Polio Eradication Initiative Pakistan

Background Document for the Independent Monitoring Board

For meeting scheduled 7-9 May

Context

This document has been prepared in response to a request from the Independent Monitoring Board (IMB) to provide information vis-à-vis:

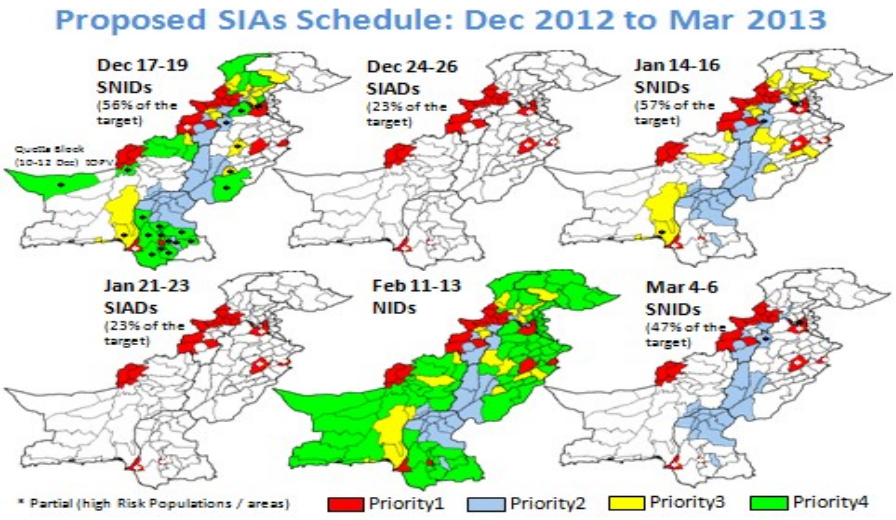
- The priority goals for Pakistan
- National Emergency Action Plan (NEAP)
- Comments made by IMB in its November 2012 report

A. Progress on Priority Goals

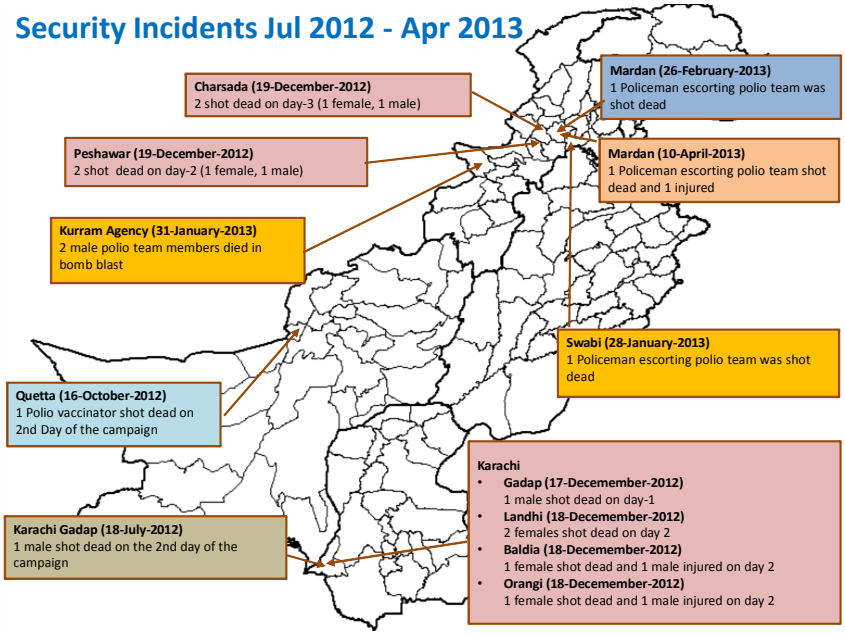
1. *Timeline; Last Low Season*

The Federal Government, along with the Provincial Governments and polio partners, conducted a consultative workshop in November 2012 to review progress on the NEAP 2012 and develop a work plan for 2013 with a special focus on the low season. Experience from 2011 and 2012 clearly indicates that quality and performance of supplementary immunization activities (SIAs) in the first half of the year, during the low transmission season, contributes significantly to decreasing circulation of wild poliovirus for the whole year. In 2012, when the first quarter (low season) was well utilized with an aggressive SIA strategy, the number of cases and positive environmental samples remained consistently low throughout the year, including during the high season.

Keeping in view this experience, one of the priority goals set for 2013 was to fully utilize the low season of 2013 (Jan-Mar) with an intensified SIA strategy. The Technical Expert Group (TEG), which met in December 2012 ,endorsed a plan to conduct 6 SIAs from end December 2012 to March 2013; including subnational rounds in December 2012 (2), January (2) and March (1) and a nationwide round in February 2013. *(Please see the maps below).*



During the first SIA following the planning exercise of December 2012, nine polio workers were killed in a series of attacks in Khyber Pakhtunkhwa and Karachi *(please see the map below)*. As a result of these killings, the second round of SIAs in December 2012 could not be conducted in many areas *(see table below),* with an overall 21% of the target children reached. Attacks on polio workers and security personnel escorting them continued in 2013, with a total of 14 workers killed between December 2012 and April 2013 *(16 since July 2012).* Hence, the programme had to make adjustment to ensure the safety of polio workers. Emergency security operational guidelines were issued by the Prime Minister's Cell and a security component was added to polio eradication plans at the district and Union-Council (UC) level, with extensive engagement of the police and other law enforcement agencies under the leadership of the Deputy Commissioner/District Coordination Officer/Political Agent (DC/DCO/PA). A security coordination committee was formed at the provincial level in each of the provinces to oversee and support the security arrangements for polio workers.



With a serious deterioration in the security situation, coupled with tight vaccine availability, the country programme continued with an ongoing assessment of the situation and planning for SIAs. In this approach, five small to medium scale SIAs were conducted between January and March 2013. It is important to mention that the NIDs planned in February could not be conducted due to unavailability of the vaccine.

The table below shows the implementation status of the SIAs during the low transmission season (Dec 2012-Mar 2013).

Children Reached During SIAs
Dec 2012 – Mar 2013

Province	Dec (17-19)			Dec (24-26)			Jan (14-16)			Jan (28-30)			Feb (18-20)			Mar (04-06)			Mar (25-27)		
	Total Population planned	Children Reached (17th to 26th Dec) No.	%	Total Population planned	Children Reached (24th Dec to 2nd Jan) No.	%	Total Population planned	Children Reached (17th to 23rd Jan) No.	%	Total Population planned	Children Reached (28th Jan to 2nd Feb) No.	%	Total Population planned	Children Reached (18th to 27th Feb) No.	%	Total Population planned	Children Reached (04th to 13th Mar) No.	%	Total Population planned	Children Reached (25th Mar to 6th Apr) No.	%
Priority-1	**7,815,285**	**6,826,782**	**87**	**7,815,285**	**1,657,089**	**21**	**7,815,285**	**5,498,556**	**70**	**7,815,285**	**2,385,947**	**31**	**7,815,285**	**6,203,620**	**79**	**7,815,285**	**6,919,309**	**89**	**7,815,285**	**6,629,902**	**85**
BALOCHISTAN	718,845	685,194	95	718,845		0	718,845	515,018	72	718,845		0	718,845	218,959	30	718,845	685,618	95	718,845	275,698	38
FATA	1,305,151	712,936	55	1,305,151	657,126	50	1,305,151	669,503	51	1,305,151	617,549	47	1,305,151	667,194	51	1,305,151	689,935	53	1,305,151	683,568	52
KP	1,815,138	1,580,527	87	1,815,138	220,099	12	1,815,138	1,169,443	64	1,815,138	852,071	47	1,815,138	1,261,142	69	1,815,138	1,600,825	88	1,815,138	1,657,237	91
PUNJAB	3,193,607	3,514,247	110	3,193,607	779,864	24	3,193,607	2,796,032	88	3,193,607	815,981	26	3,193,607	3,474,111	109	3,193,607	3,484,937	109	3,193,607	3,475,382	109
SINDH	782,544	333,878	43	782,544		0	782,544	348,560	45	782,544	100,346	13	782,544	582,214	74	782,544	457,994	59	782,544	538,017	69
Priority-2	**7,695,759**	**7,243,759**	**94**				**7,695,759**	**3,135,050**	**41**	**7,695,759**	**3,756,287**	**49**	**7,695,759**	**7,673,148**	**100**				**284,475**	**93,178**	**33**
BALOCHISTAN	282,660	282,509	100				282,660		0	282,660	309,803	110	282,660	294,447	104						
ISLAMABAD	232,454	111,230	48				232,454		0	232,454	122,507	53	232,454	120,896	52						
KP	1,058,565	917,642	87				1,058,565		0	1,058,565	509,344	48	1,058,565	951,522	90						
PUNJAB	3,240,943	3,315,170	102				3,240,943	3,003,886	93	3,240,943	197,070	6	3,240,943	3,433,930	106						
SINDH	2,881,137	2,617,208	91				2,881,137	131,164	5	2,881,137	2,617,563	91	2,881,137	2,872,353	100				284,475	93,178	33
Priority-3	**1,701,291**	**1,559,107**	**92**				**353,812**	**313,630**	**89**	**1,213,049**	**974,165**	**80**	**669,029**	**664,482**	**99**	**1,833,503**	**1,476,001**	**81**			
BALOCHISTAN	53,579	54,176	101				36,599	37,822	103	53,572	45,213	84				79,344	80,429	101			
KP	1,315,025	1,213,249	92							1,101,188	928,952	84	669,029	664,482	99	1,371,915	1,108,760	81			
PUNJAB	276,075	272,490	99				258,924	275,808	107							276,075	286,812	104			
SINDH	56,612	19,192	34				58,289		0	58,289	-	0				106,169		0			
Priority-4	**3,106,998**	**2,582,445**	**83**				**2,201,120**	**2,060,145**	**94**	**1,613,566**	**1,075,294**	**67**	**407,661**	**274,886**	**67**				**401,159**	**296,944**	**74**
BALOCHISTAN	293,536	242,076	82							186,361	150,939	81									
KP	1,060,481	954,627	90							384,020	304,983	79	129,989	114,987	88						
PUNJAB	585,427	625,197	107				1,636,425	1,758,657	107												
SINDH	1,167,554	760,545	65				564,695	301,488	53	1,043,185	619,372	59	277,672	159,899	58				401,159	296,944	74
Grand Total	**20,319,333**	**18,212,093**	**90**	**7,815,285**	**1,657,089**	**21**	**18,065,976**	**11,007,381**	**61**	**18,337,659**	**8,191,693**	**45**	**16,587,734**	**14,816,136**	**89**	**9,648,788**	**8,395,310**	**87**	**8,500,919**	**7,020,024**	**83**

The New Paradigm of Communication

Communicating in this environment is extremely complex. Experience has shown that publically announcing campaign dates has increased security risks to frontline workers, since the announcement may inadvertently provide advance information to people who wish to plan attacks. As a result, the programme reduced or eliminated any public announcement of campaigns in high risk areas. Before December, prior to every polio campaign, COMNet social mobilizers would reach over 100,000 households identified to be most at risk of being missed, with individual face-to-face outreach. This interpersonal communication is no longer possible in many high risk areas, due to insecurity. Household engagement is now an increased risk for both the frontline workers and, in some cases, caregivers themselves. Caregivers may be intimidated for engaging with the programme, in areas that are most hostile to its efforts.

Advertising in media, communicating campaign dates, and heavy use of public service announcements has been replaced with a subtle and more sophisticated approach of educating the public about child health, with polio now being framed within the context of child wellbeing and child rights. This strategic re-packaging of the public information programme will entail highly targeted content integration, media partnerships, and editorial content and programme placements on key media outlets.

Communities that are anxious about security are often conscious and motivated to understand how to better protect their children. By emphasizing the protective power of immunization, caregivers can feel confident that their decision to vaccinate is one that will improve their children's safety and wellbeing overall, rather than solely avoiding the dangers of polio.

In the highest risk areas, campaign announcements and communication about the importance of vaccination now takes place at the doorstep and through local traditional networks, in the midst of the vaccination campaign itself. This strategy relies even more on the composition and competence of vaccinators and social-mobilizers, who must now win the trust and confidence of local leaders and caregivers almost immediately. There is even less time, now, to linger in doorways to answer questions, so it is important that families are ready to engage with health workers when they arrive.

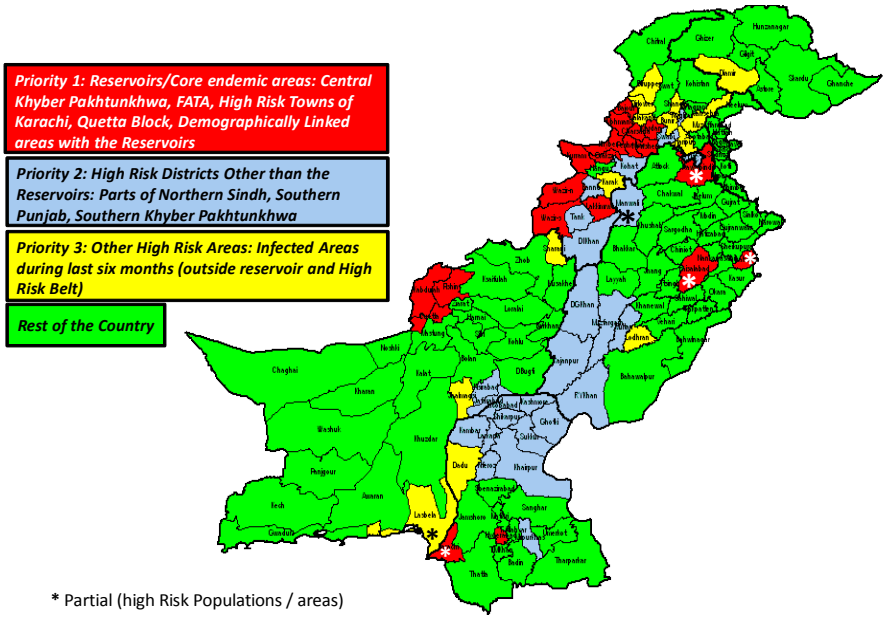
2. ***Enhanced focus on reservoirs, especially during the low season***

The country was classified into four categories based on the polio epidemiology. The Priority-1 areas are the polio reservoirs and core endemic areas that historically have driven the polio epidemiology of the country and have been proving stubborn in regards to stoppage of WPV circulation. Priority-2 areas are comprised of high risk districts with history of repeated infections and establishment of WPV circulation. Priority-3 areas are areas infected during the last 6 months and some additional areas of concern (other than reservoirs and high risk belt), while the rest of the country is classified as Priority-4. This classification was endorsed by the Technical Expert Group during its meeting in December 2012. The table below summarizes the target children population by priority and province.

Table: Target Children (aged < 5 yrs.) by Province and Priority

Province	Target Population				
	Priority-1	Priority-2	Priority-3	Priority-4	Total
Sindh	782,544	2,881,137	-	3,836,551	**7,500,232**
KP	1,815,138	1,058,565	1,472,307	765,203	**5,111,213**
FATA	1,305,151	-	-	-	**1,305,151**
Balochistan	718,845	282,660	311,020	971,516	**2,284,041**
Punjab	3,193,607	3,240,943	1,753,164	7,804,724	**15,992,438**
Islamabad	-	232,454	-	-	**232,454**
AJK	-	-	-	690,428	**690,428**
G Baltistan	-	-	44,634	169,228	**213,862**
Total	**7,815,285**	**7,695,759**	**3,581,125**	**14,237,650**	**33,329,819**

Prioritization of districts for low season SIAs *(revised as of 12th Apr.)*

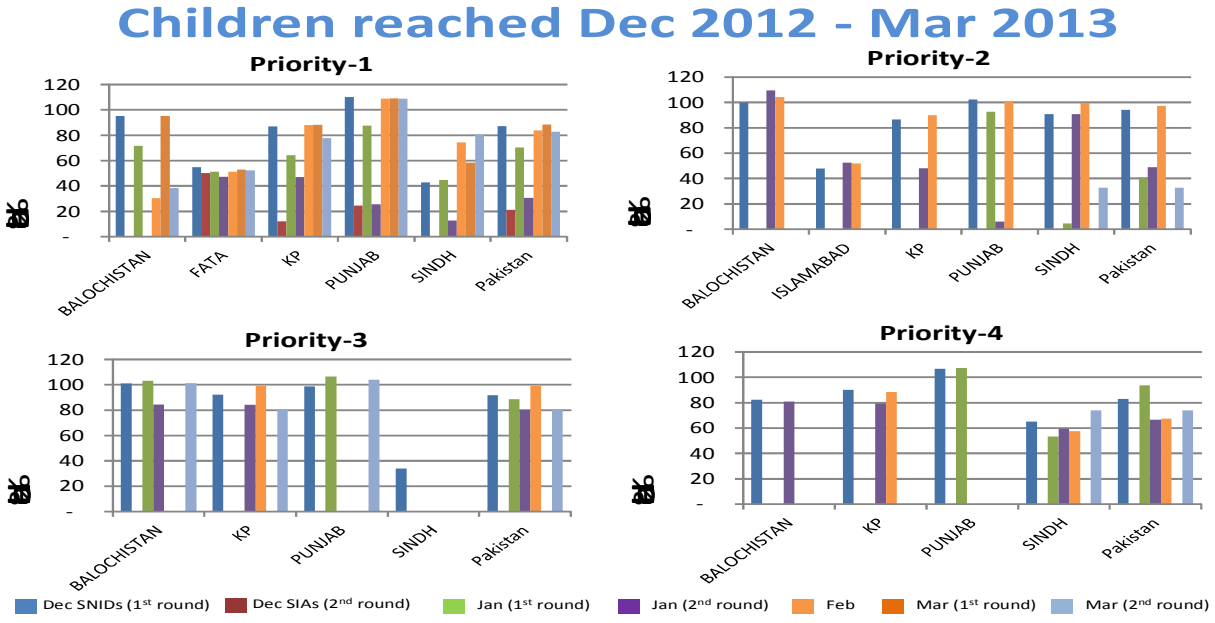


* Partial (high Risk Populations / areas)

Status of the vaccination rounds in the low transmission season (Dec. 2012 – Jan. 2013)

Five vaccination rounds were conducted between January and March 2013 (seven from December 2012 – March 2013); two in January, one in February and two in March 2013. Despite all the steps taken in the current security situation, the quality of SIAs was not up to the required level in the reservoir/endemic areas of Karachi and Khyber Pakhtunkhwa (please see the graphs below).

Children reached during SNIDs; Dec 2013 – Mar 2013



Quality and completion status of the SIAs was relatively good in Priority-2 (high risk) districts; as compared to the Priority-1 (reservoirs and core endemic) districts/towns.

It is further noted that the polio reservoir districts/towns had sub-optimal reach to the target children for 10 days from the start of the campaign *(please see the table below)*. For instance, Gadap town, Karachi missed three SIAs and never reached 50% of children during the implemented SIAs. Similarly, the Priority-1 districts of Khyber Pakhtunkhwa only once reached 90% of children (December 2012) and only twice 80% children during the implemented SIAs *(these are the proportions of children reached within 10 days of the start of the campaigns)*. Moreover, all the Priority-1 districts of Khyber Pakhtunkhwa missed one planned round of SIAs. This situation puts at risk the progress made in 2012 and the goal of NEAP 2013 to stopping WPV circulation by December 2013. More than 260,000 children in North and South Waziristan Agencies of Federally Administered Tribal Areas (FATA) continue to be unreached for polio vaccination, since June 2012.

Status of SNIDs December 2012 to March 2013

Trend of children reached in Priority1 districts

SIAs Dec 2012 – Mar 2013

Province	Dec (17-19)			Dec (24-26)			Jan (14-16)			Jan (28-30)			Feb (18-20)			Mar (04-06)			Mar (25-27)		
	Total Population planned	Children Reached (17th to 26th Dec) No.	%	Total Population planned	Children Reached (24th Dec to 2nd Jan) No.	%	Total Population planned	Children Reached (17th to 23rd Jan) No.	%	Total Population planned	Children Reached (28th Jan to 2nd Feb) No.	%	Total Population planned	Children Reached (18th to 27th Feb) No.	%	Total Population planned	Children Reached (04th to 13th Mar) No.	%	Total Population planned	Children Reached (25th Mar to 6th Apr) No.	%
BALOCHISTAN	**718,845**	**685,194**	**95**	**718,845**		**0**	**718,845**	**515,018**	**72**	**718,845**		**0**	**718,845**	**218,959**	**30**	**718,845**	**685,618**	**95**	**718,845**	**275,698**	**38**
KABDULAH	132,639	134,230	101	132,639		0	132,639	113,494	86	132,639		0	132,639	133,227	100	132,639	125,256	94	132,639	-	0
PISHIN	111,040	102,429	92	111,040		0	111,040	91,475	82	111,040		0	111,040	85,732	77	111,040	88,171	79	111,040	-	0
QUETTA	475,166	448,535	94	475,166		0	475,166	310,049	65	475,166		0	475,166	-	0	475,166	472,191	99	475,166	275,698	58
FATA	**1,305,151**	**712,936**	**55**	**1,305,151**	**657,126**	**50**	**1,305,151**	**669,503**	**51**	**1,305,151**	**617,549**	**47**	**1,305,151**	**667,194**	**51**	**1,305,151**	**689,935**	**53**	**1,305,151**	**683,568**	**52**
BAJOUR	223,804	213,955	96	223,804	212,463	95	223,804	211,857	95	223,804	211,766	95	223,804	212,360	95	223,804	213,903	96	223,804	212,627	95
FR BANNU	57,295	44,041	77	57,295	43,148	75	57,295	43,310	76	57,295	42,652	74	57,295	34,139	60	57,295	34,117	60	57,295	42,601	74
FR DIKHAN	14,342	14,002	98	14,342	14,385	100	14,342	13,810	96	14,342	14,068	98	14,342	13,858	97	14,342	11,798	82	14,342	13,103	91
FR KOHAT	20,828	20,775	100	20,828	17,295	83	20,828	17,300	83	20,828	19,791	95	20,828	21,240	102	20,828	19,765	95	20,828	20,123	97
FR LAKKI	20,140	8,479	42	20,140	7,637	38	20,140	7,798	39	20,140	8,122	40	20,140	8,108	40	20,140	7,202	36	20,140	6,940	34
FR PESHAWAR	23,355	11,727	50	23,355		0	23,355		0	23,355		0	23,355	-	0	23,355	3,621	16	23,355	3,921	17
FR TANK	18,042	10,432	58	18,042	10,516	58	18,042	10,178	56	18,042	10,462	58	18,042	10,214	57	18,042	10,051	56	18,042	10,515	58
KHYBER	310,405	147,839	48	310,405	114,299	37	310,405	125,914	41	310,405	105,986	34	310,405	127,814	41	310,405	148,713	48	310,405	132,668	43
KURRAM	142,809	117,163	82	142,809	112,670	79	142,809	113,844	80	142,809	81,560	57	142,809	115,034	81	142,809	117,855	83	142,809	117,587	82
MOHMAND	100,323	86,827	87	100,323	86,492	86	100,323	87,050	87	100,323	86,604	86	100,323	86,502	86	100,323	85,458	85	100,323	85,766	85
ORAKZAI	91,388	30,840	34	91,388	31,663	35	91,388	32,027	35	91,388	30,312	33	91,388	31,327	34	91,388	30,763	34	91,388	30,930	34
WAZIR-N	161,358		0	161,358		0	161,358		0	161,358		0	161,358	-	0	161,358	-	0	161,358	-	0
WAZIR-S	121,062	6,856	6	121,062	6,558	5	121,062	6,415	5	121,062	6,226	5	121,062	6,598	5	121,062	6,689	6	121,062	6,787	6
KP	**1,815,138**	**1,580,527**	**87**	**1,815,138**	**220,099**	**12**	**1,815,138**	**1,169,443**	**64**	**1,815,138**	**852,071**	**47**	**1,815,138**	**1,261,142**	**69**	**1,815,138**	**1,600,825**	**88**	**1,815,138**	**1,657,237**	**91**
CHARSADA	292,671	207,314	71	292,671	18,569	6	292,671	74,117	25	292,671	-	0	292,671	110,635	38	292,671	149,473	51	292,671	217,467	74
LAKKIMRWT	130,361	137,664	106	130,361		0	130,361	142,791	110	130,361	146,246	112	130,361	144,960	111	130,361	146,228	112	130,361	140,156	108
MARDAN	397,814	307,016	77	397,814		0	397,814	228,506	57	397,814	354,017	89	397,814	-	0	397,814	301,028	76	397,814	323,626	81
NOWSHERA	221,521	246,636	111	221,521	201,530	91	221,521		0	221,521	249,803	113	221,521	257,468	116	221,521	254,997	115	221,521	240,100	108
PESHAWAR	772,771	681,897	88	772,771		0	772,771	724,029	94	772,771	102,005	13	772,771	748,079	97	772,771	749,099	97	772,771	735,888	95
PUNJAB	**3,193,607**	**3,514,247**	**110**	**3,193,607**	**779,864**	**24**	**3,193,607**	**2,796,032**	**88**	**3,193,607**	**815,981**	**26**	**3,193,607**	**3,474,111**	**109**	**3,193,607**	**3,484,937**	**109**	**3,193,607**	**3,475,382**	**109**
FAISALABAD	1,074,401	1,202,143	112	1,074,401	128,829	12	1,074,401	930,131	87	1,074,401	140,479	13	1,074,401	1,231,747	115	1,074,401	1,233,921	115	1,074,401	1,230,574	115
LAHORE	1,415,308	1,572,384	111	1,415,308	363,933	26	1,415,308	1,506,823	106	1,415,308	387,725	27	1,415,308	1,508,609	107	1,415,308	1,514,381	107	1,415,308	1,513,646	107
RAWALPINDI	703,898	739,720	105	703,898	287,102	41	703,898	359,078	51	703,898	287,777	41	703,898	733,755	104	703,898	736,635	105	703,898	731,162	104
SINDH	**782,544**	**333,878**	**43**	**782,544**		**0**	**782,544**	**348,560**	**45**	**782,544**	**100,346**	**13**	**782,544**	**582,214**	**74**	**782,544**	**457,994**	**59**	**782,544**	**538,017**	**69**
HYDERABAD	285,664	197,430	69	285,664		0	285,664	126,962	44	285,664	100,346	35	285,664	309,299	108	285,664	304,632	107	285,664	293,015	103
KHIBALDIA	111,463	14,640	13	111,463		0	111,463	126,602	114	111,463		0	111,463	91,970	83	111,463	105,101	94	111,463	78,180	70
KHIGADAP	218,421	70,819	32	218,421		0	218,421	19,189	9	218,421		0	218,421	84,332	39	218,421	-	0	218,421	74,334	34
KHIGIQBAL	166,996	50,989	31	166,996		0	166,996	75,807	45	166,996	-	0	166,996	96,613	58	166,996	48,261	29	166,996	92,488	55
Grand Total	**7,815,285**	**6,826,782**	**87**	**7,815,285**	**1,657,089**	**21**	**7,815,285**	**5,498,556**	**70**	**7,815,285**	**2,385,947**	**31**	**7,815,285**	**6,203,620**	**79**	**7,815,285**	**6,919,309**	**89**	**7,815,285**	**6,629,902**	**85**

Post campaign assessment (independent monitoring, Lot Quality Assurance Sampling - LQAS, market survey) could not be conducted for the December 2012 round and the first round in January 2013 (14-16). LQAS and market survey resumed (by WHO staff) since the second round of SIAs in January 2013 (28-30) under special arrangements by the DCs and provincial governments.

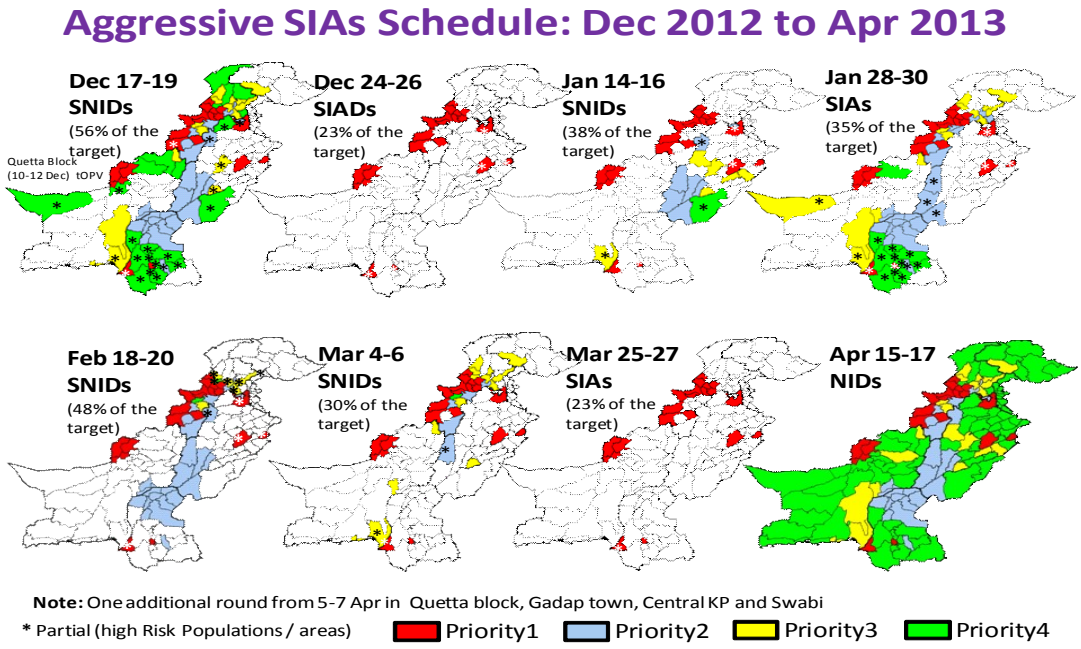
With reduced mass media presence on TV and radio, reservoir districts themselves determined the need for local visibility material. This material focused on child health and routine immunization without reference to any specific campaign. Informational and documentary

content on radio and TV was done in both Urdu and Pashto language versions with 100% of Pashto-language TV stations targeted and extensive use of local cable in the Quetta, Peshawar and Karachi reservoirs.

3. ***Short Interval Additional Dose strategy (SIADs)***

In continuation with the first three quarters of 2012, the SIAD strategy was extensively utilized in the last quarter of 2012 as well as in 2013 as one of the key strategies in the reservoirs and core endemic areas. The nation-wide round, planned in the first quarter of 2013 could not be conducted due to vaccine non-availability. Sub-national rounds were therefore planned in a way that SIADs are utilized where and whenever feasible. The two rounds of SIAs in December 2012 were planned a week apart; two rounds in January were planned two weeks apart; the single round in February and first round in March were planned two weeks apart - all following the SIAD approach. The Priority-1 districts were included in all the SIAs during the low season; hence the SIAD strategy was maximally utilized in these high risk areas. However, it is important to emphasize the inconsistent quality of vaccination during these SIAs in the Priority-1 districts.

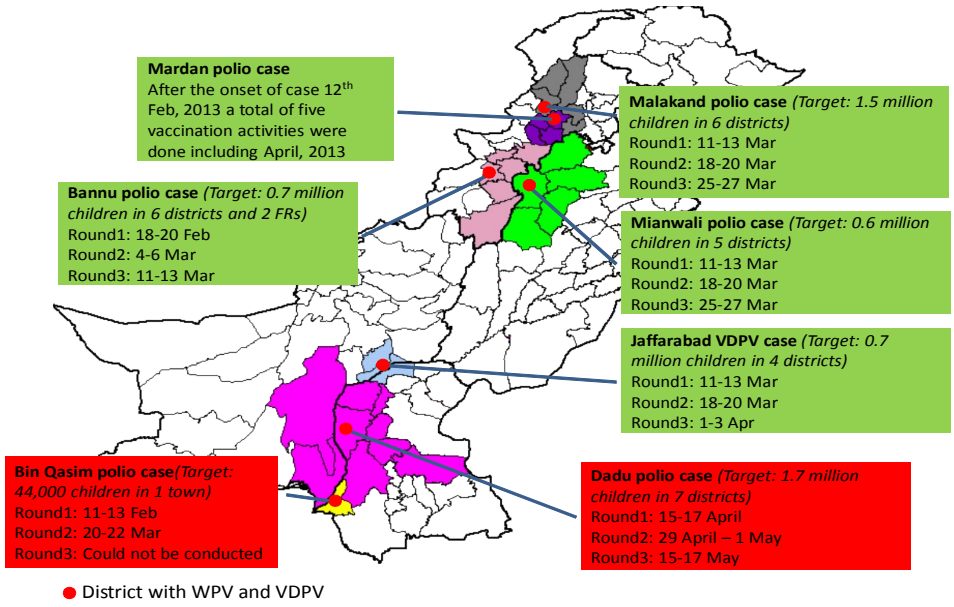
SIAs



during the low season (Dec. 2012-Apr. 2013)

As per recommendation of the Technical Expert Group in December 2012, an aggressive case response vaccination strategy is being followed utilizing the SIAD strategy *(see map below)*. All six polio cases reported so far in 2013 were responded to with three multi-district vaccination rounds within 4-6 weeks *(except for the Bin Qasim Karachi case, for which the third round could not be conducted due to security risks)*. This strategy was implemented in conjunction with the scheduled SIAs.

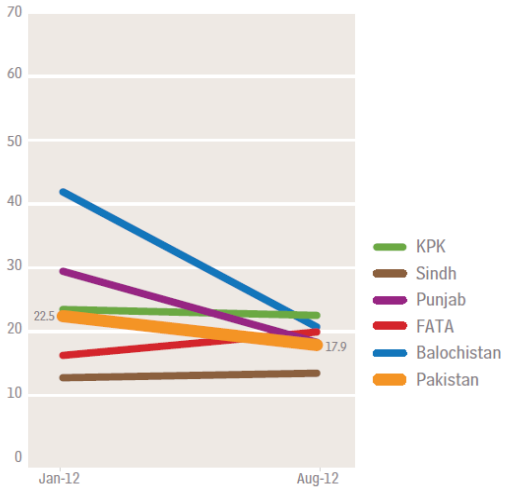
Case Response Vaccination Activities; 2013



While implementing SIADS, it has been a challenge to effectively explain to parents/community why the children should receive OPV several times a month or even a week. Data show that the already low parental concern about polio is dropping *(see figure below)*. Keeping levels of concern appropriately high, even as cases go down, will require even more sophisticated communication tactics to effectively implement the intensified SIA strategy (including SIADs)

FIGURE P5 | SOURCE: UNICEF-SUPPORTED KAP STUDIES, JANUARY AND AUGUST 2012

Share of caregivers in high-risk areas of Pakistan concerned that their child(ren) will contract Polio (%), 2012



4. ***Effectively reaching and vaccinating Pashtun populations (HR and transit strategies)***

Polio epidemiology across the country is driven by populations at highest risk of polio, including Pashtun populations. This is evident in the disproportionately large numbers of polio cases that have been reported among this population over many years. Pashtun populations are typically moving between neighboring and distant parts of the country and are often underserved, especially outside their native areas of Khyber Pakhtunkhwa, FATA and Balochistan. Surveillance data for polio cases and non-polio AFP cases indicate that these populations are more likely to be unvaccinated and under-vaccinated, which places them at higher risk of polio infection.

The Prime Minister's Polio Monitoring and Coordination Cell has developed and issued to the provinces for implementation a high risk population strategy. *It is important to mention that the majority of killings of polio workers happened in the Pashtun areas in Khyber Pakhtunkhwa and Karachi,aggravating sensitivities about mapping and tracking of these populations. However, key areas outside Khyber Pakhtunkhwa, FATA and Balochistan that also have substantial Pashtun populations were targeted multiple times during the low transmission season as part of the intensified SIAs strategy. These included the large urban areas of Lahore, Rawalpindi, Faisalabad, Hyderabad, which each had five SIAs rounds, and selected towns of Karachi other than Gadap (4 SIAs). It is of note that despite the difficult situation, Gadap (and its UC-4) conducted 3 SIAs (although with inconsistent coverage) during January-March 2013.*

Various innovative approaches were adopted to effectively reach and vaccinate children of high risk populations; particularly Pashtuns outside Khyber Pakhtunkhwa, FATA and Balochistan. Some of the key innovative approaches included:

1. Jirga (community meetings) with key influencers in the Pashtun settlements with an aim to empower influencers to spearhead polio eradication activities in their settlements/villages
2. Inclusion of Pashtun leaders and influencers in the UC Polio Eradication Committees (UPEC) to involve them in SIAs planning; special focus on creating language and culturally appropriate vaccination teams
3. Deployment of Pashtun university students (for example from Lahore) during SIAs to strengthen supervision and monitoring in Pashtun settlements. These students were paid incentives by the DCs
4. Special arrangements of covering Pashtun populations on first day of the SIAs by moving all the Pashto speaking vaccination teams to Pashtun settlements and intensifying supervision
5. Special visits of the Area In-Charges (first level supervisor of vaccination teams) and other UPEC members to Pashtun settlements on 2nd and 3rd days of the SIAs during the evening time to catch up the missed children
6. A total of 217 transit posts were established across the country to catch the children on the move (including the ones from migrant/mobile, Pashtun populations) and permanent vaccination teams vaccinated 825,109 children from January to March 2013.

5. ***Effectively tracking and vaccinating missed children (not available and refusals)***

The NEAP 2013 advises the districts' polio control rooms to track and vaccinate missed children through the Union Council Polio Eradication Committees for at least two weeks after SIAs. The key modalities in the NEAP 2013 to be implemented at the UC level include:

- The list of still missed (unvaccinated) children due to any reason (non-availability, refusal or any other) should be available at all relevant government health facilities after the campaign.
- The EPI staff of health facilities should continue tracking missed children for at least two weeks after every campaign.
- A report should be sent from each UC to the district control room on a weekly basis (for at least two weeks) indicating the coverage of those reached after the campaign and those that still remain missed.
- The health staff, including the EPI staff, Lady Health Workers (LHWs) etc, should carry a copy of the list of missed children during field visits and track and vaccinate missed children.
- The UPEC, in its meeting for the subsequent SIAs, should review the tracking and vaccination of remaining missed children from the previous campaign.
- The UC Medical Officer must conduct detailed analysis with the assistance of partners' staff at UC level (where available) on the reasons for remaining missed children. The analysis needs to be done thoroughly and sub-reasons (for non availability and refusals) need to be explored and addressed.
- Clusters of refusals are to be addressed utilizing the standard operating procedures (SOPs) established in the NEAP 2013

There was increased tracking of not available children by polio control rooms and UPECs. *The table below illustrates the number of children reported to be missed at the end of SIAs and the number that could be tracked and vaccinated before the next SIAs. The application of the NEAP 2013 tracking mechanism for missed children is still variable and needs consistent implementation.*

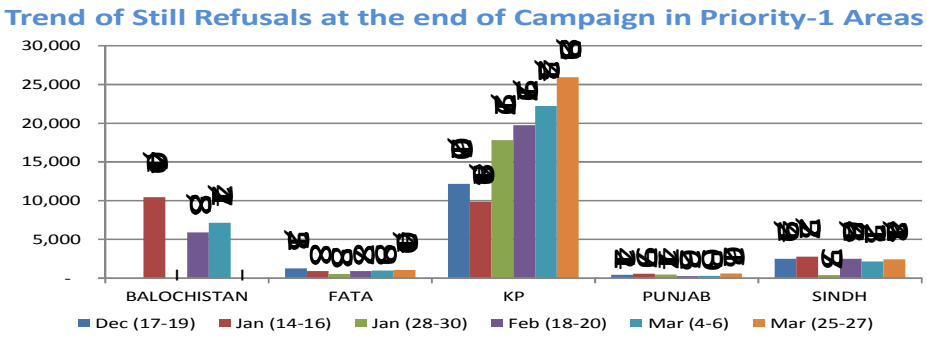
Missed Children Tracking for Vaccination Activities; 2013

Province	A					B					C				
	No. Still missed children at the end of campaign					No. of Still missed children covered during 2 weeks after the campaign					No. of Remaining Still missed children 2 weeks after the campaign				
	Jan (14-16)	Jan (28-30)	Feb (18-20)	Mar (4-6)	Mar (25-27)	Jan (14-16)	Jan (28-30)	Feb (18-20)	Mar (4-6)	Mar (25-27)	Jan (14-16)	Jan (28-30)	Feb (18-20)	Mar (4-6)	Mar (25-27)
Priority-1	16,556	*	8,496	12,260	*	11,251	*	6,866	4,184	*	5,305	*	1,630	8,076	*
Total Balochistan	**16,785**	**2,575**	**9,757**	**13,996**	*	**11,251**	**748**	**7,176**	**12,184**	*	**5,534**	**1,827**	**2,581**	**1,812**	*
Priority-1	13,630	13,555	14,278	12,893	15,282	^	1,451	538	641	1,160	13,630	12,104	13,740	12,252	14,122
Total FATA	**13,630**	**13,555**	**14,278**	**12,893**	**15,282**	^	**1,451**	**538**	**641**	**1,160**	**13,630**	**12,104**	**13,740**	**12,252**	**14,122**
Priority-1	43,919	56,285	56,990	71,013	78,249	6,035	15,054	5,181	5,736	36	37,884	41,231	51,809	65,277	78,213
Total KP	**43,919**	**111,270**	**93,691**	**103,527**	**78,249**	**6,035**	**16,998**	**6,696**	**5,736**	**423**	**37,884**	**94,272**	**86,995**	**97,791**	**77,826**
Priority-1	39,759	38,807	34,455	34,690	41,441	^	^	22,309	20,779	12,478	39,759	38,807	12,146	13,911	28,963
Total Punjab	**84,503**	**47,189**	**58,474**	**37,595**	**41,441**	^	^	**36,400**	**21,200**	**12,478**	**84,503**	**47,189**	**22,074**	**16,395**	**28,963**
Priority-1	15,540	2,118	14,384	9,587	12,148	3,168	1,434	6,528	3,047	2,220	12,372	684	7,856	6,540	9,928
Total Sindh	**37,887**	**36,487**	**53,568**	**27,529**	**23,667**	**4,100**	**22,077**	**17,319**	**8,399**	**1,644**	**33,787**	**14,410**	**36,249**	**19,130**	**22,023**

* Campaign not conducted ^ Data not available

It is important to mention that missed children tracking after the completion of SIAs is affected by the availability of security providing personnel from the police and other law enforcement departments. Unavailability or smaller number of the escorting policemen adversely affects the missed children tracking, in particular in Khyber Pakhtunkhwa and Karachi where the teams are not allowed in the field by the DCs without security personnel. Moreover, the districts (example: Mardan, Peshawar, Charsadda) and towns (example: Gadap) that conduct campaigns in a staggered manner also find it complex to track the missed children since the SIAs are conducted in a phased way over an extended time-frame (up to 8-10 days), complicating logistics of tracking missed children before the next planned SIAs.

The proportion of reported missed children due to refusal of the family/parents remained above 5% in the key Priority-1 areas of Khyber Pakhtunkhwa, Quetta Block (Balochistan) and Karachi. In both Karachi and Khyber Pakhtunkhwa, 33% of missed children in the March SIAs were due to refusal; in Balochistan, the rate was 58%. The graph below indicates a significant increase in the number of missed children due to refusal of family/parents in Priority-1 districts of Khyber Pakhtunkhwa. Between December 2012 and March 2013, the number almost doubled. Similarly, high numbers of refusals were reported from Priority-1 districts of Balochistan (Quetta Block) and Sindh (Gadap, Gulshan-e-Iqbal and Baldia towns, Karachi and Hyderabad district).



It is important to mention that persistent clusters of refusals (particularly in insecure and inaccessible areas) create pockets of susceptibility that can contribute to virus circulation, especially in Khyber Pakhtunkhwa and Balochistan. The high-risk districts of Khyber Pakhtunkhwa show a rise in refusals, and particularly a rise in religious refusals since October. Where appropriate influencers accompany teams, refusal conversion rates are higher. But overall, refusal conversion is low and has been significantly affected by the deteriorating security situation. The role of social mobilization to build the right kind of linkages with communities, and open doors to the right influencers and households, is critical. However, there is a need to establish a secure environment for polio workers including social mobilizers to carry out the proposed social mobilization activities satisfactorily.

The three central districts of Khyber Pakhtunkhwa (Peshawar, Mardan, Nowshera) have shown a rising trend in refusals since October 2012. The increasing number of refusals was linked to religious reasons, repeated campaigns, and preferences for other services. One of the three polio cases in Khyber Pakhtunkhwa this year is from a refusal family. The district Lakki Marwat in the south of Khyber Pakhtunkhwa has also shown an alarming increase in the number of refusals this year. Particular attention is being paid to address this disconcerting situation and rapidly reverse this trend.

There is a need to further investigate caregiver refusal at the UC level, to better understand the underlying reasons and devise appropriate strategies. Partners' support at the UC level has also been expanded to critical districts of southern Khyber Pakhtunkhwa in view of their risk profile, with strategic deployment of UC polio workers (WHO) and UC communication officers (UNICEF).

B. **Mile Stones; Pakistan National Emergency Action plan 2013**

	Milestones	**Status**	**Comments on progress**
1	Emergency Plan for 2013 is rolled out and the Government machinery and all the key stake holders are well aware of the plan (by January)	2013 NEAP has been developed and distributed to all districts in the country	Achieved. A revised version of NEAP with security operational guidelines was issued in February.
2	Integrated micro-plans are developed and available in all the high risk UCs of the	High risk UCs of wild poliovirus reservoir areas of Karachi, Hyderabad, Peshawar and Quetta Block have been revised and field validated during first quarter of 2013.	Partially achieved. Variability remains in quality of micro-plans and revision training have not yet happened in FATA, Rawalpindi, Lahore and Faisalabad. *Moreover, the quality of implementation of the validated micro-plans remains suboptimal in Khyber Pakhtunkhwa and Karachi since vaccination teams' movement is associated with availability of security*

	country (by January)		*providing personnel (policemen etc.) and any shortage of such personnel adversely affects the implementation of micro-plans. Nomination of UC Medical Officers in all the high risk UCs of Khyber Pakhtunkhwa is in process.*
3	Appropriately composed and functional UPECs in place in all the high risk UCs (by January)	All high risk UCs have functioning UPECs *(Reported control room data indicates 89% of all the UCs conducted UPEC meetings before April 2013 NIDs - 85% in Balochistan, 77% in KP, 100% in Punjab, and 95% in Sindh).*	Partially achieved. The quality of composition and functioning of UPECs varies.
4	Comprehensive operational plans for high risk populations rolled out across the country (by	A National Strategy for High Risk Populations has been developed and distributed. All high risk areas have operational plans including nomads, minorities and marginal populations approved by UPECs	Partially achieved. The quality of operational plans and their implementation varies from district to district (and also remains variable at the UC level).

	January)		
5	90% or more lots assessed through LQAS in key areas of Punjab (Lahore, Faisalabad and Rawalpindi) pass for 95% coverage threshold (January onwards)	Jan (14-16) = Not assessed Jan (28-30) = 83% Feb (18-20) = 95% Mar (4-6) = 100% Mar (25-27) = 92%	Achieved since February 2013
6	Minimum 90% of the lots assessed through LQAS in greater Peshawar region	Jan (14-16) = Not assessed Jan (28-30) = 69% Feb (18-20) = 71% Mar (4-6) = 77% Mar (25-27) = 67%	Not achieved

	pass for 95% coverage threshold (January onwards)		
7	DDM fully implemented in all the provinces and regions (by January)	*Sindh*: DDM fully implemented in all districts and towns *Punjab*: DDM fully implemented in all districts *Islamabad (ICT & CDA)*: DDM fully implemented *KP*: DDM fully implemented in 13 out of 25 districts. *Balochistan*: DDM fully implemented in four districts (out of 30 districts). A fifth district (Quetta) will be ready to pay through DDM once frontline teams data are available. *AJK/FATA*: DDM fully implemented in one district (Sudnuti, AJK), out of 24	Achieved. The introduction of the direct disbursement mechanism (DDM), which enables vaccinators to receive payments directly to their bank account or mobile phone, was delayed in some areas due to reduced campaign activity (resulting from increasing security risks). Payment is effected in different ways: • In cash over counter (MCB Bank) • Numeric cards or mobile phones (UBL/Omni) • bank transfer (directly to beneficiary account) • cash is delivered at the beneficiary door step by the post office. Districts that were not able to conduct campaign due to insecurity are also trained and equipped with DDM software to enable them roll-out the system as soon as the first activity takes place; cards are distributed nationwide.
8	Provincial and District Vaccine Managem	Provincial Vaccine Management Committees have been established; limited progress achieved in establishing District Vaccine Management Committees. Provincial level committees are not yet	Partially achieved - still in process

	ent Committees are established, which meet regularly and gather information on vaccine stocks and utilization (from January)	meeting regularly and not providing regular information about vaccine stocks and utilization	
9	Minimum of 90% children are accessible in each tribal agency and FR area of FATA (by March)	Accessibility for FATA is 80% 5 agencies and 5 FRs have minimum of 90% children accessible.	Partially achieved
10	Minimum 90% of	Jan (14-16) = Not assessed Jan (28-30) = Not assessed Feb (18-20) = 0%;	Not achieved

	the lots assessed through LQAS in Quetta Block are passed for 95% threshold (March onwards)	Mar (4-6) = 0% Mar (25-27) = Not assessed	
11	Market survey results in all the tribal agencies of FATA are more than 95% coverage (by March)	Jan (14-16) = Not assessed Jan (28-30) = 93% (4 out of 5 agencies achieved) Feb (18-20) = 94% (3 out of 4 agencies achieved) Mar (4-6) = 94% (4 out of 5 agencies achieved) Mar (25-27) = 94% (3 out of 6 agencies achieved)	Partially achieved, with overall market survey results almost reaching 95% in March. Market survey could not be conducted in FR areas mainly due to insecurity.
12	Minimum 90% of the lots assessed through LQAS in	Jan (14-16) = Not assessed Jan (28-30) = 100% Feb (18-20) = * Mar (4-6) = * Mar (25-27) = 100% ** No lot taken in Pashtun populations outside KP, FATA and Balochistan (data taken for Rawalpindi)*	Partially achieved. Unable to conduct LQAS specifically focusing on Pashtun areas due to sensitivity after the December killings of polio workers. However, since March SIAs, some areas conducted LQAS and had > 90%

<table>
<tr><td></td><td>Pashtun populations outside Khyber Pakhtunkhwa, FATA and Balochistan, pass for 95% coverage threshold (March onwards)</td><td colspan="2"></td><td>LQAS reach the 95% threshold</td></tr>
<tr><td>13</td><td colspan="2">Refusals in KP, FATA, Quetta Block and Karachi are <5% of missed children (intra-campaign and post campaign) (by March)</td><td>Refusals among still missed children at the end of SIAs
<table><tr><th>Province / region</th><th>Jan (14-16)</th><th>Jan (28-30)</th><th>Feb (18-20)</th><th>Mar (4-6)</th></tr><tr><td>KP</td><td>22%</td><td>25%</td><td>35%</td><td>27%</td></tr><tr><td>FATA</td><td>7%</td><td>4%</td><td>6%</td><td></td></tr><tr><td>Q.Block</td><td>63%</td><td>*</td><td>69%</td><td>58%</td></tr><tr><td>Karachi</td><td>29%</td><td>*</td><td>42%</td><td>48%</td></tr></table>* Not conducted</td><td>Not achieved. Due to the security incidents, refusal have increased in certain key areas. Efforts are ongoing to reverse this trend.</td></tr>
<tr><td>14</td><td>Stop cVDPV2 circulation in the country (by March)</td><td colspan="2">The last cVDPV2 case had onset of paralysis on 21st February (Gadap, Karachi)</td><td>It is too early to tell if the circulation has been completely interrupted.</td></tr>
</table>

C. Points made in regard of Pakistan in last IMB report (November 2012)

Comments made by IMB in November 2012	Comment on current status
Proposal made to double the pay of frontline workers in January – this must happen (in Khyber Pakhtunkhwa, KP)	*Additional funds to pay for the increase in payment to frontline staff have been allocated by the provincial government in Khyber Pakhtunkhwa but are still to be disbursed.*
Over 200,000 innocent children put in danger by anti-Government groups (in FATA)	More than 260,000 children in North and South Waziristan agencies of FATA remain un-reached (since late June 2012)
Surveillance gaps persist	• National and provincial levels achieved the target for key surveillance indicators during 2012 and 2013 so far; except FATA (73% AFP cases in 2012 and 54% in 2013 had adequate specimens) • 63% (99/157) districts/towns/agencies have non-polio AFP rate (annualized) of 2 or above in 2013 (88% in 2012) • 83% (101/121) districts/towns/agencies had 80% or more AFP cases with adequate specimens (80% in 2012) • An overall drop in AFP cases is noted (NP AFP rate 6.3 compared to 7.2 in 2011; annualized AFP rate is 3.9 in 2013 so far). • Significant drop in AFP case reporting was seen in Balochistan (42%) and FATA (34%) in year 2012 compared to 2011. *It is important to mention that there were explosive polio outbreaks in both these regions in 2011.* • The proportion of long chain (orphan) viruses has decreased from 28% in 2009 to 9% in 2012 (no long chain virus in 2013 so far). • Detailed district level analysis is underway to identify the districts with problems and to make subsequent interventions

Election disruption a massive concern	The general election, due to be held 11th May, so far has had minimal negative impact on polio campaign performance. This has mainly been due to the strong commitment of the President of Pakistan and the interim caretaker government, which has ensured continuity of polio eradication efforts through the transition period. With elections expected in 2013, an All Parties Conference was held in mid-December, 2012 with attendance of 14 mainstream political parties at senior level. Party representatives signed a declaration to pledge their commitment to continue polio eradication at an accelerated level, regardless of the political leadership outcome of the elections. In 2013, this was followed by party briefings and technical support offered for party manifesto writers. Subsequent media coverage and upcoming advocacy will further extend this momentum through the election and transition phase. Only limited vaccination activities will take place during the month of May and parts of June to ensure there is little disruption during the potentially volatile period leading to and following the election of a new government.