isolates in a timely manner and with the highest possible efficiency.

1) This team will be on call seven days a week and will serve in coordination with the provincial teams as the polio eradication program's central point for responding to polio outbreaks/ environmental wild poliovirus isolates.
2) The core team will comprise- of professionals with expertise on managing outbreak/ importation with associated case response activity targeting multiple districts in a limited time.
3) The composition of the ERT may be modified according to the area(s) to be targeted with a backup pool of experts, which can be mobilized, when required.
4) The core team should move as soon as possible to the targeted areas (outbreak areas and areas at risk), provide situational analysis and an appropriate response plan in coordination with the concerned provincial, divisional and district level teams.
5) The program will pre-position vaccines and operational funds at the provincial level to ensure timely implementation within ten days.
6) Before the start of the case response program the ERT, in coordination with DHO, will ensure:
   a) Reviewing, updating and field validation of all micro plans with a view to cover the entire population is completed and where feasible, enumeration with workload is rationalized.
   b) A third party independently validates micro-plans.
   c) Synchronization of the security and operational plans through joint work of health and security teams
   d) Duly monitored high quality training of teams and specifically all Area In-Charges
   e) Appropriate and focused communication and social mobilization interventions, including use of RSPs, are utilized
   f) Strict supervision and monitoring by relevant staff during all phases of the campaign

CROSS CUTTING STRATEGIES

Communications

The communications approach has not changed to match the difficult and complex nature of the circumstances we now face. Traditionally, polio campaigns rely on two primary sets of analyses to create awareness and demand for OPV. The current mass media communications address parents with information about polio and OPV, instead of communities and cultures with attitudes, norms and perceptions about access and acceptance of vaccinations. The static communications strategy focused on awareness of polio must become more adaptive and responsive to the changing dynamics and scenarios. To address questions coming in minds, the benefits of the vaccine and the dangers of the disease must be illustrated.

Based on experience and current analysis, those who accept a vaccination represent the vast majority of the Pakistan population. They are typically motivated to either vaccinate by fear of polio or trust in those delivering the vaccines. Those who reject the vaccine may exist anywhere. Although a minority, a reluctance to vaccinate their children based on complex and intermingled root causes defines them. Communication strategies that work well with those who accept a vaccination may not work at all with the non-vaccinating group. Rejecters may not always be parents; they may be influential community leaders or members, or even vaccinators who are not fully convinced that what they are promoting is right.

Across each step towards a successful vaccination, the moment a vaccinator has contact with a parent is the most critical to success. The over-arching communication goal is to create and shape norms, perceptions, and expectations that support vaccinators at this critical moment of contact. Key factors, which contribute towards achieving this goal, include awareness of polio, awareness of the impending campaign, fear of polio the disease, supportive social and cultural norms of routine immunization and vaccine acceptance, prior contact with a social mobiliser, positive expectations of vaccinator performance and vaccine efficacy, and a vaccinator profile acceptable to the community served. The success indicators will include vaccination coverage of continuously missed children, vaccinator contact efficiency and repeat vaccination success. Ultimately, it is imperative to support the development of a norm whereby talking with neighbours, relatives, and community members about the dangers of polio and the importance of vaccination is considered the right thing to do.

The specific communications goal is to maximize vaccinator success. Every vaccination campaign comes down to a single, critical touch-point: a short, personal interaction with a vaccinator. When it comes to their success, the truth is simple: trust is everything. At the centre of the overall polio eradication efforts is a vaccinator's performance. An enabling and supportive environment, effective training, innovation, tailored data and appropriate tools, each contribute to the overall motivation and performance of vaccinators at the frontline of each campaign. The following principles guide these strategies:

Guiding principle 1: Humanise vaccinators

Guiding principle 2: Engage social perceptions, norms and beliefs related to vaccinator access and acceptance

Guiding principle 3: Continuously refine communications to maintain authenticity.

This means communication must accurately and authentically portray the vaccinators and the work must not set false expectations that materially diverge from operational realities. Communications must reinforce operations to reinforce communications.

Strengthening external Communications

The government will strengthen communication and media interaction and response to emergencies under its leadership. To promote a better understanding of the polio eradication goals, there are plans in place to enhance engagement with the local and international media. Activities include, quarterly media briefings, engaging with elite media, pitching stories to key media personalities, engaging editors of religious publications in social mobilization and advocacy for polio vaccination in high-risk areas. The external communication activities will work in close coordination with all of the polio partners and GCP to plan, develop and disseminate awareness rising and campaign materials for print and electronic media.

Community Ownership and engaging Civil Society

Putting polio eradication in the hands of the communit□and placing prominent civil societ□actors in the driver's seat of polio eradication will address various misconceptions about the program and help build a protective and conducive environment for frontline workers□The attacks and securit□incidents of the recent past have severel□undermined their morale□Strong public support requires active communit□engagement and dialogue with ke□stakeholders at district and grassroots level□ Reaching out to caregivers in hard to reach areas and those illiterate will be undertaken through communit□meetings, radio, interactive theatre, religious gatherings, such as Jirgas and Hujras, and communit□child health support groups in high risk districts□

Expanding Network of Religious Influencers

The program is e□panding the network of religious in□uencers with outreach in all provinces to address religious misreporting through publications to increase awareness on polio and child health issues and promote the importance of polio and routine immunization□Within the light of Islamic teachings, religious in□uencers are able to ensure a broader support for polio and RI among the religious organizations all over the countr□□

Emergency communication infrastructure

The following emergenc□communications infrastructure is in place, e□ective since 15th December 2014

1) Communication Unit in the National EOC
2) Communication Units in the Provincial EOCs

Convergence of PEI/EPI professionals from Government and partner agencies sta□s the units□The Communication Unit at the federal level is responsible for providing overarching polic□ guidance, coordinating with provinces, developing guidelines and SoPs, internal and e□ternal communication through a national identit□whereas the Communication Units are responsible for taking locall□appropriate strategic decisions□ The Communication Unit at the Federal level has the following components; and Communication Units in the Provincial EOCs shall have the same components□

- Program communication
- Advocac□with Parliamentarians & Civil societ□, etc□
- Media Advocac□
- EPI/PEI convergence
- Social Media

Strategic shift

Polio Eradication (PE) Communications are introducing the following Strategic Shifts:

Primary shifts

- Shift from individual awareness and acceptance to promotion of access and acceptance as a communit□norm, the shift from mother to father as the primar□target audience re□ects the fact that fathers are the primar□decision makers in high-risk mobile population, in particular
- From the 95% covered to the 5% that are not

Message

- Convergence stor□in mass media
- Celebrate frontline workers – be□ond polio
- Communit□responsibilit□
- Use of celebrities to show true involvement/commitment

Channels

- Target radio as lead channel
- Travel and transient population media opportunities
- 2 wa□communications (IPC)
- 360/holistic engagement approach
- Proliferation through Civil Societ□

Convergence

- Integrated messages on highlighting Polio as a part of EPI program;
- Advocac□with Public Representatives to support PEI as an integrated EPI program;
- Civil Societ□Forum launched under EPI section to win support for PEI;
- Utilization of Polio infra-structure in Measles SIAs; as well as in other activities aimed at strengthening routine immunization

Functioning Security System

The Prime Minister of Pakistan has nominated a cabinet committee comprising of three Federal Ministers (Defence, Interior and National Health Services) to assist the provinces withthe unfilled security gaps whereby providing workable environments to polio workers especially in security compromised areas. Subsequently, the Ministry of Interior has nominated the Director General, National Crises Management and GHQ an officer of the Brigadier rank to be part ofthe steering committee meetings as well as part of the implementation process during polio campaign activities.

The Federal Security Advisor, based at the National EOC, is responsible to coordinate with all stakeholders and assist the provinces in security arrangements. A more robust structure is assigned the task to see the overall security situation pertaining to Pakistan's polio eradication program and to identify areas of inaccessibility due to real or perceived security issues. This developed capacity throughout 2014 includes provincial access specialists located within the provincial EOCs in Balochistan, KP, FATA and Sindh. This structure will work and perform their responsibilities during 2015-16 as given below:

- To investigate the geographical scope and scale of the restrictions on reaching missed children where it is due to security issues;
- Evaluating the alignment of operational plans with security plans, where security is required, noting that security will be appropriate in some Polio High Risk areas and not in others;
- Developing EOC structures, systems, procedures and reporting at Federal and Provincial levels to inform decision making by EOC Coordinators to achieve improved direction, oversight and support of ongoing vaccination operations; including post incident management and response

In the provinces, there are Provincial Security Coordination Committees headed by the Home Secretary/ Inspector General (IG) of Police to oversee the security situation of the province and issue instructions to the districts to provide protection to polio workers. The provincial access specialists will assist the EOCs and the provincial security committees to coordinate security issues at the Provincial, District, Tehsil and Union Council level where they relate to the polio program, including identification of reported areas of unreached children due to security concerns. At the Union Council level, the person incharge of the police station will full support polio teams during their work, where needed for protecting campaigns.

The key element of the security system for the polio campaigns is an incorporated security plan into the micro-plans at every level. The security plan is an essential planning tool, which if completed correctly as part of the micro planning, enables appropriate deployment of security forces personnel to the areas of most need, with the numbers required to provide reassurance to polio teams and to act as a deterrent. Security might not be required in all areas. The DPEC will determine the security planning with support by the district police officers.

It means involving local law enforcement in the micro-planning process so that if security personnel are required, they are fully integrated with the polio front line workers movements from the onset. Polio workers should not start a campaign activity if the prescribed security arrangements are not in place when they are to begin work. It is the decision of the DC/ DCO/ PA if a polio or other immunization campaign should go ahead or not, due to the security situation. A workup of a polio security analysis proves to be beneficial in determining more accurate figures and categories of security incidents as well as identification of the security compromised areas and security trends. In 2015-16, this work will develop in line with the aforementioned tasks required.

Security arrangements:

- All parties must continue to work together to identify areas of security concern to enable vaccination teams to work in the safest possible environment
- The Federal Security Advisor, based at the National EOC, is to ensure the strengthening of the provision of security and the preparation of security plans at the Federal and Provincial levels. The Federal Access Advisor, and at the Provincial level, the Provincial Access Specialists will support this individual with this task, by providing the necessary information products, metrics and analysis to ensure effective coordination between the Federal and Provincial EOCs, regarding access and security as well as maintaining an oversight and ownership of the provision of security to polio teams.
- Stronger links must develop between the EOC structures and a number of Law Enforcement Agencies to ensure timely coordination, especially during post incident management and detailed investigation and accountability for any lapse must be integral component.
- Analyse data on reasons for missed children due to insecurity, as per an agreed table of categories; data on the number of security forces requested (as per the micro plan) and data on the number of security forces actually deployed on a given day and the hours that they are available.

Vaccine management system

Vaccine Management's aim is to help safeguard the quality of the vaccine and ensure the cold chain remains intact from the time the vaccine arrives in the country down to the service delivery point.

Since December 2012, the Government established Standard Operating Procedures to manage and oversee stocking, utilization and wastage of vaccines and related cold chain systems from point of entry to the point of delivery. They also established vaccine management committees from National to District levels to implement these procedures and to inform decision making on all aspects of vaccine management. Improving SOP compliance and the quality of reporting will be the key priority in 2015.

For effective vaccine management and estimation of target populations, the following national and provincial indicators are used:

a) National Vaccine Management Committee meeting regularly as per TORs to oversee all the pertinent vaccine management issues in the country, including implementation of vLMIS in the country;

b) Provincial Vaccine Management Committees (PVMCs) constituted and reporting regularly to the National Vaccine Management Committee (NVMC), on Provincial and District Stores' OPV stock balance (segregated by type of OPV) on prescribed format within one week after each SIA for polio (including SIADs, Mop Ups and case responses) from January 2014, until vLMIS is up and running nationwide, which will provide this information online;

c) Vaccine management SOPs are fully implemented at all levels in the country;

d) Vaccine management data continued to be reported/included in SDMS/vLMIS;

e) Vaccine management module included in training curriculum of polio workers

Targeting High risk and underserved populations

The majority of polio cases reported in 2014 occurred within specific underserved communities residing in inaccessible or security-compromised areas. Polio plus is one of the key strategic priorities to reach these populations. Within polio plus, health camps are one of the approaches for building credibility and trust, by addressing other basic needs besides providing the polio vaccine. Currently, UNICEF and the Bill and Melinda Gates Foundation (BMGF), through the Aga Khan University (AKU), are supporting operational implementation of health camps and Rotary International is supporting the office through funding.

The Basic Health Camps, led by UNICEF, is a one-day health camp that provides basic primary health care services and polio vaccines to adults and children in the highest risk communities living within the very HRUCs. This approach will prioritize health services and polio vaccination for children under two years of age based on local poliovirus epidemiology. The scope of services provided in these health camps will include:

- Treatment of the most common ailments, including diarrhoea, ORS, respiratory tract infections, eye infections and minor injuries
- Preventive health care, including deworming and polio immunization
- Prenatal care through the provision of safe delivery kits to pregnant women
- Hygiene family kits containing such items as detergent, soap, towels, and toothpaste.

Supplementing the health camps with routine immunization will be at the discretion of each Provincial EOC based on their own priorities and capacities. Each health team will have a recorder to record attending children and their immunization history, including OPV. The primary performance indicator will be the number of children with zero OPV doses immunized with polio vaccines at the health camps.

Partnership coordination and alignment on the approach, objectives and timeline of implementation of the health camps strategy is critical to ensure synergy, avoid duplication and achieve the highest impact. This coordination is taking place within the Emergency Operations Centres (EOCs) at Federal and Provincial levels. The timing of the health camps before, during or after the various types of polio campaigns will be at the discretion of the provincial EOCs based on local considerations and constraints. The Federal EOC will focus on norms, resource allocation and oversight. Upon completion of each health camp cycle, the EOC will conduct an evaluation to inform decision making on the relative merits and utility of continuing this program to reach continuously missed children.

Transit and mobile populations

Implementing special strategies for high-riskmobile populations such as IDP, nomads, brick kiln worker families, migrant and transit populations is vital. There is a focus on implementing high-risk population strategies through:

- Map, track and reach these populations consistentl.
- Rationalize and strengthen the transit strateg. to ensure all of the children on the move and those that reside in inaccessible areas are identi.ed and vaccinated against polio
  - Development of a well-planned and anal.sed transit strateg. to reach children on the move based on thorough assessments of Permanent Transit Points and their e. cienc.
  - Deplo.ment of social mobilizers at strategicall. important PTPs based on a clear criteria
  - Rapid qualitative assessments of high-risk communities as a basis for development of a tailored communication strateg.
  - Firewall FATA –KP bordering districts through strengthening vaccination at Permanent Transit Points
  - Development of an adequate supervision and monitoring plan for each Permanent Transit Point

Optimizing the Polio Eradication Initiative for strengthening Routine Immunization

Routine immunization is one of the cornerstone strategies for polio eradication. It is ver. important to have good qualit. routine immunizations to sustain the achievements ofpolio eradication. In view of the Polio Endgame Strateg. and taking into consideration the polio eradication priorities and the availabilit. of polio assets, the countr. initiated the implementation of the Polio Eradication Initiative (PEI)-E.panded Program on Immunization (EPI). In which EPI started in 16 districts, selected b. provincial governments in coordination with WHO and UNICEF, based on the availabilit. of the polio assets.

In ke. reservoir districts the program plans to decrease the number of children unimmunized with DTP3 b. 10% b. December 2015 compared to Januar. 2015 through enhanced communit. engagement, e.panded outreach/ mobile sessions, boosted health camps, and child-health da.s.

With reduced frequenc. SIAs, the program will e.pand the PEI-EPI s.nerg.. Since the time of the project's initiation of the implementation of Federal, Provincial and District trainings, subsequent micro-planning and monitoring activities have commenced. The program proposes to e.pand this project to 30 more districts from the four major Provinces and Federall. Administered Tribal Areas (FATA) using the same selection criteria. UNICEF and WHO will work together in a complementar. fashion , using their PEI assets to support the government in strengthening routine immunization in the selected districts.

In light of the recent serious problems with vaccine management and storage at the Federal level and known problems at provincial and district levels, identi.ed through the EVM assessment, it is necessar. to re-orient all .eld sta. to do the following:

- Make weekl. checks on cold chain equipment functioning at provincial, district and UC levels
- Check VVM status and e.pir. of all vaccines at each level on a weekl. basis
- Check for stock-outs and over stocking of an. EPI vaccine and ancillar. equipment (A-D s.ringes, safet. bo.es, etc.)
- Insist that ever. UC has >1 .. ed site providing routine immunization during polio or other SIAs
- Adjust activit. schedule in order to monitor routine immunization session while going to the same area for another purpose
- WHO and UNICEF sta., while assisting with SIA micro-plans, should take time to assist the UC with routine immunization micro-plans
- WHO and UNICEF sta. should monitor at least four outreach RI sessions in his / her area of jurisdiction on a standard check list and report its .ndings to the DPEC through respective UPEC
- WHO and UNICEF sta. should assist with the planning, training and monitoring of other SIAs, including measles, IPV or TT; sta. can also assist with the planning of inclusion of routine immunization in selected places during these SIA and with health camps
- Whenever a PEO conducts a record review or active search at a facilit., in addition, check for:
  - Acute fever and rash or o. cial reported of measles in the registrar
  - Neonatal deaths > 3 da.s and < 28 da.s
  - Other vaccine preventable diseases such as diphtheria and pertussis when the. appear in registrars
- UCPWs should report the following to the PEO or DSV when during the course of their duties the. hear about suspect AFP, acute fever and rash, neonatal deaths > 3 da.s and < 28 da.s and an. other VPD cases such as diphtheria or pertussis

OVERSIGHT AND MANAGEMENT OF THE PROGRAM

To achieve the goal of interrupting polio transmission by December 2015, strong program management and a decisive oversight mechanism, governance framework, and responsive organizational structures are required to full coordinate and drive forward program implementation. The Polio Eradication Program in Pakistan is a national program and the responsibility for implementation rests with the Federal and Provincial Governments. For the detailed Terms of Reference and function of each Polio Eradication Committee see annex 1.

National management and oversight of the NEAP

a) The Prime Minister's Focus Group for Polio Eradication headed by the Prime Minister meets on a monthly basis and reviews the progress and takes remedial measures

b) The Prime Minister's National Task Force is responsible for fast-tracking implementation of the National Emergency Action Plan and meets on a quarterly basis

c) The three members' Cabinet Committee (Ministers of Defence, Interior and National Health Services) on immunization started assisting the provinces in provision of security cover to the field teams in security-compromised areas.

d) Prime Minister's Focal Person for polio eradication provides oversight and oversees implementation of the NEAP, and liaises with the Prime Minister's Office, the office of the President, the Ministry of National Health Services, Regulations and Coordination and other relevant Ministries at the federal level as well as provincial authorities. The Prime Minister's Focal Person will be a member of the National Task Force and the PM Focus Group and will report progress accordingly.

e) The newly established National Emergency Operations Centre (N-EOC) is a central point for all activities of polio eradication led by the government and assisted by the partner agencies: WHO, UNICEF, Bill and Melinda Gates Foundation, etc. The National EOC will continue its assistance to the Prime Minister's Focal Person and will be responsible for monitoring the NEAP indicators and tracking effective implementation of the strategic decisions and guidance provided by the National Task Force and the National Technical Advisory Group.

f) The National Steering Committee (NSC) for PEI/ EPI will meet fortnightly (chaired by Prime Minister's Focal Person for Polio Eradication) to review the Program performance and implementation of the NEAP 2015. There are several sub-committees to report to the National Steering Committee including the following:

   i. Weekly Surveillance Committee (reviews current polio updates and lab results)

   ii. National Communications Technical Committee (leads all kinds of matters related to communication and social mobilization)

   iii. Technical Supervisory Group for vaccine management (to periodically review status of polio vaccine for SIAs and present the status to the National Steering Committee for action as well as advise to the Federal EPI to release of vaccine to provinces as per SIAs schedule).

g) The Central Polio Control Room functions at the National EOC to receive reported (administrative) data during pre-campaign preparation and the campaign implementation phases and provide timely feedback to the provinces. Polio Control Room functioning will be optimized at the provincial level in the offices of the Chief Ministers/ Secretaries and at the district level in the Deputy Commissioners office (Political Agent office in FATA).

h) The Ministry of National Health Services, Regulations and Coordination is an executing agency of the PC-1 for the Emergency Action Plan of Polio Eradication and routine immunization program at the federal level and will ensure resources for these programs. The Ministry also coordinates

with provincial health departments to manage the SIAs' vaccine suppl□□

i□ The National Vaccine Management Committee led b□the Ministr□of National Health Services is in place, meets regularl□; to assess available vaccine stocks within the countr□at provincial and district levels, to forecast vaccine requirements, and reports to the National Steering Committee□

ii□ The Federal EPI receives the polio vaccine for SIAs, manages stock position and releases vaccine to the provinces as per SoPs endorsed b□the NSC□

i) Progress against the NEAP indicators shall be communicated to the media and general public after each SIA b□the National Steering Committee's designated spokesperson□ Progress on NEAP implementation shall also be available online through the National EOC website for Polio Eradication□ The National Communication Technical Committee, led b□ the head of the Communication unit, will report to the National Steering Committee on communication and social mobilization strategies and decisions□

j) The necessar□measures are in place to ensure that all of the political and religious parties are on board for the national cause of polio eradication□

Oversight mechanism in provinces for NEAP implementation

a) The Chief Secretar□must lead the Provincial Task Force for Polio Eradication and s/he will fast-track implementation of the National Emergenc□Action Plan in the respective province□

i□ The Provincial Task Force will ensure oversight to the program and accountabilit□based on low performing areas as well as take necessar□steps for motivating the DCs/DCOs/ PAs of the districts/agencies consistentl□ performing well during all the phases of the campaign□

b) Provincial Security Coordination Committee will review the securit□situation of all districts before implementation of campaigns□This committee will take appropriate action to ensure safe implementation of the polio immunization campaigns□In the advent of a securit□incident in respective area of jurisdiction, this committee will ensure detailed investigations and accountabilit□□

c) Ever□province established state of the art Provincial Emergency Operations Centres (P-EOC) for Polio Eradication with the concept of one team under one roof led b□the Government, as per the decision of the National Task Force□ A senior full time dedicated senior government o□cer will be invariabl□deputed in each province and in FATA to lead the provincial Emergenc□Operations Centre with the assistance of partner agencies, (Bill and Melinda Gates Foundation, WHO, UNICEF, etc)□The Emergenc□Coordinator will be a member of the Provincial Task Force and will report directl□to the chairperson of the Provincial Task Force□

d) The Provincial EOC ma□also notif□the Emergency Coordination Committee (ECC) comprising of the EOC Coordinator, heads of units, and provincial representatives of partner agencies□It will ensure tracking of NEAP indicators and will propose low performing districts and union councils to maintain accountabilit□□The EOC ma□also review surveillance, ongoing polio vaccination activities in the province and logistics support□The EOC ma□also constitute some committees such as a vaccine management committee, communication committee, and technical committee, which will facilitate the work of provincial EOC□

e) The Provincial EOCs must situate and operationalize the Provincial Polio Control Rooms□These Control Rooms will gather and collate the reported (administrative) data during the pre-campaign preparation and the campaign implementation phases, along with transmitting timel□ actionable information to the authorities concerned□ The Control Room will prepare a report ever□evening during campaign da□s and circulate with advises to the problematic districts and concerned provincial departments, as well as Central Control Room, for information□

f) Provincial Vaccine Management Committees headed b□ EPI Managers should improve their functioning to maintain all stock positions at the provincial stores and to gather information from the districts, provide feedback to them and present input to the Federal Vaccine Management Committee□These committees will review the available vaccine stocks in the province on a regular basis and monitor vaccine distribution versus utilization on a dail□basis during the campaign□The□will take corrective action to address an□discrepancies while ensuring adherence to vaccine distribution based on micro-plan requirements, avoiding an□ vaccine wastage and accounting for all doses distributed in the □eld□

Oversight and accountability at the district level

a) The Deputy Commissioner is the administrative head of the district and continues to lead the polio and routine immunization Program as a program of the highest national priority. The Chief Secretary must review the performance of the district, in particular through indicators for preparation and implementation of SIAs. The Chief Secretary may issue warnings and take necessary action for quality campaigns if s/he considers the DC of the low performing districts is inefficient. The Annual Confidential Report (ACR) may show adjustments of appropriate actions of reward and accountability for the DC's performance.

b) The EDO-H of the respective district will lead the district health management team's role in Polio eradication activities. To ensure the optimal ownership of health department, the EDO-H will invariably participate in all meetings of the DPEC and execute action points.

c) A designated Government officer (Additional Deputy Commissioner/ Assistant Commissioner) of the DC is to lead the District Polio Control Room, as per its functions, and develop close liaisons with all chairpersons of tehsils and UPECs. The officer is to collect data on the indicators for preparation and implementation of SIAs, present thedata/information to the DPEC for appropriate actions, finalize readiness reports of each campaign, report to the chairperson of the DPEC and ensure accountability for the implementation of the Emergency Action Plan 2015.

d) The Divisional level structure was restored and presently the Commissioners are responsible for at least 4-5 districts in their respective division. In this scenario, the Divisional Emergency Operations Centres will play a coordination and monitoring role. The Divisional Polio Eradication Committee headed by the Commissioner may provide leadership to the preparatory program and review, and post campaign indicators at divisional level.

e) The concerned authorities in the Provincial Governments will ensure availability of a Medical Officer in every UC (UCMO), particularly in the HRUCs, who may function as the UPEC Chairperson. The respective DC will monitor the compliance of Union Councils dedicating a Medical officer to guide the PEI activities. Where an appropriate medical officer is not available, a dedicated senior government health official and/ or senior official from a government department based in the particular UC will work as UPEC Chairperson. Where available, the government UC head will participate as a co-chair of UPEC. The UPEC will be responsible for all aspects of preparation and implementation of SIAs in the UC. The UCPW, UCCO and FCV recruited by partners, where available, will assist the UCMO in ensuring vaccination of every child in the UC, especially those from the highest risk UCs.

f) The DC will ensure that the UC Medical officer is posted permanently (with no or minimum turnover) to follow up the issues effectively as per the NEAP. The EDO-H (in consultation with the DC) will evaluate their performance. Strict accountability will be enforced in the face of inadequate performance at the UCMO level by the DC and EDO-H. Partners will support training of UCMOs to enable them to perform their functions. The planning and implementation of the activities of UCPWs and UCCOs through their district supervisors will be coordinated through Area Coordinators at the sub-provincial level.

ANNEX I: ESSENTIAL COMMITTEES FOR POLIO ERADICATION

Essential Committees for Polio Eradication: National Level

1) Prime Minister's Focus Group on Polio Eradication

The Prime Minister Office constituted the Focus Group on Polio Eradication headed by the Prime Minister to review progress of the Polio Emergency Program on monthly basis and take immediate remedial measures to implement quality polio campaign activities in the country. Following are the members of the Focus Group:

i. Minister of State, Ministry of National Health Services, Regulations & Coordination (MoNHSRC)
ii. Prime Minister's Focal Person for Polio Eradication
iii. Secretary to the Prime Minister
iv. Federal Secretary Ministry of National Health Services
v. Additional Secretary, Prime Minister's Office
vi. Joint Secretary, Prime Minister's Office
vii. Director General, Ministry of National Health Services
viii. Deputy Secretary Prime Minister Office
ix. Emergency Coordinator, National EOC
x. National Technical Consultant, National EOC

2) National Task Force for Polio Eradication

In pursuance of the Prime Minister's Office U.O No. 881/M/SPM/2014 dated 18th April 2014, the Prime Minister has approved the National Task Force for Polio Eradication with the following composition;

i. Prime Minister Islamic Republic of Pakistan (Chairman)
ii. Governor Khyber Pakhtunkhwa
iii. Chief Ministers of all provinces
iv. Prime Minister, Azad Jammu & Kashmir
v. Minister Incharge, Ministry of National Health Services, Regulations & Coordination (MoNHSRC)
vi. Prime Minister's Focal Person for Polio Eradication (Secretary)
vii. Secretary to the Prime Minister
viii. Secretary, Ministry of National Health Services
ix. Chief Secretaries of four provinces
x. Additional Chief Secretary, FATA
xi. Representative of Chief of Army Staff

The task force shall perform the following functions and meet on quarterly basis;

a) To oversee and monitor the progress made against the National Emergency Action Plan for Polio Eradication and direct necessary remedial measures.
b) To ensure Inter-provincial and inter-sectoral coordination and give direction on issues.
c) To ensure adequate resources are secured for the implementation of National Emergency Action Plan for Polio Eradication.

3) Cabinet Committee on Immunization

The Prime Minister has constituted three members Cabinet Committee on Immunization given below:

i. Minister for Defence
ii. Minister for Interior
iii. Minister of State for National Health Services

The Committee will deliberate and assist in provision of security to the provinces and FATA during polio campaign activities in security compromised areas.

4) Inter-Ministerial Committee on Immunization

The Ministry of National Health Services has notified the Ministerial Coordination committee headed by the Minister State of the Ministry of National Health Services.

This committee will manage resources for the programme, □nalize □nancial documents and ensure transparenc□in utilization of resources□

The Ministr□will process to secure funds to □ll the gaps in this current PC-1 and also for ne□t three □ears period (2016-2018)□

5) National Steering Committee (NSC) for Polio Eradication Initiative (PEI) and Expanded Program on Immunization (EPI)

The National Steering Committee (NSC) for PEI/ EPI will meet fortnightl□(chaired b□Prime Minister's Focal Person for Polio Eradication) to review the Program performance and implementation of the NEAP 2015-16□

The Emergenc□Coordinator is a secretar□of this committee and the representatives from the Ministr□of National Health Services, Federal EPI and heads of polio partners (WHO, UNICEF, BMGF, Rotar□Int, USAID, N-STOP etc) are the core members□ The chairperson of the NSC can e□tend membership as per need of the time□

Terms of reference:

- NSC will guide the program implementation based on decisions of the National Task Force and advice of Technical Advisor□Group (TAG) and Independent Monitoring Board (IMB) for Global Polio Eradication Initiative
- It will periodicall□report on the current epidemiological status of Polioviruses
- Will be responsible for all the activities under Polio Eradication Initiative including development amd implementation of oversight
- Calculate the need, location and frequenc□of Supplementar□ Immunization Activities (SIAs) in the countr□based on surveillance data review
- Review logistics requirement and procurement for the forthcoming campaigns
- Endorse the communication plan
- NSC will also be responsible for campaign evaluation results and feedback to the provinces
- EPI Manger will report on EPI performance, especiall□the OPV3 status of non-Polio AFP cases and give feedback to the provinces
- EPI Manager will also give regular updates on the vaccine suppl□situation for both Polio campaigns and EPI
- EPI Manager will provide updates on other vaccine preventable disease outbreaks

There are several sub-committees to report to the National Steering Committee including the following:

Weekl□Surveillance Committee (reviews current polio updates and lab results)

a) National Communications Technical Committee (leads all kinds of matters related to communication and social mobilization)

b) Technical Supervisor□Group for vaccine management (to periodicall□review status of polio vaccine for SIAs and present the status to the National Steering Committee for action as well as advise to the Federal EPI to release of vaccine to provinces as per SIAs schedule)□

6) National Emergency Operations Centre (N-EOC)

Pursuant to decisions of the National Task Force on Polio Eradication meeting chaired b□the Prime Minister on November 5, 2014 in the Prime Minister's O□ce, Islamabad the National Emergenc□Operations Centre (EOC) for Polio Eradication has been established with the following Terms of Reference;

a) To act as national hub for planning, coordinating, information gathering, surveillance and monitoring of Polio Emergenc□ activities in accordance with National Emergenc□Action Plan for Polio Eradication□

b) To provide technical inputs, situation anal□sis as well as the other information on regular basis to the Prime Minister's o□ce, Ministr□of National Health Services, Regulations and Coordination and all relevant stakeholders highlighting issues and challenges for information and required interventions□

c) To coordinate and develop e□ective liaison with all Provincial Task Forces for Polio Eradication on regular basis with a view to monitor the progress against set targets□

d) To instill a sense of urgenc□in the implementation of polio eradication activities and thereb□control Poliovirus transmission b□the end of 2015□

e) To review monitoring and surveillance data and give feedback to the provinces and districts for remedial measures to improve the qualit□of polio campaign and control the poliovirus□

f) To act as ape□bod□at national level coordinating amongst the provinces to ensure standardized immunization service deliver□for Polio Emergenc□and sustained availabilit□of technical and material resources□

g) To prepare forecast of project requirement for the Ministr□ of National Health Services, Regulations and Coordination to generate resources and provision of securit□for Polio teams in high risk areas through Cabinet Committee on Immunization□

h) To review the progress of the routine immunization regularl□ and advise relevant o□ces for prompt action□

Led b□the Emergenc□Coordinator, the newl□established National Emergency Operations Centre (N-EOC) is a central point for all activities of polio eradication led b□the government and assisted b□the partner agencies (WHO, UNICEF, Bill and Melinda Gates Foundation, etc)□The National EOC will continue its assistance to the Prime Minister's Focal Person and will be responsible for monitoring the NEAP indicators and tracking e□ective implementation of the strategic decisions and guidance provided b□the National Task Force and the National Technical Advisor□Group□

Essential Committees for Polio Eradication: Provincial Level

1) Provincial Task Force (PTF) / Provincial Steering Committee (PSC)

The Chief Secretar□must lead the Provincial Task Force for Polio Eradication and s/he will fast-track implementation of the National Emergenc□Action Plan in the respective province□

The Provincial Task Force will ensure oversight to the program and accountabilit□based on low performing areas as well as take necessar□steps for motivating the DCs/DCOs/PAs of the districts/agencies consistentl□performing well during all the phases of the campaign□

The Health Secretar□will act as a Secretar□of the PTF and representative of senior o□cial from line departments (Home/law and enforcement agencies, Education, Information, Local Government, Auqaf and Chief Minister O□ce)□DG Health, EPI Manager and provincial representatives of partner agencies (WHO, UNICEF, BMGF, Rotar□Intetc)□

All Deput□Commissioners/ District Coordination O□cers of the province / Political Agents (PA) of FATA will attend the meeting of PSC/PTF□

Functions of PSC/PTF

The PSC/PTF should review and monitor the following aspects of Polio eradication initiative after NIDs and SNIDs campaigns:

a) Progress made in province against National Emergenc□Plan of Action for eradication of Polio and provides guidance on challenges being faced b□each district□
b) Involvement of district and sub-district level arm of government to assume the responsibilit□of ensuring implementation of District Speci□c plan□
c) Involvement of the line departments and assigning speci□c roles and tasks to each department for the successful campaign implementation□
d) The plan and progress for advocac□and social mobilization activities at provincial and sub-provincial levels and ensure availabilit□of adequate resources and their optimal use

There are several sub-committees to report to the Provincial Task Force including the following:

a) The Provincial Security Coordination Committee of the PTF will review the securit□situation of all districts before implementation of campaigns□This committee will take appropriate action to ensure safe implementation of the polio immunization campaigns□
b) Provincial Vaccine Management Committees headed b□EPI Managers should improve their functioning to maintain all stock positions at the provincial stores and to gather information from the districts, provide feedback to them and present input to the Federal Vaccine Management Committee□These committees will review the available vaccine stocks in the province on a regular basis and monitor vaccine distribution versus utilization on a dail□basis during the campaign□The□will take corrective action to address an□discrepancies while ensuring adherence to vaccine distribution based on micro-plan requirements, avoiding an□vaccine wastage and accounting for all doses distributed in the □eld□
c) Ever□province has established state of the art Provincial Emergency Operations Centres (P-EOC) for Polio Eradication with the concept of one team under one roof led b□the Government, as per the decision of the National Task Force□A senior full time dedicated senior government o□cer must be deputed immediatel□in each province and in FATA to lead the provincial Emergenc□Operations Centre with the assistance of partner agencies, (Bill and Melinda Gates Foundation, WHO, UNICEF, etc)□□The Emergenc□Coordinator will be a member of the Provincial Task Force and will report directl□to the chairperson of the Provincial Task Force□
d) The Provincial EOC ma□also notif□the Emergency Coordination Committee (ECC) comprising of the EOC Coordinator, heads of units, and provincial representatives of partner agencies□It will ensure tracking of NEAP indicators and will propose low performing districts and union councils to maintain accountabilit□□The ECC ma□also review surveillance, ongoing polio vaccination activities in the province and logistics support□The EOC ma□also constitute some committees such as a vaccine management committee, communication committee, and technical committee, which will facilitate the work of provincial EOC□

2) Divisional Polio Eradication Committee

The Divisional level structure has been restored and presentl□the Commissioners are responsible for at least 4-5 districts in their respective division□The Commissioner has its regular meetings with the Deput□Commissioners who are responsible to provide leadership to polio eradication in their respective districts□It is being proposed to have a divisional level committee headed b□the Commissioner to meet as and when required to discuss and □nd out solutions for proper implementation of polio eradication activities in the division□

The Divisional Polio Eradication Committee meets immediatel□after DPEC meetings under the leadership of the Commissioner and with participation b□Deput□Commissioners of all districts within the Division□

The committee reviews preparation of the campaign including operational, securit□and awareness arrangements as well as focuses on the missed children and missed areas identi□ed in the last campaign to cover in the forthcoming campaign□

Essential Committees for Polio Eradication: District Level

3) District Polio Eradication Committee (DPEC)

Each District/Agenc will have a District Polio Eradication Committee (DPEC/APEC) to oversee Polio eradication and routine immunization activities at district/agenc level and coordinate all line departments and local partners including NGOs to ensure high qualit implementation of vaccination campaign strategies and plans to achieve recommended results in the National Emergenc Action Plan

The District PEC headed b the DC/DCO and Agenc PEC headed b the Political Agent meets 5-10 da s before the campaign The participation of the Chairperson and the Secretar of Committee is mandator with binding attendance of all concerned departments – Health, police, education, Revenue, local government as well as representatives of partner agencies, district heads of public health programs and private sector organizations In addition, the communit representatives (parliamentarian), district Khateeb (Religious preacher) Head of the DPEC can e tend membership on need basis

The meeting is to review the status of preparations and the results of UPEC meetings (completeness and timeliness) and consider speci c requests from the UPECs and an interventions required to make corrections at the UC level

The meeting of the DPEC must have in its agenda:

a) The follow-up of actions / decisions from the last meeting and person(s) to be held accountable in case of faltering; review of performance indicator trends (process and outcome)

b) Appropriateness for plans for pre-SIA, during-SIA and post-SIA phases with focus on comprehensiveness of micro-plans, including transit strateg with supervision plan, training qualit and e ective house to house visits to all families with follow-up of those having absent children

c) To review the outcome of the last campaign against the set of standard indicators and review the progress of the actions taken for the poor performance in the last campaigns

d) Speci c tasks assigned to the DPEC members in relation to the ne t SIA

e) The Secretar of the DPEC must maintain record of all approved meeting minutes for sharing, when required

The health department and local law enforcement must submit a jointl prepared district security plan, for implementation of the campaign, to the DC and reviewed in the DPEC It is the responsibilit of the DC to authorize whether or not a campaign can proceed with the necessar securit arrangements for vaccination teams The DC and local law enforcement should seek advice of communit in uencers and religious leaders about securit plans and measures If necessar , the DC ma approach to the Chairman of the Provincial Securit Coordination Committee for additional support

4) Tehsil Polio Eradication Committees (TPEC)/ Sub-division Polio Eradication Committee (SPEC)

There is occasionall a management gap between the district and UC level, therefore it is proposed to ll such gaps with the involvement of Tehsil/taluka administration and health departments in supervision and monitoring support of the UCs Therefore, it is proposed to establish Tehsil Polio Eradication Committees (TPEC) Four member teams, headed b the Assistant Commissioner (AC), is being proposed wherever required, to assit the UCMOs in implementation of polio campaign activities as well as monitor progress The AC ma also represent the tehsil in the DPEC meetings

The functionalit of the TPEC must be ensured with designation of the Assistant Commissioner (AC) as chairman, Deput District Health O cer (DDHO) as its secretar and the police o cer in charge of the Tehsil as an integral part

The meeting of the TPEC will be conducted the ne t da after the last da of UPEC meeting and at least 1-2 da s before the DPEC meeting The DDHO will hold a meeting with the TPEC chairman in Tehsil/taluk of his / her assignment before the DPEC meeting and present information on their Tehsil/taluka during the DPEC meeting including UC wise information/data of their assigned Tehsil The partners' sta will ensure training of the DDHO (Tehsil focal person) A review meeting chaired b the TPEC chairman should be held with all chairpersons of UCs and will bring the particular challenges to the DC for resolve

5) Union Council Polio Eradication Committees (UPEC)

The UPECs formation, composition and functionalit have been variable in all of the provinces The functionalit of the UPEC must function with the designation of the full time Union Council Medical O cer as Chairman and the Revenue O cer as Secretar , with binding membership of important UC level stakeholders

The meeting of the UPEC should be 15 da s before the campaign with an agenda including,

- the review of the implementation status of the previous meeting's decisions;
- the review and endorsement of the integrated micro-plans including composition and qualit of vaccination teams and transit team strateg with supervision plans;
- the engagement of the communit in uencers for information and motivation of the communit ;
- plans for qualit training, supervision and real time process data transmission on a dail basis

Information/data management at the UC level will be the responsibilit□ of the UC Medical O□ cer (UCMO, UPEC Chairman)□ The UCMO will ensure that all Area In-Charges in the UC meet their teams dail□ at the end of each da□'s assignment□ The Area In-Charges will collate and compile the data/information from the tall□ sheets of the teams and report to the UCMO; who will collate and compile all of the data for the UC and report to the District Control Room□ The Area In-Charges and the UCMO will critical□ anal□se the tall□ sheets of the teams on a dail□ basis and strategize the interventions accordingl□□ The partners' UC level sta□ (where available) will assist with the tall□ sheet anal□ses, strategizing □eld interventions□

6) O□ ce bearers of the local bodies at the Union Council

Local Bodies are a s□stem of Government that provides the facilities to the people in speci□c areas to solve people's problems at local level, allow public participation in decision-making□ It has three levels district, tehsil and union council in ever□ district under the administrative control of provincial local government□ The essence of this s□stem is that the Local Governments would be accountable to the citizens for all their decisions□

The lowest tier, the Union Council is a corporate bod□ covering the rural as well as urban areas across the whole District□ It consists of Chairman, Vice Chairman, 8 – 13 members (general council members and representatives of ladies, farmers / laborers and minorities)□

In ever□ union council, the local government has placed the Union Council Secretar□ to coordinate and facilitate to the elected bod□ of the union council in communit□ development, functioning of the Union Committees and deliver□ of municipal services□ The UC Secretar□ is also responsible to manage work of births, marriages and deaths registration and securit□ s□stem through chowkidars□

The UC Secretar□ has been assisting the health department in routine vaccination of children b□ providing list of registered births to vaccinators as well as pla□ing role as the Secretar□ of Union Council Polio Eradication Committee□ The□ can also bridge the gap between UPEC and local police for securit□ arrangement in securit□ risk areas, monitor the campaign activities and assist in vaccination of missed children especiall□ refusals□

There is a need to establish o□ cial agreement with the local government to use the services of the UC level Secretaries for Routine Immunization and Polio Eradication□

ANNEX II: NEAP OPERATIONAL/ COMMUNICATIONS INDICATORS

- Indicators to assess the oversight& preparation of the campaign at the UC & district levels (To be used by the ECCs and Provincial Task Force, DPEC and the UPEC)
  These indicators are to be assessed by the Provincial Task Force/ steering committee 8 days before the campaigns.

1	% of DPEC Meetings held 10 da s before the campaign (DPEC/ APEC meeting to be considered valid if chaired b the DCO/ DC/ PA and attended b the EDO-H)
2	% of the High Risk UPEC meeting summaries (minutes) received and reviewed b the DPEC for actions
3	UC micro-plans of 30% UCs (50% of each UC's Area In-charges) in the district, eld validated b the district level sta including the EPI Coordinator, EPI focal person, DDHO/ DHO, DSV and his sta , PEO, DHCSO etc
4	% UCs that tracked and vaccinated 90% of the still missed children after the last campaign (target: 95%)
5	% of the DPEC meetings that formulated district securit plan with special focus on UCs/ areas of concern (insecure areas, areas with fear factor etc)
6	% of required vaccine received at district level minimum three (3) da s prior to campaign start
7	% of vaccine consignments arrived at port of entr minimum three (3) weeks prior to campaign start of each campaign including mop up and outbreak contingencies

- UC-Indicators to assess the functionality and e ciency of the UPEC; & status of preparation:
  To be assessed 10 days before the campaign during the DPEC meeting

- In addition to the above; the below indicators are to be assessed 5 days before the campaign

1	% UCs with all the Area In-charges trained using standardized, national module including IPC module (target: 100%)
2	% UCs with all the vaccinators trained using standardized, national module including IPC module (target: 100%)
3	% children tracked and vaccinated that had remained unvaccinated at the end of last campaign (target: 100%)
4	% UCs, where all the Vaccination Teams & Area In charges received pa ment for the previous vaccination campaign

- Indicators to be considered for possible deferment of the campaign
  The campaign will be deferred in the UC which did not achieve any of the following indicators

1	% UPEC meetings held 15 days before the campaign
2	% UPEC meetings chaired by the UC Medical O cer / designated senior health o cial (UPEC Chairman) and co-chaired by the UC secretary (UPEC meeting to be considered valid if chaired by the UC Medical O cer and co-chaired by the UC secretary)
3	% UCs in which all the AICs submitted team composition (names, NIC No. and assigned areas)
4	% UCs with all the micro-plans of Area In-charges eld validated by the UC level supervisory sta (UC MO, UCPW, UCO) for: inclusion of all the components and their quality as per the national guidelines including names of the team members, area maps and teams assignment maps eld validation: checking and validating as per the eld validation checklist and to con rm if the descriptions made in the micro-plan and map match the grounds facts
5	% UCs with all the mobile teams having all team members over 18 years of age
6	% UCs with at least 100% mobile teams having one local member (suited to local norms and culture)
7	% UCs with at least 80% mobile teams having at least one female member
8	% children tracked and vaccinated that had remained unvaccinated at the end of last campaign (target: 100%)
9	% UCs with all the micro-plans having high risk populations (mobile, migrants, multifamily dwellings etc.) and their in uencers clearly marked and mapped
10	% UCs with UC micro-plan having a security component duly veri ed by the SHO/ equivalent
11	# of Very high-risk UC where community mobilizers are deployed
12	# of missed children reported and vaccinated b communit mobilizers
13	% of parents in ver high risk union councils aware of and accepting vaccination of their children

1	All the micro-plans (of Area In-charges) reviewed and eld validated b the UC level supervisor sta (UC MO, UCPW, UCCO) and independentl veri ed b 3rd part for inclusion of all the components and their qualit as per the national guidelines including names of the team members, area maps and teams assignment maps
2	UC micro-plans of 20% UCs in the districts eld validated b the district level sta including the EPI Coordinator, EPI focal person, DSV and his sta , PEO, DHCSO etc
3	Number of mobile teams complete per micro-plan; with either of the following targets met:
	a At least 100% mobile teams having one local member (suited to local norms and culture)
	b
	c At least 80% mobile teams having at least one female member
4	All team members trained using standardized, national module including IPC module “Post Campaign Indicators”

Post Campaign Assessment Indicators

1□	LQAS a□% of the LQAS lots Passed (Target: 80%) b□% children missed due to No Team (target: <1%) c□% children missed due to NA (target: <5%) d□% children missed due to Refusal (target: <1%)
2□	Market Survey a□% Tehsils that achieved 95% vaccination estimates b□□nger marking (target: 90%)
3□	3rd party Independent Monitoring a□% districts that achieved vaccination estimates b□□nger marking (target: 95%)

Add a new item:

ANNEX III: SIA PRIORITIZATION FRAMEWORK

Based on two-part model estimating probabilit□of a case and the number of cases given an importation the program in collaboration with IDM will develop SIA prioritization□

Indicators include in the model:

- Population immunit□
- RI Zero-dose fraction
- Under-immunized fraction
- Recent WPV1 cases
- Recent neighbouring WPV1 cases
- Recent neighbouring compatible cases
- Remaining risk based on total historical WPV cases

- Tier 1: Reservoir District (12)
  - These area the areas that must be □□ed if the program is to succeed□
  - NIDs + SNIDs + CCPV
- Tier 2: High Risk/ Vulnerability Districts (30)
  - These area areas that are frequent recipients of virus of have known qualit□& immunit□problems
  - All districts in FATA and southern KP receive a minimum prioritization of Tier 2
  - These areas ma□harbor virus even if eliminated from reservoirs and subsequentl□re-infect them
  - NIDs + SNIDs
- Tier 3: Outbreak Districts (Flexible),11
  - Areas not at high risk that report a case or become problematic
  - In this case, instead of conducting SIADs, these areas should be added to the SNID calendar for the ne□t 1-2 rounds
- NIDs + SNIDs Tier 4: Rest of Pakistan
  - Areas where RI is strong, qualit□is known to be high, or risk is known to be low□
  - NIDs

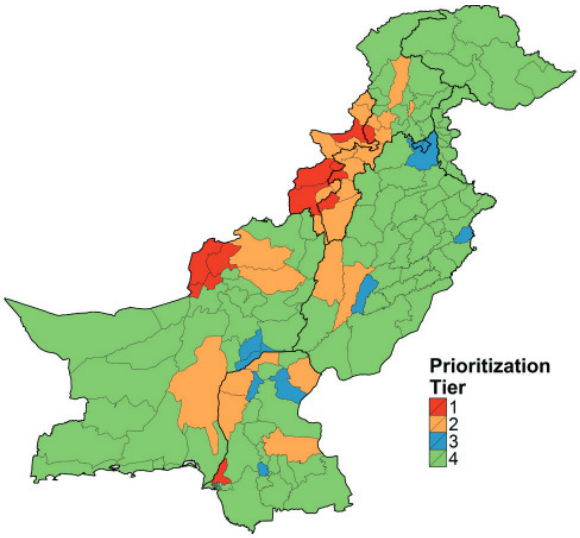
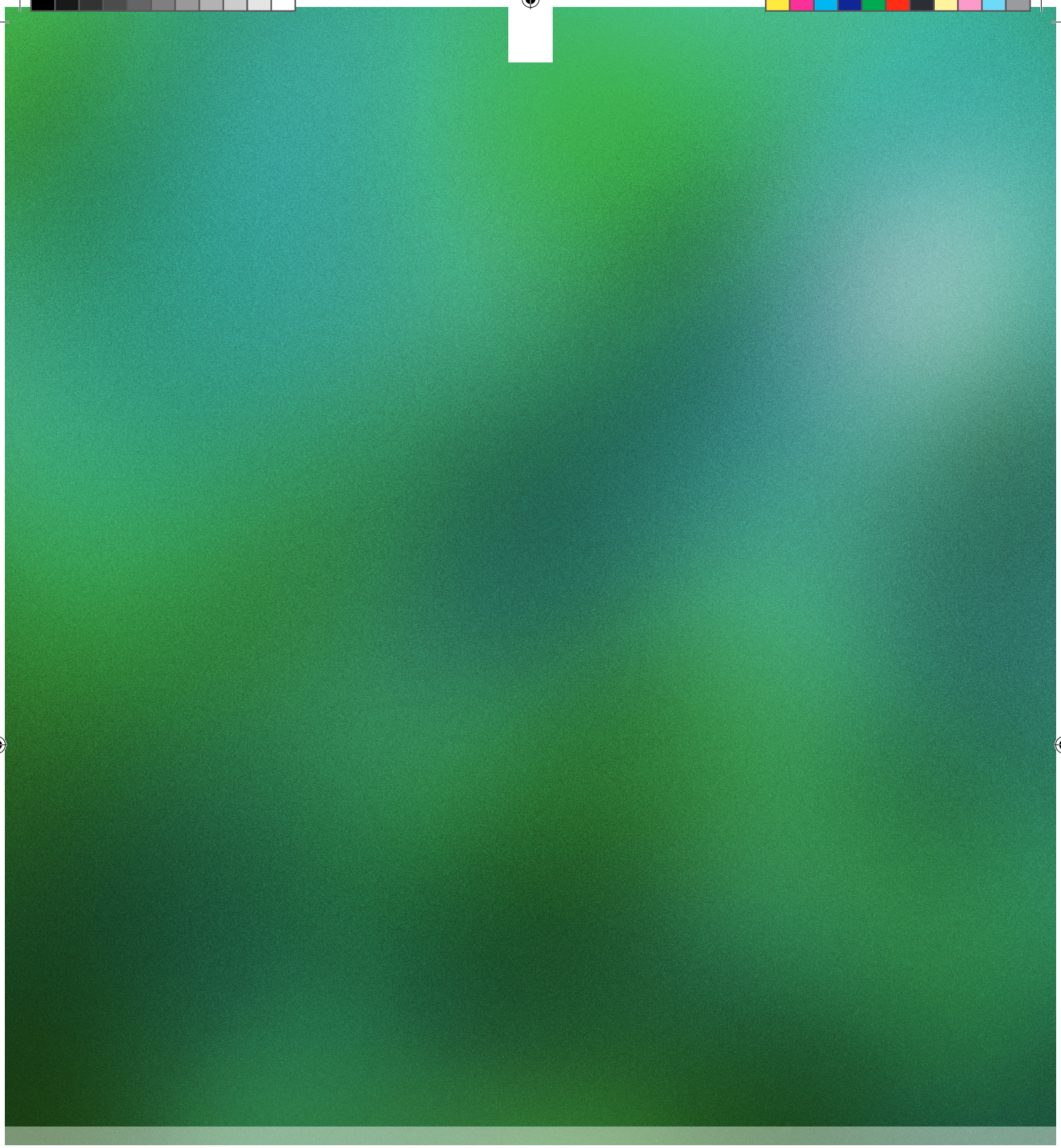


Figure 3: January–Jun 2015 district prioritization map using IDM model

Credits:
- Photo on cover: WHO
- Design and Layout: Paprika-annecy.com



The Prime Minister of Pakistan / Chairman of the National Task Force for Polio Eradication endorsed the National Emergenc Action Plan for Polio Eradication in a meeting held on 11 June 2015, Prime Minister's House, Islamabad

Mian Muhammad Nawaz Sharif
Prime Minister, Islamic Republic of Pakistan
(Chairperson, National Task Force for Polio Eradication)