



NATIONAL EMERGENCY ACTION PLAN 2013

For Polio Eradication



Government of Islamic Republic of Pakistan



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Foreword

Pakistan has made progress towards achieving the goal of polio eradication over the last year. This has been possible only with the support and impressive efforts of Provincial Governments, and the commendable endeavors of the Deputy Commissioners/District Coordination Officers and Political Agents.

On 18th December, the Honourable Prime Minister of Pakistan chaired a meeting of the National Task Force on Polio Eradication attended by the Chief Ministers, Governor Khyber Pakhtunkhwa & FATA and Prime Minister Azad Jammu & Kashmir. The meeting reviewed the lessons learnt during 2012 and endorsed the National Emergency Action Plan (NEAP) for Polio Eradication in 2013.

It is important to mention that the NEAP 2013 was developed after a thorough consultative process that involved the Provincial Governments, the partner organizations, international experts, independent academia, political and religious advocates. The plan was also reviewed by a technical expert group together with the provincial health departments before it was endorsed by the National Task Force. The document details the strategies to be implemented during 2013; a number of which are the continuation of 2012 strategies with more emphasis while there are some new strategies to improve the program interventions and reach to more and more children with polio vaccine.

The goal of NEAP 2013, is to interrupt transmission of wild polio virus in Pakistan by December, can only be achieved if all the strategies outlined in the plan are rigorously implemented with special focus during low transmission season in the first half of the year. Meaningful oversight and accountability at the UC level is one of the major areas that the program needs to be improved to have a real impact if practiced adequately.

Currently, the country is poised at a juncture where quality of polio eradication activities in the first half of 2013 can be a matter of 'make or break'. The program counts on the Provincial Administrative and Political Leadership, headship of the DCs/DCOs/PAs, supervision and monitoring of UC Medical Officers and last but not the least the motivation of the 'Frontline Workers' to expedite the march and make 2013 the last year of polio in Pakistan.

Towards the end of 2012, the security incidents affecting the polio eradication workers constitute an additional challenge for the program. Sound security plans will have to be ensured in 2013 at the district and UC levels, in addition to operational and communications plans; to enable vaccination teams reach every child. Loosing is not an option and we have to win to make sure our generations to come are free of the danger of the lifelong disability due to polio.

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A Executive Summary

Polio Eradication is a priority programme for the country. National emergency has been declared by the Government of Pakistan to interrupt polio transmission and achieve the goal of eradication.

The National Emergency Action Plan (NEAP) for Polio Eradication was developed and approved in 2011 by the Prime Minister of Pakistan along with all the Chief Ministers, Governor Khyber Pakhtunkhwa and the Prime Minister AJK in 2011 and subsequently launched by the President of Pakistan.

Based on the lessons learnt, the plan was augmented for 2012 with focus on enhancement in the oversight at the national, provincial and district levels. The Augmented NEAP 2012 has generally been instrumental in bringing a programmatic paradigm shift from traditionally being the sole responsibility of the department of health to being the responsibility of the District/Agency administration for the polio eradication activities at the district and UC level. Another major development was to achieve enhanced programmatic focus at the UC level. There is now an utmost need to translate the provincial and district level high commitment into meaningful accountability at the UC level.

Towards the end of 2012, the security incidents affecting the polio eradication workers constitute an additional challenge for the program. Sound security plans will have to be ensured in 2013 at the district and UC levels, in addition to operational and communications plans; to enable vaccination teams reach every child.

Review of the Augmented NEAP 2012:

A critical review of the Augmented NEAP 2012 was initiated in the last quarter of 2012. The Prime Minister's Polio Monitoring and Coordination Cell in collaboration with WHO and UNICEF held a special consultation meeting in November 2012 to appraise the impact of the Augmented NEAP 2012 implementation with special focus on polio reservoirs and outbreak areas. The Government of Pakistan, Provincial Governments, partners, international experts on polio, independent academia as well as political and religious advocates participated in the consultation. Key strategies and actions for improving implementation of the NEAP were identified and utilized to develop reservoir specific work plans for 2013. The additional strategies for the NEAP 2013 detailed in this plan should be implemented in conjunction with existing NEAP strategies, which remain in force.

This 2013 revision of the NEAP builds upon the experiences and lessons learnt from implementing the 2012 plan, with a renewed sense of urgency to interrupt polio transmission in the first six months of 2013.

The Goal of the National Emergency Action Plan 2013:

To interrupt transmission of wild polio virus in Pakistan by December 2013, focusing on first six months low transmission season of the year

Elements of the NEAP:

Key elements of the NEAP 2013 and salient strategies are described in this document, some of which are enhancement of strategies already included in the NEAP 2012, and some of which are new approaches.



The following are the key elements of the Augmented NEAP 2012 that remain valid and in force:

- Polio is a national emergency that must be urgently addressed by ensuring that all arms of Government are engaged in eradicating polio
- Oversight at the national level will be through the National Task Force headed by the Prime Minister. ***There will be a full time Senior Government Official (Additional Secretary level) designated in the Prime Minister's Polio Monitoring and Coordination Cell to oversee the implementation of the NEAP 2013. The Prime Minister's Focal Person for Polio Eradication will continue to lead program's coordination*** with the office of the Prime Minister, President, and other relevant Ministries at the federal level.
- Oversight at the district level through DPEC headed by the DC/DCO/PA and provincial level through Provincial Task Force headed by the Chief Secretary
- Highest emphasis to implement activities at UC level
- Concentrating efforts on highest risk areas and populations and ensuring that all children in these areas are reached with polio vaccine every immunization round, by the implementation of innovative strategies and partnerships where necessary.
- Implementing a broad ranging communications programme to engage communities and build demand for immunization at household level.
- Closely monitoring the quality of programme performance to identify problems, and to design specific actions to address them

New elements and special emphasis in NEAP 2013:

Special emphasis on polio reservoirs that includes development of individual integrated reservoir action plans that includes the aspects of operations, communications and security. There will be jointly agreed accountability mechanisms for these plans at the DPEC and UPEC levels. New elements in NEAP 2013 are:

- Tracking of missed children with special focus on clusters. Analysis will be conducted to determine underlying causes and sources of the causes to be addressed through appropriate and targeted strategies. The analysis and the actions will be disaggregated down to the UC level.
- Fully implementing Short Interval Additional Dose Strategy (SIADs) where appropriate to more rapidly boost population immunity levels in key areas
- Implementing Special strategies targeting Pashtun, migrant and transit populations
 - o Focus on implementing Pashtun population strategies nationwide to map, track and reach these populations consistently and effectively
 - o Strengthening the Transit Strategy to ensure all the children on the move are identified and vaccinated against polio
 - o Devise and strengthen strategies to ensure that all children in the migrant communities are reached optimally throughout the country
- Ensuring effective polio control/operations rooms at provincial level and district/agencies/town level



- Strengthening monitoring and evaluation mechanisms
- Focusing on high risk UCs will be the focus for implementation of all new strategies (including Polio Plus for selective communities/areas) that improve quality of operations, communications and data.
- Strengthening partnerships at all levels to ensure every child is reached in FATA
- Enforcing Zero tolerance for data misreporting/hiding and financial misappropriations
- Implementing Direct Disbursement Mechanism (DDM)
- Strengthening cross border coordination with Afghanistan
- Improving vaccine management at provincial, district and sub-district levels to ensure efficient utilization of this important resource
- Optimizing the polio eradication operations for strengthening routine immunization
- Ensuring safety and security of the polio eradication workers will be critical to keep their confidence and hence the performance

Reviewing implementation status of NEAP:

The implementation status of the NEAP 2013 will be reviewed by:

- The Prime Minister's Task Force for Polio Eradication every three months
- Provincial Task Forces chaired by the Chief Secretaries (Additional Chief Secretary in FATA) to review the performance for every SIAs (preparation and results) and report to the Chief Ministers (Governor for FATA)
- DPECs headed by the DCOs/DC/PA and report to respective Commissioners and Provincial Task Force
- The district polio control/operations rooms situated in the DC/DCO/PA offices will be responsible for overseeing the NEAP implementation and quality of the polio eradication activities at the district and UC levels. All the polio partners will work as 'ONE TEAM' under the flag of District control room under the leadership of DC/DCO/PA.
- The provincial control room will be established at the Chief Secretary's office led by a senior officer (Additional Secretary level) and technically supported by the Provincial Technical Focal Person for NEAP and technical polio partners.
- The National Control Room led by the Prime Minister's Polio Monitoring and Coordination Cell, with technical assistance of WHO, UNICEF and other key polio partners, will oversee the program at the national level.



B Context

i. Progress in 2012 and development of the NEAP 2013

Pakistan after remaining in a continued outbreak situation from 2008 to 2011 has demonstrated progress in 2012. **There has been almost 70% decrease in the number of polio cases in 2012 as compared to 2011.** This progress can substantially be attributed to the augmentation of National Emergency Action Plan towards the end of 2011 and its effective implementation in 2012. **The hallmark of 2012 has been the impressive leadership from the Prime Minister's and President's offices that translated effectively to the provincial and district levels and relatively less effectively at the UC level.** Key areas of concern like Karachi and Quetta block seem to have moved in the right direction. Likewise, accessibility in Khyber Agency in FATA also improved during the course of the year due to better civil military coordination. **It is however important to highlight that the situation in all the reservoir (and outbreak) areas remains fragile and requires solid and sustained progress to achieve interruption of wild polio virus transmission.**

In FATA, on one hand there seems to be an improvement in the access to children in Khyber Agency. On the other hand, a ban has been imposed on polio vaccination in South and North Waziristan Agencies rendering more than 260,000 children at risk. So far, children in these agencies have missed six OPV doses as compared to children from other parts of FATA and neighboring Khyber Pakhtunkhwa. There is also no significant progress towards the reversal of the ban so far.

In Khyber Pakhtunkhwa there has been an outbreak since July 2012. The province has reported the highest number of polio cases during the last four months (as of end November) compared to rest of the country. The area of central Khyber Pakhtunkhwa is of particular concern as it demonstrates persistent presence of wild polio virus as detected by Acute Flaccid Paralysis (AFP) and environmental surveillance.

Quetta Block (Quetta, Pishin and Killa Abdullah) demonstrated some improvement in performance but it has been very inconsistent, thus putting the block at a constant risk. Failure of management and accountability at district and UC levels is still leading to programme failures including **a)** deployment of inadequate numbers of vaccination teams, **b)** inappropriate selection and poor training of vaccinators, **c)** misuse of transportation support provided for teams and supervisors, and **d)** poor accountability for sub-optimal performance. Despite high commitment of the provincial administrative leadership, interventions at the district and sub-district levels and accountability have been weak and leading to inconsistent performance. It is pertinent that there is an ongoing intense viral circulation in adjoining areas of southern Afghanistan that has frequent and ongoing population movement with Quetta Block. The recently detected cVDPV2 has made the situation even more complex in this region.

Gadap Town, Karachi exhibited some progress after the innovative initiative of permanent female volunteer teams in April 2012. However, the situation has become volatile since July 2012 when serious security incidents created a sense of insecurity among the front-line workers and prevented the polio partners' staff from visiting some areas including the reservoir UC-4 Gadap Town. The district administration however, demonstrated high commitment and strong leadership that enabled the program to continue conducting SIAs amid this security compromised environment.



High risk districts and UCs other than the reservoir areas also received special focus during the SIAs. This is in view of the fact that there are ongoing large scale population movements between the polio reservoirs areas and other non-high risk areas of the country.

The Government of Pakistan through the Prime Minister's Polio Monitoring and Coordination Cell and together with its partners critically reviewed the implementation of the Augmented National Emergency Action Plan and appraised all its components to draw the lessons learnt and formulate the plan for 2013. The review and planning process included participation of Provincial Governments, WHO, UNICEF, Rotary International, the Bill & Melinda Gates Foundation and other partners. Consultations were also made with independent academia, political and religious advocates. Progress against the NEAP 2012 was appraised and key strategies and actions for an improved National Plan for 2013 were identified, intended to significantly improve accountability and implementation. The process of review and planning comprised of a special consultation meeting attended by all the key stakeholders and polio partners along with international experts on polio eradication. Working groups in the consultation came up with key challenges, strategies to overcome those challenges and specific work plans with focus on the polio reservoirs and outbreak areas. The consultation was followed by provincial follow up strategy sessions supported by the representatives from the national level. This document incorporates ***the key new strategies and special emphases of the National Emergency Action Plan for Polio Eradication in 2013. The key strategies outlined in Augmented NEAP 2012 remain in force.***

ii. Current Epidemiology

A total of 58 polio cases were reported from Pakistan in 2012, compared to 198 polio cases in 2011. All but three wild polio cases were due to wild poliovirus type-1 (WPV1). The epidemiological patterns in 2012 are summarized below:

- Though Karachi did not report any wild polio case in 2012, there was persistent isolation of WPV in the sewage samples collected from the three high risk towns of Karachi, particularly Gadap Town.
- No wild polio cases were reported from Killa Abdullah and Pishin districts in 2012 (three polio cases were reported from Quetta district). Moreover, the environmental samples collected in Quetta from February through November 2012 were also negative for wild polioviruses. The positive environmental sample in November 2012 was a new introduction from Gadap Town, Karachi. Moreover, there was an outbreak of cVDPV in Quetta Block with its epicenter in Killa Abdullah district.
- There was a 66% decrease in the number of polio cases reported from FATA compared with 2011. Khyber Agency has reported 11 polio cases compared to 25 in 2011; the last case had onset of paralysis in October 2012. Bara tehsil of Khyber Agency was the only place in the country (and entire Asian continent) that had type-3 polio reported in 2012, with the last type-3 polio having an onset of paralysis in April 2012. No environmental samples in Pakistan identified WPV3 in 2011 and 2012.
- There was an upsurge in the number of polio case in Khyber Pakhtunkhwa since July 2012. The province reported 27 polio cases (from 13 districts) in 2012 that constitute 47% of the cases reported nationally. During the last four months of 2012, Khyber Pakhtunkhwa reported 12 (60%) polio cases (from 8 districts) among the total 20 cases reported nationally. The reasons for this outbreak in Khyber Pakhtunkhwa are gaps in migrant and mobile population



strategies, continued transmission in central Khyber Pakhtunkhwa region and persistent pockets of missed children. Moreover, the province did not conduct the additional vaccination passages during the low transmission season in the first four months of 2012.

- The major risks for continued transmission in FATA and Khyber Pakhtunkhwa was primarily because of insecurity resulting in compromised access to children, gaps in adequately implementing the transit and migrant strategies, persistent pockets of refusals and not tracking and reaching the missed children after every SIA.
- The highly mobile populations and poorly covered areas constitute the greatest risk of re-introduction of WPV and further spread of the ongoing local transmission.
- The program expanded environmental surveillance to 11 cities and towns in 2012. This helped in better understanding the virus transmission patterns and tailoring appropriate strategies to interrupt it.
 - There was significant decrease in the proportion of positive environmental samples compared to 2011. In 2012, 88/236 (37%) samples had wild poliovirus isolated compared to 136/205 (66%) in 2011.
 - There was evidence of reduction in isolation of “indigenous” viruses from a number of sites (Quetta, multiple sites in Punjab, Baldia, and Gulshan e Iqbal), while few sites continue to show persistent transmission (Gadap, Peshawar, and Hyderabad)
 - Until late November, all environmental samples from Quetta collected from February 2012 were negative for WPV. Since November, one out of the three sites produced two positive samples for WPV1. However, genetic analysis of the virus has shown that viruses were new introductions from Gadap Town, Karachi.
 - Although samples from all sites across the Punjab province (Multan, Lahore, and Rawalpindi) produced positive results; contrary to previous trend, there was no isolation of “indigenous” virus from any sites since August 2012. During this time, all viruses isolated are closely related either to cases from KP, or to environmental samples from Peshawar, Gadap Town, Gulshan-e-Iqbal Town or Hyderabad.
 - While consecutive samples from Sukkur (Sindh) during the last quarter of 2012 were negative for WPV, samples from Hyderabad persistently produced positive samples signifying local transmission. It is pertinent to note that, Hyderabad did not have any security problems, and failure to achieve the required result was solely due to poor management and accountability of district health management team.
 - There was a remarkable decrease in a number of positive samples from Baldia and Gulshan-e-Iqbal Town, circulation of indigenous virus continues unabated in Gadap Town. Results from Baldia was remarkable with only one positive sample (linked to Lahore) during the entire 2012. Results from Gulshan-e-Iqbal was also promising with most of the few isolates being introductions from other sites.



- o Results from Gadap Town Karachi remain extremely alarming, especially in Sohrab Goth where security situation since June 2012 made it extremely difficult to reach children. Based on current data Gadap Town (and Peshawar) remain to be the key reservoir areas not only in sustaining the transmission, but to be the source of infections and circulation across the country.
- o Environmental samples from Peshawar, with exception of few occasional negative results, were persistently positive for WPV indigenous to KP and FATA, and were the origin of viruses isolated in other parts of the country. The outbreak in the second half of 2012 has clearly held back the country in its goal to further localize the circulation of the virus, and recent security incidents in central KP have created further serious challenges to interrupt the transmission.
- There was significant reduction in the genetic biodiversity in 2012. The total number of WPV-1 genetic clusters reduced from 11 in 2011 to 4 in 2012.

C Lessons Learnt in 2012

Overall the Augmented National Emergency Action Plan has been successful in achieving gains in several areas despite many obstacles. There has been an enhanced Government ownership at the highest levels and an increased commitment of the district level leadership. Federal and Provincial Governments have either allocated local financial resources to support polio vaccination campaigns or have pledged to do so. However, real meaningful and functional accountability is still lacking at the UC level.

The key operational lesson from 2012 is that optimally implemented vaccination rounds as per the SIADS in the low transmission season is the most effective strategy to rapidly boost the immunity profiles and reducing the viral circulation.

Experience from Gadap Town Karachi indicates that locally acceptable vaccination teams are ***the key to achieving better quality SIAs. Moreover, if the district administration demonstrates ownership and commitment, even the most severe challenges can be overcome at the district and UC level as proven by the district administration of Malir.***

Another lesson learnt during the course of 2012 was that the involvement and leadership of the provincial and district level Chief Executives (Chief Secretaries and DCs) is the key to effective implementation of quality activities. Moreover, the regular provincial and district level review meetings led by the Chief Secretaries, closely coordinated with the Prime Minister's Polio Monitoring and Coordination Cell have shown a real impact on the level of engagement of the district administration and in improving campaign quality.

Pakistan's Polio Eradication team also learned that the quality of SIAs is important, not just the numbers, and that every missed child must be tracked and vaccinated before the campaign is considered finished.



D Guiding principles for 2013

- Integrated action plans with operational, communication and security components for reservoirs, missed children & high risk populations
- Short Interval Additional Dose strategy (SIADs) is the key strategy across all reservoirs, high risk areas and outbreak areas
- Special strategies will be strengthened targeting Pashtun, migrant and transit populations
- All missed children to be tracked and vaccinated after each campaign
- Effective and integrated control rooms will be ensured at all levels
- Independent intra campaign monitoring will be introduced for all SIAs
- Zero tolerance for misreporting and financial misappropriation
- Direct Disbursement Mechanism (DDM) will be the only method for payment to front line workers

E The National Emergency Action Plan 2013

i. GOAL

The goal of the National Emergency Action Plan for Polio Eradication is to stop wild polio virus transmission throughout Pakistan by the end of 2013; focusing on the low transmission season during the first 6 months of the year

ii. MILESTONES

By January 2013

- Emergency Plan for 2013 is rolled out and the Government machinery and all the key stake holders are well aware of the plan (first week of January)
- Integrated micro-plans are developed and available in all the high risk UCs of the country
- Appropriately composed and functional UPECs in place in all the high risk UCs
- Comprehensive operational plans for high risk populations rolled out across the country
- 90% or more lots assessed through LQAS in key areas of Punjab (Lahore, Faisalabad and Rawalpindi) pass for 95% coverage threshold (January onwards)
- Minimum 90% of the lots assessed through LQAS in greater Peshawar region pass for 95% coverage threshold (January and onwards)
- DDM fully implemented in all the provinces and regions
- Provincial and District Vaccine Management Committees are established (which meet regularly and gather information on vaccine stocks and utilization)

By March 2013

- Minimum of 90% children are accessible in each tribal agency and FR area of FATA
- Minimum 90% of the lots assessed through LQAS in Quetta Block are passed for 95% threshold (March onwards)



- Market survey results in all the tribal agencies of FATA are more than 95% coverage
- Minimum 90% of the lots assessed through LQAS in Pashtun populations outside Khyber Pakhtunkhwa, FATA and Balochistan, pass for 95% coverage threshold (March onwards)
- Refusals in KP, FATA, Quetta Block and Karachi are <5% of missed children (intra-campaign and post campaign)
- Stop cVDPV2 circulation in the country

By June 2013

- Cessation of WPV3 circulation in all the provinces and regions

By October 2013

- Minimum 90% of all LQAS lots assessed nationally and in each province pass for 95% threshold for every SIA for October and onwards

By December 2013

- Stop circulation of all WPVs in the country

iii. OBJECTIVES

- a) Translate high level government oversight and ownership into meaningful accountability at district and UC levels;
- b) Ensure highest quality polio vaccination in the high risk Districts/Agencies, UC/Areas and priority populations (Pashtun) that suffer from persistent transmission of polio virus or recurrent re-introductions of polio virus through improved quality and innovative approaches;
- c) Ensure consistent access to all children in FATA.

iv. OVERSIGHT AND MANAGEMENT OF THE PROGRAM

Most of these are the key strategies of augmented NEAP 2012 that showed impact and will remain valid for 2013)

1. National management and oversight of the NEAP

- a) The Prime Minister's National Task Force is responsible for fast-tracking implementation of the National Emergency Action Plan.
- b) A senior Focal Person for polio eradication has already been appointed by the Prime Minister to oversee implementation of the Plan, who will keep liaising with the office of the Prime Minister, President, the Ministry of the Inter-provincial Coordination (IPC) and other relevant Ministries at the federal level. The Focal Person will continue providing an oversight to implementation of the Augmented NEAP and coordinate with the provinces on behalf of the Prime Minister. A senior full time officer will be designated by January 2013 and be responsible for coordinating between the PM Secretariat and secretariats of the Governors and Chief Secretaries, Provincial Task Forces (Steering Committees), and PEI partners. The Focal Person and the above mentioned senior officer will be members of the National Task Force, and will report directly to the Prime Minister on fortnightly basis.



- c) The Monitoring and Coordination Cell in the PM Secretariat will support the Prime Minister's Focal Person and will be responsible for monitoring the NEAP indicators at all levels and for tracking effective implementation of the strategic decisions and guidance provided by the National Task Force and the National Technical Advisory Group. The Inter-provincial Coordination Ministry is currently coordinating the immunization program at federal level and maintains close collaboration with provincial health departments.

Progress against the NEAP indicators shall be communicated to the media and the general public after each SIA by the Prime Minister's designated national spokesperson. Progress against the NEAP indicators shall also be made available online through the Government's website for Polio Eradication in the shape of Provincial, District and UC-level "progress report cards" against the NEAP indicators for each SIA. The National Communication Technical Committee, led by the Prime Minister's Monitoring and Coordination Cell, with UNICEF, WHO and other partners represented, will report to the National Steering Committee on critical communication and social mobilization strategy and decisions.

- d) The National Steering Committee for Polio will meet fortnightly (chaired by Prime Minister's Focal Person for Polio Eradication or National Coordinator Prime Minister's Polio Monitoring and Coordination Cell) to review the program performance and implementation of NEAP 2013.

- e) The program will start preparing now for maintaining adequate oversight, management and accountability for polio eradication during the period around the National Elections in 2013. The current structures for polio eradication at the national and provincial/regional levels (PM's Polio Monitoring and Coordination Cell, National Control Room, Provincial Control Rooms etc.) will be institutionalized to ensure the polio eradication activities are not compromised during the time around National Elections. Moreover, the Prime Minister's Polio Monitoring and Coordination Cell will take necessary measures to ensure that all the political parties are on board for the national cause of polio eradication. An "All Parties Conference" was organized by the Prime Minister's Polio Monitoring and Coordination Cell on 19th December in collaboration with Pakistan Institute of Legislative Development and Transparency (PILDAT). The meeting was attended by the representatives of all the leading political parties of the country including the religious parties. It was the consensus that Polio Eradication is a national cause above all other interests and that all the political parties will thoroughly support polio eradication across the country. It was also agreed that all the political parties will include in their manifesto a common formulation on polio free Pakistan that will have no conflict of opinions. Representatives of all the political parties signed a joined declaration resolving their support for polio eradication (please see annex). The international polio partners and civil society organizations will play their roles to engage the interim Government for carrying on the polio eradication activities with the same thrust during the critical first half of the year.

- f) The Polio Control Room will be functional and streamlined at the national level within the Polio Monitoring and Coordination Cell to receive the collated reported (administrative) data during pre-campaign preparation and the campaign implementation phases and timely provide feedback to the provinces. Polio Control Rooms will be functionalized at the provincial level in the offices of the Chief Secretaries and at the district level in the DCO/DC/PA office.



These control rooms will gather and collate the reported (administrative) data during the pre-campaign preparation and the campaign implementation phases along with actionable information transmitted in a timely fashion to the next level. The Polio Control Room should also coordinate collection of real-time information from the field for all operational activities (please see annex). Information/Data management at the UC level will be responsibility of the UC MO (UPEC Chairman). The UC MO will ensure that all the Area In-charges meet their teams daily at the end of each day's assignment. The Area In-charges will collate and compile the data/information from the tally sheets of the teams and report to the UC MO; who will collate and compile all the data for the UC and report to the District Control Room. The Area In-charges and the UC MO will critically analyze the tally sheets of the teams on a daily basis and strategize the interventions accordingly. The partners' UC level staff (where available) will assist the tally sheet analyses, strategizing and field interventions.

- g) Vaccine Management Committee at the Federal Level will be led by the Ministry of IPC and will meet on a regular basis (at least fortnightly) with documented minutes to assess available vaccine stocks within the country at various levels and versus requirements and report to National Steering Committee.
- h) The Polio "Hot-Line" operation shall be reviewed and rolled-out on a wider scale as a key mechanism for public accountability. The Government owned media will leverage own resources and ensure that Polio Control Cell phone number is highly publicized several times a day during NIDs through TV and radio channels (PSAs/tickers), and print outlets (PSA insertions). The number of callers reporting poor service delivery shall be an indicator of community demand for OPV and public monitoring of campaign quality. Data on the numbers of received calls (province and district wise) and the response to those calls will be collated and submitted to the Polio Monitoring and Coordination Cell within a week following each campaign.

2. Oversight mechanism in Provinces for NEAP implementation

- a) The Provincial Task Force for polio eradication will be led by the Chief Secretary and will fast-track implementation of the National Emergency Action Plan.
- b) A senior full time government officer (Additional Secretary level) will be designated in each province and in FATA by January 2013 to manage the provincial Polio Control Room with the assistance of Provincial Technical Focal Person for NEAP, WHO and UNICEF representatives. The incumbent will be a member of the Provincial Task Force and will report directly to the Chief Secretary (and Additional Chief Secretary in FATA).
- c) Polio Control Rooms will be situated and operationalized at the provincial level in the offices of the Chief Secretaries. These Control Rooms will gather and collate the reported (administrative) data during the pre-campaign preparation and the campaign implementation phases along with actionable information to be transmitted timely to the next level. The Control Room will also coordinate with the office of the Minister for Health, the Secretary Health, Secretaries of other departments, and the PEI partners at the provincial level for ensuring tracking of NEAP indicators and accountability at the district and union council levels, in particular. (Please see annex).



- d) The Provincial Task Force will take necessary steps for motivating the DCs/DCOs/PAs of the districts consistently performing well during all the phases of the campaign.
- e) Provincial Vaccine Management Committees will be established which would 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 daily basis during the campaign. They will take corrective action to address any discrepancies to ensure adherence to vaccine distribution based on micro-plan requirements and to avoid any vaccine wastage and account for all doses distributed in the field.

3. Oversight and accountability at the district level

- a) In the persistent transmission and repeatedly infected districts (please see Annex), the Chief Secretary of the province will ensure appointment of proficient DCOs/DCs/PAs/ and EDOs(H) having proven capabilities of management and a good track record by January 2013. These officials will be charged with ensuring implementation of the NEAP in their districts. The public representatives of these districts will be requested to fully back the DCO and EDO-H for implementation of the NEAP and for ensuring meaningful accountability at all levels. As per the national structure, the DC is the administrative head at the district level and will continue to lead the polio program as a program of the highest national priority. Appropriate actions of reward and accountability for the DC's performance will be reflected in the Annual Confidential Report. The performance of the DC/DCO/PA and the EDO-H will be reviewed monthly by the Chief Secretary, in particular through indicators for preparation and implementation of SIAs (indicators for the UPEC and DPEC efficiency and the percentage of UCs achieving the target of 95% finger marking coverage by independence).
- b) The DC/DCO/PA as Chairman of the DPEC/APEC will designate a full time Government officer (Additional Deputy Commissioner/Assistant Commissioner & APA for FATA) to ensure accountability for implementation of the District Emergency Action Plan by January 2013. This official will manage the district control room and be responsible for ensuring the collection of data on the indicators for preparation and implementation of SIAs, and for presenting this information to the DPEC for appropriate actions, and will report to the DCO as chair of the DPEC.
- c) The concerned authorities in the Provincial Governments and Peoples' Primary Healthcare Initiative (PPHI) will ensure availability of a Medical Officer in every UC (UC MO) particularly in the high risk UCs; who will function as the UPEC Chairman (please refer to section below on UPEC and the annex). 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 Chairman. The UPEC under the chairmanship of UC MO will be responsible for all aspects of preparation and implementation of SIA in the UC, including training of AICs and teams, monitoring of daily proper dispatch of teams, field supervision, end-day review meeting, coordination with UPEC members and data flow as per timeline during all the phases of the campaign. The UC MO will work closely and coordinate with the UCPW and UCCO recruited by partners where available, in ensuring vaccination of every child in the UC especially those from the highest risk UCs.



The DPEC will ensure that the UC Medical Officer is posted permanently (with no or minimum turnover) to follow up the issues effectively as per NEAP. Their performance will be evaluated by the EDO-H (in consultation with the DCO). Strict accountability will be enforced in the face of inadequate performance at the UCMO level. Partners will support training of UC MOs to enable them to perform their functions by January 2013. The planning and implementation of the activities of UCPWs and UCCOs through their district supervisors will be coordinated through Area Coordinator at the sub-provincial level.

4. District and Sub-District level committees to oversee campaign operations (preparation and implementation)

a) District Polio Eradication Committee (DPEC)

The DPEC headed by the DC/DCO/PA meets 10 days before the campaign and its meeting is considered as valid if presence of DCO as Chairman and EDO-H as Secretary is ensured (presence of the DCO and EDO-H is mandatory) with binding attendance of all concerned (please see annex). The meeting reviews the status of preparations and the results of UPEC meetings (completeness and timeliness) and considers specific requests from the UPECs and any 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 holding person(s) accountable in case of faltering; review of trend of the performance (process and outcome) indicators; **b)** appropriateness for plans for pre-SIA, during-SIA and post-SIA phases with focus on comprehensiveness of micro-plans, training quality and effective house to house visits to all families with follow up of those having absent children; and **c)** specific tasks assigned to the DPEC members in relation to the next SIA.

Copy of approved minutes of the meeting must be available within 2 days of the meeting and should reflect follow up of previous meeting's decisions and action points for future with clear indication of responsible official and timeline; and actions based on trend of a set of indicators. A sub-committee meeting will be held 5 days prior to the campaign to assess implementation of key recommendations, and to decide on implementation or deferment of implementation UC by UC on the basis of preparation indicators (see section 5 below). The assessment of the functionality of the DPEC is based on a defined set of indicators (please see annex).

The DPEC Chair will lead all communications and social mobilization activities in the district with the support of partners' communication staff. The DCO/DC/PA will be responsible for providing logistical and administrative support to all social mobilization activities carried out at the district and union council levels. The partners' communication staff (where present) will lead the technical assistance on communications and will advise the DPEC on Social Mobilization and Communications priorities based on Social Mobilization and communications data. The partner organizations' UC and district based staff (UCPW/UCO, PEO/DHCSO) will share their observations / findings about the quality of preparations for the consideration of DPEC and appropriate response / action including deferment of the campaign, if required.

Parliamentarians (MNAs/MPAs) will assign a nominee in each UC of their constituencies to be part of the UPEC and support the operations at the UC level. These nominees will bear direct responsibility and accountability for activities at the



UC level as per the NEAP indicators; which will be shared by the DC with the parliamentarians during DPEC at the district level and by the Secretary Health / provincial Focal Person with the Chief Minister / Chief Secretary at the provincial level. The parliamentarians will also participate in the UC level inaugurations before each campaign.

b) Tehsil level management by the DDHO (or senior official deputed by DCO/EDO-H)

The Deputy District Health Officer (DDHO) or a senior official deputed by the DCO/EDO(H) will be member of the DPEC and responsible to represent the UCs from each tehsil (assigned to him) within a district. The DDHO will hold a meeting with the UPEC chairmen in tehsil/taluka of his assignment before the DPEC meeting and present their tehsil/taluka during the DPEC meeting including UC wise information/data of the tehsil of their assignment. The partners' staff will ensure training of the DDHO (tehsil focal person).

c) Union Council Polio Eradication Committees (UPEC)

The UPECs formation, composition and functionality have been variable in all the provinces. The functionality of the UPEC must be ensured with designation of the full time Union Council Medical Officer as Chairman and Secretary UC as co-chair of the Committee with binding membership of important UC level stake holders (please see annex).

The meeting of the UPEC will be conducted 15 days before the campaign with an agenda including: a) review of implementation status of the last meeting's decisions; b) review and endorsement of the integrated micro-plans including composition and quality of vaccination teams and engagement of the community influencers for information and motivation of the community; and c) plans for quality training, supervision and real time process data transmission on daily basis.

5. Deferment of scheduled campaigns in case of inadequate preparations

Meticulous monitoring of the preparatory phase of SIAs will continue through the collection and transmission of information on key indicators prepared by the national programme (see above). The indicators will establish a satisfactory preparedness level for UCs and districts, and will be monitored for UC level by the responsible officer designated by the DCO, and verified by partner agency staff. UC indicators will be assessed by the DPEC: **i)** 10 days before the campaign, when a first alert will be issued for any UC with inadequate preparations, and **ii)** 5 days before the campaign, when a decision will be made for each UC to implement, or defer implementation if preparation is inadequate.

If more than 25% of UCs conducting campaign have inadequate preparation, then the DPEC must defer implementation for the district as a whole until the poor preparation is addressed.

If the campaign is postponed in any UC due to inadequate preparation, an emergency meeting of DPEC sub-committee will be arranged by the DCO to investigate and report for corrective action. The committee will devise a clear plan with responsibility and timeline and will make a re-assessment of readiness after 7 days. UPEC will be responsible to ensure safety of the resources until the UC get the clearance to go ahead for the campaign. A second failure will initiate an enquiry by the Provincial Health Authorities under the supervision of the Chief Secretary.



The provincial control room through its members will field validate the readiness situation reported by the districts for samples of high risk UCs participating in the campaign.

6. Communication Strategies

Communication strategies will more and more focused on high-risk and reservoir areas with specifically catered communication social mobilization responses. These strategies are based on extensive consultation and robust research, monitoring and evaluation to ensure that the strategy is responsive to internal and external operational realities in each area. Ultimately the overall objective is to influence behavior to ensure parents, particularly priority populations have high demand and have their children immunized against polio and the other childhood vaccine-preventable diseases.

These strategies address the following key communication objectives

1. Polio advocates political leaders, media, celebrities, and partners actively participate and are accountable to ensure the objectives of the Polio Eradication Programme are understood and shared
2. Parents, grandparents and influential gate-keepers in insecure areas demand or accept OPV as a key health service for children <5 years in their communities
3. Parents, grandparents and influential gate-keepers understand the importance of taking OPV each time it is offered and accept it

The Government in collaboration with UNICEF, WHO and polio partners is working towards these objectives through provision of IEC materials, active engagement with the media, social mobilization with special focus on high risk areas, private partnerships for advocacy and strengthening of training of field workers in inter-personal communication skills. The partners' staff is supporting the communications and social mobilization in high risk districts and UCs.

F Key strategies for 2013 with special focus on reservoirs

1. All missed Children to be tracked and vaccinated after each campaign

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 the children missed during the SIAs are effectively tracked and vaccinated. The campaign must not be considered finished until all the children are reached at the UC level. All means must be used to track and reach the unvaccinated children using the services of the existing health system and any other innovative approaches.



The list of still missed (unvaccinated) children due to any reason (non-availability, refusal or any other) should be available at all the relevant Government health facilities after the campaign. The EPI staff of the health facility should carry on tracking the missed children for at least 2 weeks after every campaign. A report should be sent from each UC to the district control room on weekly basis (for at least 2 weeks) indicating the coverage of those reached after the campaign and those that still remain missed. The district control room will report further on this (through SDMS) to the provincial control room on weekly basis. The Provincial Control Room will compile the provincial information and report to the Federal Control Room within 18 days of the end of the campaign. The health staff including the EPI staff, LHWs etc, should carry a copy of the list of missed children during their field visits and track and vaccinate these missed children. The UPEC in its meeting for the subsequent SIAs should review the tracking and vaccination of still missed children in the previous campaign.

The UCMO must conduct detailed analysis with the assistance of partners' staff at UC level (where available) on the reasons of Still Missed Children. The analysis needs to be done thoroughly and sub-reasons (for non availability and refusals) need to be explored and addressed. Special attention must be paid to clusters of missed children (due to any reason) and all necessary measures must be taken to track and vaccinate them. Clusters of refusals should be addressed through Standard Operating Procedures for addressing refusal clusters. These SOPs (please see annex) will ensure detailed tracking of refusals by EPI staff with support of partners' staff where available, complete with collection of contact information and regular high-level follow-up throughout campaign days and after the campaign as well. Any outstanding refusals will be shared with the office of DC/DCO/PA who will then be responsible for any remaining follow-up.

2. Short Interval Additional Dose strategy (SIADS) is the key strategy across all reservoirs, high risk areas and outbreak areas

The main objective of the SIADS is to rapidly build up population immunity by conducting short spaced successive rounds, together with intensive supervision and monitoring to ensure a campaign of the highest possible quality.

Experience in 2012 proves SIADS to be very useful if implemented in letter and spirit. Implementing SIADS in the low transmission season has an exponential effect in building the immunity profiles and controlling viral circulation.

The SIADS must be efficiently utilized in the low transmission season during first half of 2013 with special focus on reservoir areas, high risk areas, outbreak areas and for Pashtun communities residing outside KP/FATA.

3. Special Strategies targeting Pashtun, migrant and transit populations

More than 80% of the polio cases in 2012 are reported from Pashtu speaking communities. This has been the trend for the past 3 years. Areas outside Khyber Pakhtunkhwa, FATA and southern Balochistan have disproportionately high number of polio cases from this community. This disproportionate circulation of polio virus can be attributed to the fact that Pashtun populations are mostly under served in areas other than Khyber Pakhtunkhwa, FATA and Balochistan and have consistent links with their parent areas (Khyber Pakhtunkhwa, FATA and Balochistan) having intense



viral circulation. The program must ensure implementation of Pashtun population strategies nationwide to map, track and reach these populations consistently. Tailoring of all polio eradication activities for the Pashtun population should be ensured by January 2013. It is important to systematically engage Pashtun population community leaders and by ensuring that all frontline workers deployed are Pashto speakers (preferably belonging to the communities they serve) in order to effectively implement the polio eradication strategies for this population group.

Epidemiological data of the polio cases complemented by genetic analysis of the isolated viruses highlights that there is sharing of polio virus circulation among certain geographically distant areas within the country as well as across the border with Afghanistan. The migrant groups can be broadly classified into traditional Nomads, seasonal migrants, economic migrants, Afghan refugees and Internally Displaced Populations (IDPs). The program must be geared from the outset of 2013 to efficiently implement the strategies for migrant/mobile populations and ensure vaccinating all children of these groups during every campaign by making certain their inclusion in the relevant UC micro-plans. Moreover, all measures and innovative approaches must be adopted to raise the immunity of internally displaced children, especially the ones displaced from areas that were not visited by vaccination teams for long time.

The SIAs monitoring reports and information review indicates that a substantial number of children are missed by house to house vaccination teams during campaigns simply because they are 'out of the house'. There is a need to effectively track and reach and vaccinate these children. These traveling children are mainly moving through road transport. However, substantial numbers do travel by rail and air. Likewise, a number of children are out on the street, in the markets and in the playgrounds and fields. In April 2012, the program enhanced its transit strategy by increasing the number of permanent transit posts (PTPs) outside the campaigns. A substantial number of children have been vaccinated so far in 2013 on these carefully identified posts. It is important to efficiently implement the transit strategy and ensure that all the traveling children passing through PTPs are vaccinated. Similarly all the children outside the houses on the busy streets, markets and parks during the SIAs must also be reached and vaccinated. Specifically designed trainings, dedicated supervisors and intensified supportive supervision and monitoring are the keys to effective functioning of the PTPs and efforts to reach "out of the house" children.

Specific communication strategies will be designed for priority populations to ensure that all communication material is appropriately tailored for target communities. The communication strategy will take advantage of credible influencers and will also ensure that measures are taken to deliver culturally-appropriate messages in the right language and dialect for the target communities. Special measures will also be undertaken to identify and address refusal clusters. A special tracking and reporting system will be designed and implemented to assess the impact and measure trends.

A detailed social map will be developed for every UC focusing on priority populations. In UCs where such social maps already exist, at least 10% will be validated by district level partners' staff (UNICEF). The focus of social mapping will be to identify and list all credible influencers in the communities, mosque Imams and the local health care providers.

Inter-provincial coordination will be strengthened in relation to the ongoing movement of the priority populations among the provinces focusing on strengthening ways and means to track and vaccinate these populations either when they are on the move or in their settlements.



Specifically tailored communication activities will be undertaken for migrant groups. Communication staff in the district/UC will make special efforts to visit brick kilns and construction sites to identify and list brick kiln owners, construction site manager and local community leaders and get them on board to help create awareness and acceptance for polio immunization.

4. Effective and integrated control rooms at all levels

The details on control rooms have been outlined in the section on oversight and management. During 2012, the functioning of the control rooms at the district level has been variable from non-functional to moderately functional. An adequately composed and functioning district control room is the key to oversee the UC level activities and provide timely information for action to all concerned to ensure effective campaign planning and implementation. The provincial and districts administrative leadership must ensure properly composed and functional control rooms at the district level.

The provincial control rooms were proposed to be situated in the office of the Provincial EPI in 2012. Considering the fact that the Chief Secretaries are leading the program at the provincial level under the auspices of Chief Ministers, in 2013 the provincial control room will be set up by the Chief Secretaries at their offices. This will enable the control room to more efficiently relay the actionable information to the provincial administrative leadership and timely interventions from the Chief Secretary's office. The office of the EPI Manager will continue to support the collation/compilation of the information/data; assisted by the Provincial Technical Focal Person for NEAP and technical partners.

The national control room will continue to function under the auspices of the Prime Minister's Polio Monitoring and Coordination Cell with the assistance of the technical partners. The composition and key functions of the control rooms at all levels are annexed.

PCR data will be used regularly to improve vaccine management during the SIAs. PCR data available on vaccine distribution, utilization and remaining stock will be reviewed more regularly and discrepancies highlighted for corrective action during the campaign.

5. Strengthening Monitoring and Evaluation mechanisms

The program is currently relying on the district level Government and partners' staff for intra-campaign monitoring. More than 120 WHO Medical Officers (PEOs and Area Coordinators) across the country and nearly 50 UNICEF supported District Health Communications Support Officers (DHCSOs) in 33 high risk districts; support the intra-campaign monitoring. More than 250 WHO supported UCPWs and more than 900 UNICEF supported UCOs support the intra-campaign monitoring at the UC level. WHO also supports independent temporary tehsil monitors in the areas of concern (and areas without support of UCPWs) for intra-campaign monitoring. Observations of all the intra-campaign monitors are shared with the district administrative leadership during an 'end-day review meeting (evening meeting)' during the campaign days and corrective actions are taken.

The UCMO will share clear monitoring plans for pre-campaign, campaign and post-campaign activities. The quality of trainings and display (and utilization) of IEC materials will be monitored with special focus during the pre-campaign phase. During the campaign, the monitoring plans will outline who will be going where for monitoring of pre-campaign, campaign and post-campaign activities. For all monitoring, the UC level



supervisors including UCMOs and the partners' UC level staff (UCOs and UCPWs) will be in the field as per the monitoring plans to appraise the performance of the Area In-charges and vaccination teams. During the post campaign phase, the tracking of missed children will be closely monitored.

In the post campaign phase independent monitoring and Lot Quality Assurance Sampling (LQAS) is performed to assess the campaign quality. LQAS data appears to be more accurate (and often shows significant quality problems). The program has significantly expanded the LQAS in 2012 compared to 2011; utilizing all district based WHO Polio Eradication Officers and Area Coordinators (UNICEF supported DHCSOs in Sindh). The provincial and national level WHO staff also support LQAS to assess the UC level performance. There will be further gradual expansion of LQAS in 2013 by involving other partners (UNICEF) followed by addition of campaign awareness component to LQAS. The expansion will be done without any compromise on the quality of the activity.

The independent monitoring will continue with special focus on the quality of monitors, their training and data validation (5%-10%) by the partners' staff (WHO & UNICEF). Collection of information on social mobilization / communications will continue during the Independent Monitoring for National Immunization Days (NIDs).

Following key steps can be taken to improve the process and monitoring.

- i) The independent monitoring process will be reviewed by end January 2013 and any key changes in process will be implemented by the March SIA round, including disaggregation of data for priority (Pashtun) populations.
- ii) The intra-campaign monitoring can be expanded through independent monitors in certain key areas.
- iii) LQAS will continue after every SIA round, concentrating on known high risk areas, as a supplement to independent monitoring data. LQAS will be used to assess impact of quality changes in key high risk districts and UCs.

6. Special focus on the High Risk UCs including implementation of innovative strategies like Polio Plus

There will be focused efforts on high risk UCs to achieve consistent Government oversight, ownership and accountability of polio programme performance. All district Control Rooms will be fully functional and must have information / data on high risk UCs displayed and monitored by January 2013. Moreover, all the missed children for any reason(s) will be tracked and vaccinated after each campaign (please see section above on 'tracking missed children'). SIADS is the key strategy for high risk UCs/Areas, particularly during the low transmission season in 2013. Polio Plus strategy will be utilized as and when required in the high risk UCs / areas. This may include periodic establishment of medical camps by the Department of Health (DoH) offering immunization services in addition to basic curative services. The community may also be offered incentives in the form of basic necessities e.g. soap, combs, towels etc. (supported by partner organizations) to motivate and create demand.

The criteria for the flagging the high risk areas will be UCs with Pashtun and mobile/migrant population, Pashtun population (since the population in Balochistan, Khyber Pakhtunkhwa and FATA is predominantly Pashtun in a number of districts, so this category can be considered as under served Pashtun population for those districts),



cluster of refusals, persistent transmission and/or repeated infections, UCs draining in the environmental surveillance sites, UCs with inaccessibility and UCs with Weak Service Delivery. A UC with any one or more of the above factors will be flagged as high risk UC. Interventions will be designed according to the factors rendering it high-risk.

7. Strengthening partnerships at all levels to ensure every child is reached in FATA

Continued difficulty in consistently vaccinating all the children in FATA during every campaign, constitutes a major risk to the program. The reach to the children has recently improved in Khyber Agency; however, more than 260,000 children in North and South Waziristan Agencies have not been reached and vaccinated since June 2012. Moreover, there are pockets of under-immunized children in other tribal agencies of FATA as well, due to inconsistent reach of the vaccination teams to these areas.

The Federal and Provincial Governments will take all necessary steps to strengthen the already in place Civil Military Coordination Committees (CMCC) at the provincial/regional, agency and sub-agency levels. These CMCCs at the agency and sub-agency levels will meet before every campaign and strategize to ensure every child is reached for vaccination.

The program will also strengthen engagement of the religious leaders and influential to mobilize the community in FATA, especially the high risk tribal agencies. The inclusion of the community representatives and local influential (Maliks, elders etc.) will be ensured in the agency and sub-tehsil level polio eradication committees in order to make certain that the campaign planning and implementation is in a way that is acceptable to the local community and that every child is reached and vaccinated.

The program will also use all possible innovations like successive vaccinations rounds (SIADS) to rapidly build the immunity, using windows of opportunity to reach and vaccinate the children in areas of FATA and strengthening the transit strategy making sure all children on the move from the un-reached areas are vaccinated by transit team. The population groups from FATA that are living outside FATA (in Khyber Pakhtunkhwa and large urban cities of other provinces like Karachi, Lahore and Rawalpindi) will also be properly mapped and specially focused during all the campaigns.

8. Zero tolerance for misreporting and financial misappropriation

The district polio control room provides the basic platform for receiving, analyzing and validating campaign information/data from all the UCs. The UC Medical Officer with his UC team will be responsible and accountable for the data quality of his UC. The district control room members will carry on validating the campaign preparation and intra-campaign data / information (control/operation room data). The district administrative leadership will take appropriate action about any misreporting (or hiding) of the data for the pre-campaign (preparatory) data and intra-campaign data (control/operations room data). The partners' staff (WHO and UNICEF) will continue validating the data of independent monitoring and take appropriate actions about any misreported data. The LQAS in addition to be used for monitoring the campaign quality will continue to be used as quality check for independent monitoring (keeping in view the difference between the two methodologies).



The district and provincial administrative leadership (DCO/DC/PA and Chief Secretary respectively) will ensure timely payment of incentives to the frontline workers. Stringent action will be taken about any element intentionally causing hurdle in this regard.

9. Direct Disbursement Mechanism (DDM)

The DDM was piloted in the four major provinces and AJK during the second half of 2012 under the auspices of the Prime Minister's Polio Monitoring and Coordination Cell. The Mechanism utilizes the services of different institutions to make sure full incentives reach the front line workers in a timely manner. The mechanism ensures that the right person receives the payment on the condition of having the Computerized National Identity Card (CNIC). The mechanism during the pilot phase seems to have helped ensuring that all the teams mentioned in the UC micro-plans actually participate in the campaign and also in improving the teams quality, especially preventing kids teams (due to condition of CNIC). The DDM will be optimized using the services of the banks and cellular phone companies (and possibly some other institutions, if needed) to ensure that the frontline workers receive their incentives with ease.

In 2013, DDM will be the only mechanism of paying incentives to the front line workers. The district administration must ensure provision of all the documents and information (correct and precise) essential for DDM. Following this, the concerned partners will ensure timely disbursement to the front-line workers.

10. Strengthening Cross Border Coordination

Afghanistan and Pakistan are sharing long porous borders with extensive population movement in both directions. Epidemiological data complemented by the genetic analysis of isolated wild polio viruses indicate sharing of wild polio viruses on both sides of the border; hence the two countries constitute one epidemiological block and have to work together to stop polio transmission.

There is ongoing good collaboration between Pakistan and Afghanistan for polio eradication demonstrated by immediate sharing of surveillance data, testing of all samples of AFP cases from Afghanistan in Pakistan Regional Reference Polio Laboratories, synchronization of polio campaign, permanent vaccination teams working in a coordinated way on two sides of the border and cross border meetings at regional and national levels. However, there is a need for more effective collaboration among the two countries to stop polio virus transmission during the upcoming low transmission season. The areas which need further improvement are:

1. Joint integrated (operations and communications) micro-planning for border villages including proper mapping and clear assignments of the border villages to the teams on both sides of the border
2. Cross monitoring of the border areas and permanent vaccination teams at the cross border posts
3. Operational level (border districts) meeting before each supplementary immunization activity
4. Ensuring the support of the Army and Law Enforcement Agencies to vaccination teams working at the border villages and cross border posts
5. Monthly video conference between the senior Government officials of both countries to review the progress on cross border activities



11. Improving overall vaccine management during SIAs

Recently, the Government of Pakistan has enhanced the programmatic focus on ways and means of ensuring the most judicious use of oral polio vaccine (OPV). Special actions are being planned based on the recommendations of an independent mission that assessed the vaccine management in the major provinces of the country in September 2012. Standard Operating Procedures (SOPs) are in place to be followed during the Campaigns to conserve OPV. A National Vaccine Management Committee (NVMC) has already been constituted under the chairmanship of the Additional Secretary, Ministry of IPC. Similar Committees will be constituted at the Provincial and District levels under the guidance of the Chairman of the NVMC and the relevant staff of the Prime Minister's Polio Monitoring & Coordination Cell. The key steps to improve OPV management include:

- Polio Control Room data on vaccine availability, distribution, utilization, and remaining doses will be regularly monitored and reviewed on a daily basis and actions will be taken to address any discrepancies / inconsistencies.
- Special tools will be developed by the Prime Minister's Polio Monitoring and Coordination Cell which will be used to gather information from the Provinces and Districts about the quantity of vaccine received, utilized and available in balance for use in subsequent campaigns.
- Vaccine management SOPs will be implemented in an integrated manner with overall campaign guidelines to conserve resources and avoid wastage of polio vaccine.

The Government of Pakistan will take all necessary steps with collaboration of the international partners to ensure vaccine availability for the polio vaccination campaigns.

12. Optimizing the Polio Eradication for strengthening Routine Immunization

Routine immunization is one of the corner stone strategies for polio eradication. It is very important to have good quality routine immunization to sustain the achievements of polio eradication. Quetta block is currently experiencing a massive outbreak (12 cases) of circulating vaccine derived polio virus type 2, mainly due to weak routine immunization. Polio programme in Pakistan has adopted some key strategies to help improve routine immunization including registration of zero dose routine EPI children by mobile vaccination teams during polio SIAs and monitoring of routine EPI fixed sites during active surveillance activities. However, these strategies have been variably implemented with little or no impact in improving routine immunization coverage. The National Emergency Action Plan for 2013 calls for using the well established polio oversight and management structure to improving routine immunization through:

1. Reviewing the progress on routine immunization during Polio Task Forces meeting at the National and Provincial Levels and during DEPEC and UPEC meetings
2. Using advocacy and social mobilization activities of polio eradication to promote for routine immunization
3. Tracking and vaccinating zero dose routine EPI children recorded by mobile vaccination teams during SIAs



4. Proper response by EPI teams to the monitoring data generated by polio eradication officers during their active surveillance visits
5. Polio Eradication Officers to support in investigating outbreaks of vaccine preventable diseases
6. EPI teams to perform field investigation for all the 'Zero Routine Dose' children ages less than 2 years found through AFP surveillance; and appropriate response to all such cases
7. Regular sharing of the OPV-3 coverage data of AFP surveillance with the EPI managers at the provincial and district levels and adequate response in any districts / areas / UCs with low OPV-3 coverage
8. Where feasible, Polio capacity in high risk districts and areas will be provide monitoring feedback regarding planned EPI sessions, availability (stock outs etc.) of routine vaccines in EPI centers and functional cold chain capacity at district and sub-district levels. This routine EPI situation will be reviewed at the various levels through the polio established committees and management mechanisms (where feasible) to guide corrective measures.

13. Ensuring safety and security of the polio eradication workers

Security incidents towards the end of 2012 affecting the polio eradication workers constitute a challenge for the program. The DC/DCO/PA of every district/agency will ensure safety and security of all the field polio eradication workers (including the workers supported by the partner organizations) with the assistance of the provincial governments. The District Police Officer being member of the DPEC will liaise with all the relevant stakeholders (and security agencies) to ensure safety and security of the polio eradication workers. They will also ensure that the SHO in every UC is member of the UPEC and participates in all its meetings to finalize and implement the security plan at the UC level as part of the UC micro-plan. All the police stations and check posts will be actively engaged in ensuring protection of the polio eradication workers. Moreover, other law enforcement agencies will also be engaged where necessary.

The emergency security and operational guidelines have been put in place (attached), to be utilized at relevant levels. These guidelines will be periodically reviewed and modified if required.

G Conclusion

Pakistan has demonstrated progress in 2012 which can be attributed to rapid and dramatic increase in the oversight and accountability at the national, provincial and district levels, triggered by the Augmented NEAP 2012. The NEAP 2013 built upon the lessons learnt in 2012, is meant to accelerate meaningful accountability at the UC level, enhance focus on high risk UCs/area and populations and triggering integrated efforts at all levels. The plan aims at fully utilizing the low season in the first half of 2013 and make it the 'last low season' for polio eradication in Pakistan.

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Annex-I Acronyms & Abbreviations

AFP	Acute Flaccid Paralysis
AJK	Azad Jammu & Kashmir
APEC	Agency Polio Eradication Committee
CM	Chief Minister
CNIC	Computerized National Identity Card
DC	Deputy Commissioner
DCO	District Coordination Officer
DHCSO	District Health Communication Support Officer
DPEC	District Polio Eradication Committee
DDHO	Deputy District Health Officer
DDM	Direct Disbursement Mechanism
EDO	Executive District Officer
EPI	Expanded Program on Immunization
FATA	Federally Administered Tribal Areas
FR	Frontier Region
IDPs	Internally Displaced Persons
IM	Independent Monitoring
IMB	Independent Monitoring Board
KP	Khyber Pakhtunkhwa
LQAS	Lot Quality Assurance Sampling
MNA	Member of National Assembly
MPA	Member of Provincial Assembly
MO	Medical Officer
NEAP	National Emergency Action Plan
NID	National Immunization Days
NIPA	National Institute of Public Administration
OPV	Oral Polio Vaccine
PA	Political Agent
PEI	Polio Eradication Initiative
PEO	Polio Eradication Officer
PM	Prime Minister
PPHI	Peoples Primary Healthcare Initiative
PSA	Public Service Announcements
PTPs	Permanent Transit Points
SHO	Station House Officer
SIAs	Supplementary Immunization Activities
SIADS	Short Interval Additional Dose Strategy
UC	Union Council
UCMO	Union Council Medical Officer
UCO	Union Council Communication Officer
UCPW	Union Council Polio Worker
UPEC	Union Council Polio Eradication Committee
WPV	Wild Polio virus



Annex-II

District Polio Eradication Committee (DPEC)

Each District/Agency/Town will have a Polio Eradication Committee (DPEC/APEC) to oversee polio eradication activities at district/agency/town level and coordinate all line departments and local partners including NGOs to ensure high quality implementation of vaccination campaign strategies and plans to achieve recommended results in the National Emergency Action Plan and its augmentation for 2012.

The DPEC should meet at least 10 days before the start of polio vaccination campaigns to review and critically analyze the status of preparation in all the UCs of the district. The committee is authorized to defer the campaign in any UC(s) with inadequate preparations and take appropriate action about it (see the main document).

Functions of DPEC

Before the campaign:

- a) To ensure that specific micro-plans for every UC/Area (and equivalent) have been updated before each campaign. Each plan should be endorsed by the designated UPEC chairman i.e. Union Council Medical Officer (or designated health official) and the designated official by the DC/DCO/PA (from outside the health department e.g. UC Secretary) for the UC and reviewed by EDO(H) and technical staff from partners. These should be specific, standalone plans for high quality vaccination coverage in high risk areas and populations e.g. brick kilns, construction sites, nomadic/migrant camps, IDPs, refugees etc.
- b) To ensure proper selection, training and deployment of the vaccination teams according to the laid down criteria.
- c) To ensure that the line departments and local NGOs help in local resource mobilization (Human resources, vehicles, POL and banners etc.)
- d) Planned activities for social mobilization suited to local culture and requirements targeting towards promotion of vaccination and creating demand
- e) To ensure a comprehensive campaign monitoring and supervisory plan with the involvement of all the line departments.
- f) Efficient and appropriate utilization of resources based on the district micro plan and in time payment of entitlements to the workers.

After the campaign:

- a) To review the outcome of the last campaign against the set of standard indicators.
- b) Review the progress of the actions taken for the poor performance in the last campaigns.
- c) Recommend actions to be taken immediately to cover areas with low vaccination rate and/or missed children to avoid repetition in future.



Committee Composition:

Must Attendance (for the meeting to be considered valid)

- Deputy Commissioner (DC)/District Coordination Officer/Political Agent (PA)/Town Municipal Officer (TMO) – Chairman
- Executive District Officer Health – Secretary
- District Police Officer (Senior Superintendent of Police)
- Executive District Officer (Revenue) and DDOs (R) from each Tehsil
- Executive District Officer Education, Community Development,
- District Auqaf Officer and District Information Officer
- District Khateeb
- District Coordinator for National Program for Primary Health Care & Family Planning (LHWs Program)
- District Heads of Governmental NGOs working in health, education, and social development sectors e.g. NCHD, HANDS, Rural Support Programs, etc.
- District Head of the PPHI
- Active medical professional organizations e.g. Pakistan Medical Association and Pakistan Pediatrics Association etc.
- Members of parliament (MNAs, MPAs, Senators); Members of the Parliament in a district will be represented by one parliamentarian (MNA and / or MPA) who must participate in the DPEC meeting before each campaign.
- Local representatives of the partner organizations (where assigned) – WHO (PEO), N-STOP, UNICEF (DHCSO) and Rotary International

Other members

- Medical Superintendent - District Headquarters Hospital
- District Heads of PRSP
- Civic Society organizations
- Traders Organizations
- District Heads of NGOs engaged in social development (health and/or education)
- Respectable religious leaders
- Any other relevant notable



Annex-III

Union Council Polio Eradication Committee (UPEC)

Each Union Council will have a Polio Eradication Committee (UPEC) to plan and coordinate polio vaccination campaign activities at UC level. The main role of the UPEC is to ensure that every child is reached in every polio supplementary immunization activity (SIAs) and the campaign is successfully conducted in the union council.

Functions of UPEC

The UPEC should meet at least 15 days before the commencement of polio SIAs to review the preparation for the forthcoming SIA and to guide on the steps ahead till the commencement of the campaign. The committee is also responsible to critically analyze situation and communicate the summary of its findings to the DPEC before its meeting is held 10 days before the campaign. The key things to be reviewed by the committee include all the area level micro-plans in the UC, the planning and implementation for teams' selection & training, logistics availability and social mobilization and communication activities planning and implementation. The roles & responsibilities are elaborated below. Progress on preparatory measures will be reviewed 5 days before each campaign and the summary of findings will be sent again to the DCO's office clearly indicating if the UC is ready for the campaign or the needs deferment for strengthening the preparations. The functions of the UPEC will be the responsibility of the UPEC Chairman i.e. Medical Officer (or designated health official) and the UC Secretary officially designated by the offices of the EDO-H and the DC/DCO/PA respectively.

Pre campaign

- Perform desk and field validation of the micro-plans of all the AICs in the UC/ward 11-15 days before the start of SIA
- Ensure the teams' composition in the UC meets all the criteria / indicators mentioned in the NEAP
- Ensures proper team and AICs selection, justifiable work load and area assignments
- Makes plans for logistic distribution
- Separate micro-plan for the high risk areas/populations
- Training: All teams and AICs should be trained by MO to ensure both the quantitative as well as qualitative aspects of training
- Ensures the social mobilization activities in the union council e.g. arrangements for mosque announcements beginning 2-3 days before the start of the campaign, announcements in the school assembly, display of posters, UC level inauguration etc.
- Monitors the team's turnover and ensure that only teams properly trained before each campaign work in the field
- Submits the summary of the UPEC findings to the DPEC (DCO office) 15 days before the campaign (immediately after the UPEC meeting) and the final report on the UC readiness 5 days before the campaign clearly indicating if the UC is ready for the campaign or recommend deferment in case of inadequate preparations



During campaign

- To have daily field visits to monitor the progress in field using standardized checklist
- Ensure the presence and quality supervision by the AICs in the field through screening their check lists, supervisory plans.
- Ensures that the mobile populations are properly covered in line with the National Guidelines.
- Conduct the evening meeting with the team leaders as a group at the end of day to review the work done and solve problems that have arisen and to compile list of missed children.
- Check with vaccination team members whether they have received full entitlement within the stipulated period.
- Ensure that the catch-up plans have been prepared and implemented properly.
- Prepare a report and share it with DCO on daily basis during the campaign days.

Post campaign

- Ensures that catch up activities for the recorded missed children are being effectively implemented
- Ensures tracking of missed children (Not available, refusals and any others) till 2 weeks after the completion of SIAs; through the EPI staff of the local health facility
- Compiles information from tally sheets, including AFP cases and zero routine doses children and analyses the tally sheet data
- Ensures that list of children with zero routine immunization identified during the campaign and still missed children are handed over to the vaccinator for follow up
- Review of the micro-plan in the light of the findings/observations of the last campaign.
- Submit a detailed campaign report to the DCO office within 3 days after the campaign.

Committee Composition:

- Medical Officer (Senior Health Official) – Chairman (this applies to Medical Officers of Health Department, PPHI and/or any NGOs working in the local health facilities)
- UC Secretary/official designated by the DC/DCO/PA/TMO (from outside the health department) – Co-Chair
- SHO (Station House Officer) of respective Police Station
- Area In- Charge/s of the UC
- Lady Health Supervisor
- Community members' representatives such as notables, public representatives and religious leaders
- Revenue Officer (Patwari)
- Partner Organizations' UC Polio Worker (UCPW) and UC Communication Officer (UCO), where present.
- Representative(s) of UC level NGO(s)
- Principal / Headmaster of school (the senior most)
- School Supervisor designated by EDO Education
- Lead Religious person/s



Annex-IV Proposed SIAs schedule for 2013

Annex IV : Proposed SIAs schedule[^] for 2013					
Month	Dates	Campaign	Type of vaccine	Interval b/w SIAs (weeks)	Interval b/w NIDs (weeks)
January**	14 - 16	SNIDs	bOPV	4	
January	21-23	SIADS	bOPV	1	
February**	11 - 13	NIDs	bOPV	4	17
March**	04 - 06	SNIDs	bOPV	3	
March	11-13	SIADS	bOPV	1	
April**	08 - 10	NIDs	tOPV	5	8
April	22-24	SIADS	bOPV	2	
June	10-12	SNIDs	bOPV	9	
July	01-03	NIDs	bOPV	3	12
August	19-21	SNIDs	bOPV	7	
Sep/Oct**	30th Sep. - 2nd Oct.	NIDs	tOPV	6	13
October	14-16	SIADS	bOPV	2	
December**	02-04	SNIDs	bOPV	9	
December**	09-11	SIADS	bOPV	1	

** Followed by additional round (s) in the high risk districts/areas/UCs
[^] This schedule is proposed at the time of launch of the NEAP 2013 and is subject to modifications/changes according to evolving situation in the country

Holidays				
Islamic*		Public		
Eid Milad-un-Nabi	24-Jan		Kashmir Day	5th February
Ramzan	07 July - 07 August		Pakistan Day	23rd March
Eid-ul-Fitar	08-10 August		Labour Day	1st May
Eid-ul-Adha	15-16 October		Independence Day	14th August
Youm-e-Ashoora	14-15 November		Allama Iqbal Day	9th November
			Quaid-e-Azam Day	25th December

* There can be few days' variations subject to sighting of the moon



Annex-V

High Risk Districts



Provinces	Punjab	Sindh	Khyber Pakhtunkhwa	FATA	Balochistan
High Risk Districts	Multan	Hyderabad	Peshawar	Bajour	Killa Abdullah
	DG Khan	Kambar	Mardan	Orakzai	Pishin
	Rajanpur	Ghotki	Nowshera	North Waziristan	Jaffarabad
	Rahim Yar Khan	Kashmore	Charsada	South Waziristan	Nasirabad
	Muzaffargarh	Khairpur		Kurram	Quetta
		Larkana		Khyber	
		Shikarpur		Mohmand	
		Sukkur			
		Jacobabad			
		Baldia Town KHI			
	Gadap Town KHI				
	Gulshan Iqbal KHI				



Annex-VI

Indicators to assess the oversight & preparation of the campaign at the UC & district levels

(To be used by the Provincial Task Force, DPEC and the UPEC)

Indicators to assess the oversight, functionality and efficiency of the DPEC

These indicators are to be assessed by the Provincial Task Force/steering committee 8 days before the campaigns.

1. % of DPEC Meetings held 10 days before the campaign (DPEC / APEC meeting to be considered valid if chaired by the DCO/DC/PA and attended by the EDO-H and held 10 days before the campaign)
2. % of the DPEC meetings sharing the minutes (mentioning decisions and actions taken) with the provincial task force/steering committee within 2 days of the meeting
3. % of the DPEC meetings that issued clear action plan with timeline and responsibility (for pre-campaign phase monitoring)
4. % of the High Risk UPEC meeting summaries (minutes) received and reviewed by the DPEC for actions
5. % of the DPEC meetings where EDOs-H presented implementation status of the last meeting's decision and making specific requests for the upcoming campaign
6. % of the DPEC meetings that pledged financial and/or logistics support for the campaign
7. UC micro-plans of 30% UCs (50% of each UC's Area In-charges) in the district, field validated by the district level staff including the EPI Coordinator, EPI focal person, DDHO/DHO, DSV and his staff, PEO, DHCSO etc.
8. % UCs that tracked and vaccinated 80% of the still missed children after the last SIAs (target: 80%)
9. % of the DPEC meetings attended by the DPO as notified member
10. % of the DPEC meetings that formulated district security plan with special focus on UCs/areas of concern (insecure areas, areas with fear factor etc.)
11. % of the DPEC meetings that extended support for the proposed district security plan
12. % of the DPEC meetings that shared the district security plan as part of the minutes of the meeting (within 2 days of the meeting)
13. % of the DPEC meetings minutes that discussed and shared the vaccine analysis data of last campaign and took action accordingly.
14. % Districts submitted Vaccine Management Form. 1: to Province.
15. % of the UCs that met the targets of all the indicators assessed for the UCs / UPECs



UC-Indicators to assess the functionality and efficiency of the UPEC; & status of preparation

To be assessed 10 days before the campaign during the DPEC meeting

It is expected that the information on the below indicators will be available by the AICs to the UPEC for review. Moreover; the UPEC after its meeting, will validate the UC micro-plans and share with the DPEC before its meeting.

1. % UPEC meetings held 15 days before the campaign
2. % UPEC meetings chaired by the UC Medical Officer / designated senior health official (UPEC Chairman) and co-chaired by the UC secretary (UPEC meeting to be considered valid if chaired by the UC Medical Officer 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 field validated by the UC level supervisory staff (UC MO, UCPW, UCO) for:
 - a. 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
 - b. field validation: checking and validating as per the field validation checklist and to confirm 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 80% mobile teams having one local member (suited to local norms and culture)
7. % UCs with at least 80% mobile teams having one government accountable worker (including the ones from registered non government organizations; for example Rural Support Program Network; National Commission for Human Development etc.)
8. % children tracked and vaccinated that had remained unvaccinated at the end of last campaign (target: 80%)
9. % UCs with at least 80% mobile teams having at least one female member
10. % UCs with all the micro-plans having high risk populations (Pashtun populations, migrants, multifamily dwellings etc.) and their influencers clearly marked and mapped
11. % UCs that submitted complete plans for AICs and teams trainings and social mobilization; on the prescribed format indicating timeline and responsibility (target: 100%)
12. % UCs that received IEC material (Source: UC MO)
13. % UCs where SHO attended the UPEC meeting as notified member
14. % UCs with UC micro-plan having a security component duly verified by the SHO/equivalent
15. % of the UPEC meetings minutes that discussed and shared the vaccine analysis data of last campaign and took action accordingly



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 team members trained using standardized, national module including IPC module (target: 100%)
3. % of UCs with 75% of missed children due to refusal (reported during the last campaign) were converted before the campaign
4. % UCs where key influencers listed in the micro-plan were engaged and mobilized
5. % UCs with all the identified mosques (in the micro-plans) demonstrating highly visible support (through banners/posters & mosque flyers) to polio campaigns
6. % UCs with all the identified schools (in the micro-plans) demonstrating highly visible support (through banners/posters & school flyers) to polio campaigns
7. % UCs demonstrating highly visible IEC materials (through banners/posters) at identified sites as per pre-campaign checklist
8. % UCs, where all the Vaccination Teams & Area Incharges received honorarium for the previous vaccination rounds through DDM after provision of the essential documents/information i.e. CNICs

“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. All the micro-plans (of Area In-charges) validated by the UC level supervisory staff (UC MO, UCPW, UCO) for:
 - a. 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
 - b. field validation (checking and validating if the descriptions made in the micro-plan and map match the grounds facts)
2. UC micro-plans of 30% UCs in the districts field validated by the district level staff including the EPI Coordinator, EPI focal person, DSV and his staff, PEO, DHCSO etc.
3. All the mobile teams having all team members over 18 years of age
4. At least 80% mobile teams with one government accountable worker (including the ones from registered non government organizations; for example Rural Support Program Network; National Commission for Human Development etc.)
5. Number of mobile teams complete per micro-plan; with either of the following targets met:
 - a. At least 80% mobile teams having one local member (suited to local norms and culture)
 - b. At least 80% mobile teams having at least one female member
6. All team members trained using standardized, national module including IPC module

“Post Campaign Indicators”

1. % of the LQAS lots passed for 95% (Target: 90%)
2. % UCs that achieved 95% vaccination estimates through post campaign independent monitoring (target: 90%)
3. % children missed due to refusal as per Independent Monitoring (<5% of missed children)

Annex-VII Polio Control / Operations Rooms



District Polio Control / Operations Room

- The district level control/operations room will be based in the office of the Deputy Commissioner (DC)/District Coordination Officer (DCO)/Political Agent (PA)
- The district level control room is to be led by a senior officer (ADC/APA) designated by the DC/DCO/PA.
- The DC/DCO/PA has to ensure that the district control room is fully equipped with all the necessary equipments and documents (e.g. computers, printers, fax, internet/e-mail, phone, UC wide map of the district walled, necessary indicators showing the performance displayed etc.)

Functions

- Control rooms to be operational throughout the month with enhanced functioning 15 days before the campaign till week after.
- Gather information/data from all the Union Councils (UCs) during the pre-campaign preparation phase; collate it in the SIAs Data Management System (SDMS) and relay it to the provincial level within the stipulated timeline
- All partners including DHMT,WHO-UNICEF_CommNet, NSTOP will assist in data quality check through data validation mechanisms
- Present summary of A-NEAP preparation indicators to the DPEC during its meetings before the campaign in the stipulated dates with focus on Pashtun populations and high risk groups in high risk and non high risk UCs
- Gather data/ information daily from all the UCs during the campaign implementation, collate/compile it in the SDMS and relay it to the provincial control room on daily basis. (Sample sheet attached)

The minimum essential variables include:

- o Target children (mentioned in SDMS; any modification to be officially communicated with proper justification)
 - o Children vaccinated
 - o Children recorded by the teams as not vaccinated (classified by reasons i.e. not available, refusal, any other)
 - o Children that remain unvaccinated till the end of the campaign
 - o Number of vaccine vials distributed, used and returned and the vaccine wastage
- Documenting the action points from the end day review meetings (evening meetings) during the campaign implementation phase, track the progress and share it with all the concerned (DPEC members, UC Medical Officers etc.)
 - Relay the results of the post campaign assessment (performed by the partner organizations) to the UCs and follow up (through the DPEC) the response vaccination activities in the sub-optimal performing areas
 - Ensure relaying actionable information during all the phases of campaign to DC/DCO/PA for immediate response.



Compositions of District Polio Control Room

- Designated officer by the DC/DCO/PA
- Executive District Officer Health (EDO-H)
- District Surveillance Coordinator
- National STOP Team Member (where assigned)
- WHO Polio Eradication Officer (where assigned)
- UNICEF District Health Communication Support Officer (where assigned)
- Data Manager designated by the DC's office
- Representative of the Rotary International
- Representative of any other local important organization as deemed necessary by the DC/DCO/PA Office

Following should be available in every District Polio Control Room:

- Copy of NEAP
- Map of the District/Agency/Town by UC highlighted/marked with Pashtun population and any other High Risk Groups
- Spot map of the District/Agency/Town with confirmed polio cases for last three years
- Lists of contact numbers of all the members of the District Control Room and all UPEC chairmen and co-chairs
- Schedule of SIAs
- Previous rounds performance indicators by UC/District (sample below)
- Minutes of previous DPEC meetings
- Copy of minutes of meeting of UPECs
- Vaccine stock record in the district/Agency
- UC wise Performance indicators (Sample sheet on next page)

Provincial Polio Control / Operations Room

- The provincial level control/operations room is to be based in the office of the Chief Secretary.
- The provincial control room is to be led by the Technical Focal Person (TFP) for NEAP assisted by the polio partners
- The office of the Chief Secretary has to ensure that the provincial control room is fully equipped with all the necessary apparatus and documents (e.g. computers, printers, fax, internet/e-mail, phone, district wise map of the province walled, necessary indicators showing the performance displayed etc.)
- Office of the EPI Manager will assist the Control Room in gathering and collation/compilation of the information/data

Functions

- Gather information/data from all the districts during the pre-campaign preparation phase; collate it in the SIAs Data Management System (SDMS) and relay to the National level within the stipulated timelines. At the same time the provincial control room may provide necessary feedback to the district control rooms based on data review.



Polio Control / Operations Room; Sample sheet for data collation at Provincial level during campaign *

District	Total target population for the campaign	Reported Coverage		Reported unvaccinated children												Vaccine Analysis									
		Children vaccinated (n)	% Children vaccinated among total target population	Children recorded as unvaccinated				Children vaccinated from recorded unvaccinated				Children still unvaccinated among recorded unvaccinated				Vials distributed (3)	Vials used (n)	Vials returned (n)	Wastage (%)						
				Not Available		Refusal		Total		Not Available		Refusal		Total						Not Available		Refusal		Total	
				n	% among targeted	n	% among targeted	n	% among recorded	n	% among recorded	n	% among targeted	n	% among recorded					n	% among targeted	n	% among targeted	n	% among targeted
Sherani	58,492	59,490	102	5,642	10	283	0.48	5,925	10	1,015	18	2	1	1,017	17	4,627	7.9	281	0.48	4,908	8.39	3,373	3,280	93	9
Zhob	68,003	64,592	95	6,019	9	2,059	3.03	8,078	12	5,821	97	1,373	67	7,194	89	198	0.3	686	1.01	884	1.30	3,962	3,485	477	7
Chitral	31,977	31,595	99	2,623	8	26	0.08	2,649	8	2,383	91	22	85	2,405	91	240	0.8	4	0.01	244	0.76	1,835	1,693	142	7
Total	158,472	155,677	98	14,284	9	2,368	1.49	16,652	11	9,219	65	1,397	59	10,616	64	5,065	3.2	971	0.61	6,036	3.81	9,170	8,458	712	8

* SDMS to be used for campaign data entry and collation

Polio Control / Operations Room; Sample sheet for data collation at District level during campaign *

UC	Total target population for the campaign	Reported Coverage		Reported unvaccinated children												Vaccine Analysis									
		Children vaccinated (n)	% Children vaccinated among total target population	Children recorded as unvaccinated				Children vaccinated from recorded unvaccinated				Children still unvaccinated among recorded unvaccinated				Vials distributed (n)	Vials used (n)	Vials returned (n)	Wastage (%)						
				Not Available		Refusal		Total		Not Available		Refusal		Total						Not Available		Refusal		Total	
				n	% among targeted	n	% among targeted	n	% among recorded	n	% among recorded	n	% among targeted	n	% among recorded					n	% among targeted	n	% among targeted	n	% among targeted
UC1	4,924	4,915	100	367	7	37	0.75	404	8	40	11	10	27	50	12	327	6.6	27	0.55	354	7.19	12,280	12,080	200	8
UC2	4,243	4,089	96	374	9	10	0.24	384	9	103	28	5	50	108	28	271	6.4	5	0.12	276	6.50	3,060	2,940	120	9
UC3	2,749	2,829	103	279	10	28	1.02	307	11	42	15	15	54	57	19	237	8.6	13	0.47	250	9.09	3,580	3,320	260	11
Total	11,916	11,833	99	1,020	9	75	0.63	1,095	9	185	18	30	40	215	20	835	7.0	45	0.38	880	7.39	18,920	18,340	580	10

* SDMS to be used for campaign data entry and collation

Annex-VIII Field SOPs for addressing refusal clusters



- During Campaign days, the vaccination teams will record the refusals on back of tally sheet (the already in place practice) with complete address of the house (phone number where possible) and number of children in the household.
- The Area In-charge (AIC) will visit the refusal household the same day with partners' communications staff (Social Mobilizer) wherever available.
- AIC if converts refusal will crosses it off the tally sheet, if not, then places it in the refusal list for the day and reports through UCMO to the control room (same day)
- UCMO to follow up on clusters of refusals (cluster: 2 or more refusal households in one team's one day work) the next day - and share the list with partners' UC based communications staff (UCO) where available
- UCO (where assigned) will provide list to Social Mobilizers (where available) who will make attempt for conversion the next day. Where the partner's staff is not available, the health staff of the local health facility will try to convert the refusals.
- UCMO if unable to cover refusals individually will travel along with the UC secretary or any staff from local government/ administration. The community influencers (that should already have been listed in the micro-plan) will be mobilized to convert the refusals.
- If the refusal cluster(s) are not addressed through attempts of UC level staff/influencers, the UCMO will compile the list(s) and share with the District Polio Control Room latest by the end of the campaign
- The Head of the Control Room and the partners' staff (DHCSOs) will jointly make effort to convert the refusals; as soon as received from the UCMO
- The DC/DCO/PA will be intimated about the cluster(s) of refusals if remained un-addressed by the efforts of UC and district level staff. The DC will then be responsible and will use all his influence to convert the refusal(s).
- All attempts to convert should be made before the next campaign.



All Parties Conference



Polio: A National Emergency

Wednesday, December 19, 2012;
Islamabad, Pakistan

Joint Declaration

Preamble

Recalling resolution WHA (World Health Assembly) 61.1 on poliomyelitis where nations of the world made a commitment to eradicate Poliomyelitis; a disease that was paralyzing 3,50,000 children every year.

Mindful of the resolutions of the Organization of Islamic Conference calling upon the last three Muslim nations harbouring the Poliovirus to redouble efforts towards a Polio-free Ummah;

Noting that Pakistan is a victim of and in a state of war against terrorism which has so far hampered polio eradication efforts;

WE the Political Parties of the Islamic Republic of Pakistan AFFIRM our commitment to saving every Pakistani child from disability for life caused by the Polio virus through the following interventions:

1. Make Polio Eradication plan a part of our Manifestos for General Election 2013
2. Will declare Polio transmission a "National Public Health Emergency" making poliovirus eradication a national priority programme, requiring the development and full implementation of emergency action plans, to be updated every six months, until such time as poliovirus transmission has been interrupted;
3. Allocate resources, both financial and human, for full implementation of all current and future Polio Eradication strategies as endorsed by international and national technical bodies and forums for Polio Eradication;
4. Full implementation of current and new Polio Eradication strategies by evolving an institution of strong national oversight and accountability mechanisms for all areas affected by poliovirus;
5. To institute an effective elected Local Government system which is vital for the eradication of Polio;
6. We appreciate the dedication and efforts of Polio Workers Teams working across Pakistan. All Political Parties of Pakistan condemn any attacks or deterrence caused by anyone in the effective discharge of responsibilities of Polio Workers Teams;

Awami National Party (ANP):	National Party (NP):
Balochistan National Party - Mengal (BNP-M):	Pakistan Muslim League (PML):
Jamaat-e-Islami Pakistan (JIP):	Pakistan Muslim League - Functional (PML-F):
Jamiat Ulema-e-Islam - Fazlur Rehman (JUI-F):	Pakistan Muslim League - Nawaz (PML-N):
Jamiat Ulema-e-Islam - Nizriati (JUI-N):	Pakistan Peoples Party (PPP):
Jamiat Ulema-e-Islam - Samiulhaq (JUI-S):	Pakistan Tehreek-e-Insaf (PTI):
Muttahida Quami Movement (MQM):	Quami Watan Party (QWP):

Emergency Operational and Security Guidelines



Note: These guidelines will be periodically reviewed and modified if required.

1. Introduction

Polio Eradication is a priority program for the country. National emergency has been declared by the Government of Pakistan to interrupt polio transmission and achieve the goal of eradication.

The National Emergency Action Plan (NEAP) for Polio Eradication was developed and approved in 2011 by the Prime Minister of Pakistan along with all the Chief Ministers, Governor Khyber Pakhtunkhwa and the Prime Minister AJK in 2011 and subsequently launched by the President of Pakistan.

Based on the lessons learnt, the plan was augmented for 2012 with focus on enhancement in the oversight at the national, provincial and district levels. The Augmented NEAP 2012 has generally been instrumental in bringing a programmatic paradigm shift from traditionally being the sole responsibility of the department of health to being the responsibility of the district/agency administration for the polio eradication activities at the district and UC level. Another major development was to achieve enhanced programmatic focus at the UC level. There is now an utmost need to translate the provincial and district level high commitment into meaningful accountability at the UC level.

A new NEAP has been made for 2013 with a special emphasis on increased quality activities including, Short Interval Additional Doses (SIADs) and SNIDs in the remaining reservoir areas, especially in the low transmission season December 2012-March 2013. It is the goal of the program that this is the last low season needed to stop polio virus transmission.

2. The Current Context that requires Emergency Operational and Security Guidelines

The NEAP 2013 was ready to be implemented with full force when the killing of 9 health workers during the December 17-19, 2012 polio vaccination campaign in Pakistan raised a number of questions about the response of the program and the next steps by the Government of Pakistan and GPEI partners. The polio reservoirs and core endemic areas of the country remain the regions of concern epidemiologically. Security risks are mainly in the epidemiologically high risk areas of Karachi and Khyber Pakhtunkhwa. The Law and Order situation in FATA remains volatile.

Despite all the steps taken in the current security situation; the quality of SIAs in December 2012 and January 2013 has not been up to the required level in the reservoir/endemic areas of Karachi and Khyber Pakhtunkhwa. This puts at risk the progress made in 2012 and the goal of NEAP 2013 (stopping WPV circulation in 2013).

The questions relate to 1) how best to plan for and conduct campaigns in a more secure environment; 2) how to build broader and stronger support for the program among the most affected communities; 3) how best to achieve reconciliation and removal of ban on polio vaccination by some militants, and de-politicize polio eradication in Pakistan.



The tragic events have resulted in an unprecedented outpouring of support from the civil society in Pakistan (a wide range of liberal, secular and religious institutions), political parties across the ideological spectrum, and the provincial and federal governments. Similarly, there has been international condemnation and calls for continued support of the program.

Given the national and international outrage on the deaths of health workers and the strongly expressed support for the program, now is the most opportune time to harness this energy and develop a positive momentum for the program. This will require a number of concerted actions at the UC, district, provincial and national levels.

Goal: Conduct technically sound polio SIAs in the safest manner possible while maintaining the momentum and epidemiological integrity of the 2013 NEAP.

3. Guiding Principles:

Safety first while being focused and fast

4. Implementation Guidelines

- (a) Full ownership, commitment, coordination and leadership of the district administration. The focus of planning and coordination should be the office of the DC (overseen by UC level and reports to provincial control room);
- (b) Well planned and managed engagement of local religious and community leaders;
- (c) Inclusion of local police in UPEC and District Police Officer and representatives of other law enforcement agencies in DPEC
- (d) Form a Provincial Security Coordination Committee chaired by Secretary Home Department
- (e) Local risk assessment of security situation by UPEC, DPEC and provincial control room/task force down to vaccination team work area about feasibility of conducting SIA before sending vaccination teams to work
- (f) Community engagement is required to make the locally tailored security assessment and plan with strategic use of LEAs-not to threaten the community but to reassure vaccinators
- (g) Technically sound micro-plan (refer to approved UC micro-planning guidelines) incorporating security element, community and religious leader support and appropriate communication strategy
- (h) Quick and quality campaign (limited area and limited time) in high risk security area instead of larger campaign using longer time
- (i) Flexible scheduling when necessary according to local conditions. The district administration will decide how to proceed (making sure the campaign finishes within 7 days of the scheduled end date).
- (j) The planning process should follow the schedule of the NEAP 2013.

5. Epidemiological Reservoirs and Core Endemic Prioritization

Priority 1: Reservoirs/Core endemic areas: central Khyber Pakhtunkhwa, FATA, high risk Towns of Karachi, Quetta Block, demographically linked areas with the wild polio virus Reservoirs. These areas are also those that have had the most security incidents and highest risk for security problems as well as wild polio virus transmission.



Priority 2: High Risk Districts other than the Reservoirs: Parts of northern Sindh, southern Punjab, and southern Khyber Pakhtunkhwa

Priority 3: Other High Risk Areas: Infected areas during last six months (outside reservoir and high risk belt)

Priority 4: The rest of the country

The proposed SIAs' schedule for February and March 2013:

Targeted areas	Dates	Target Population
SIAs targeting priority-1 and priority-2 districts/towns/agencies	18-20 February	15.5 m
SIAs targeting priority-1 and priority-3 districts/towns/agencies	4-6 March	9.6 m
SIAs targeting priority 4 districts/towns/agencies	25th March*	25 m

* Selection of districts and geographical extent will be finalized later according to the evolving epidemiology and status of SIAs (quality and completion)

The decision about security prioritization will be done by the local authorities! Areas that are not considered to be a security risk by local authorities will be able to conduct their activities normally as laid out in the 2013 NEAP. However, in high security risk areas other special strategies may be involved including communications. It is important to emphasize that all the possible measures have to be utilized to ensure access to all the target children with special focus on priority 1, 2 and 3 areas.

6. Communications for Emergency Situation in Polio Eradication Initiative

Keeping in mind the current context and tragic incidents in the course of polio campaigns, it is essential to revisit all communication strategies for the proper execution of the National Emergency Action Plan (NEAP) without impeding its pace and progress. In light of the current security situation, the following can be considered essential communication guidelines to support the National Emergency Operation and Security Guidelines.

- Focus mass public information efforts on disease education and risk perception, rather than campaign awareness;
- Increase use of content integration and existing editorial space, rather than advertising and marketing approaches;
- Present polio as a part of a broader package of health services for children;
- Avoid the promotion campaign dates on mass media materials. If local security situations allow, districts may choose to promote dates using ground materials and community outreach;
- Share information about positive environmental samples with affected communities to increase risk perception;
- Reduce visibility of teams on the ground;
- Integrate communication plans with operational plans.

6.1 Mass Media Campaign for Polio Rounds

- (a) District-level announcements of campaign dates to be made subject to individual security situation;
- (b) All communication, audio visual and visibility material to feature the logo of the relevant Provincial / Area Government Health Department;



- (c) Disease education and risk awareness messages to be placed on cable and electronic media programming integrated into existing programming and channels;
- (d) High Risk UCs inside High Risk Districts to have standard messages placed on a rotating basis to create ground level awareness;
- (e) List of High Risk Districts/UCs (in the context of positive environmental circulation) to be shared with public at large through local media.

6.2. COMNet

- (a) Door to door activities to be avoided, except to address refusal clusters (following NEAP SOP for refusal clusters);
- (b) Greater local/community ownership of the program to be facilitated through influencer mapping and involvement of influential community groups and individuals;
- (c) Mobilizing of existing social groups/multipliers to be given greater focus;
- (d) Activities and messaging to be broadened to include a wider package of child health commodities and development projects;
- (e) Communication activities to be closer integrated with District Administrations;
- (f) Implementation and leadership of the refusal conversion process to be strengthened.

6.3. IEC Material for Polio Rounds

- (a) All printed IEC Material to address the localized demands of the new vaccination strategy, staggered campaigns, no announcement of dates and campaigns concentrated in smaller areas;
- (b) All communication and visibility material to feature only the logo of the relevant Provincial/Area Government Health Department. Audio Material to have the same attribution;
- (c) No COMNet, vaccinators or campaign specific overt messages to be featured on IEC material;
- (d) IEC Material to encourage parents to take children to the nearest health facility if he vaccinators have not come to their home.

6.4. Involvement of religious leaders/public representatives and community elders

- (a) District Khateeb to be offered membership of DPEC, and encouraged to issue instructions to all Pesh Imams for making polio campaign announcements;
- (b) The focus to be shifted to strategic partnerships with religious leaders, local media mainstream and religious publications), parliamentarians, CSOs, and sectors beyond Health (Motorway Police, Highway Police, Transporter Associations, PPA, PMA and GPs);
- (c) Participation of community representatives (as identified by UPEC) to participate in security assessments by providing input to the Police SHO, to be made mandatory;
- (d) Mosque and mega phone announcements to be used as key communication support activities for the rapid response strategy;
- (e) UPEC to ensure that one local community member for each team in security sensitive areas during the campaign days.

6.5. Fixed point centres

- (a) Visibility of Polio Vaccination to be increased as part of an essential child health package at BHUs, RHCs, Government Dispensaries, Hospitals and Fixed Points;



- (b) WHO PEO to engage local / UC level GPs to become Polio Vaccination Centres – each centre to receive a specific set of communication and visibility material to promote vaccination.

6.6. Transit Points

- (a) Transit points leading to and from high risk areas to be given more visibility, where security allows.

6.7. Guidelines for polio vaccination teams

- (a) All vaccinators to carry duly authorized ID Cards at all times in the field. ID cards can be concealed under clothing but should be shown to parents in every door-to-door visit. No visibility/identification material other than the ID card to be worn or carried to minimize risk;
- (b) Micro-Plans to be updated before and after every round; copies of the micro-plan to be monitored and accounted for pre and post campaign;
- (c) Interpersonal Communication skills of vaccination teams to be improved through training;
- (d) Risk minimization guidelines to be incorporated in the training program for vaccinator teams.

6.8. Morale building of polio teams

- (a) Provincial and National Level recognition of the deceased and injured to be publicized to improve vaccinator morale. Efforts made towards compensation and rehabilitation to be effectively publicized at all levels.

7. Special Operational Strategy Options for Priority 1 High Risk Security Areas

7.1 Before Starting SIA please:

- (a) Establish security coordination and planning protocols with the concerned local law enforcement agencies that are implemented through UPEC, DPEC and Provincial task force and monitored through polio control rooms at all levels
- (b) A security risk analysis is provided by the DPO to the DC 5 days before the SIA
- (c) DC and DPO are the final decision makers on whether to go ahead in an area!!!
- (d) Garner full engagement and support of the most affected communities
- (e) Identify and activate all channels of mediation to remove threats to polio vaccination and depoliticize polio and other health services
- (f) Make micro-plan that involves all line government departments and community influencers
- (g) Do not make high profile announcements about polio round vaccination dates
- (h) Provincial and District Control Rooms in consultation with the UPECs play a pivotal role to relay information to and from the lower level regarding security issues before, during and after the SIAs

7.2 Option 1 in highest high security risk areas-Sector Approach (“Fast Track approach”)

This approach is based on trying to cover a limited area in a limited amount of time. In a high risk security area this would involve employing as many vaccination teams and supervisors as necessary to cover all children in a UC within the shortest time possible



(1-2 days). It should be easier to provide enough security to protect vaccinators in a small area. After the teams complete this area they can move on to another area using the same approach. A return visit to mop-up missed children may be done when the security situation permits.

- Will have to employ additional vaccinators and supervisors from the same community as necessary
- Additional fixed sites can be set up at strategic points such as vaccinator house site, private practice clinics, community centers or near mosques, etc. These fixed sites could provide other immunizations, soap, micro-nutrients, etc.
- All line government department staff led by the DC or ADC should be available to lead the efforts in the designated sector campaign
- Increase transit vaccination teams for the areas leading in and out of high risk security areas

Advantages to this approach:

- (a) Able to finish the vaccination in less time
- (b) Less time in the high risk area means less exposure to security threats
- (c) Can provide security forces more effectively due to smaller area and concentration of teams
- (d) Can also provide more effective supervision because teams are more concentrated in a smaller area therefore easier to see all teams and spend more time with the teams

Disadvantages of this approach:

- (a) Need detailed planning to have enough vaccination teams and logistics
- (b) May draw more attention because more teams in the area at the same time

7.3 Option 2: Staggering Approach

This approach is similar to the present way of conducting SIA using 4 days but does not conduct the entire area at the same time. It is staggered with some UCs done in one week then moving to other UCs. The best vaccination teams and supervisors are selected for this activity meaning some may come from another UC. Some more vaccination teams may be employed so that it resembles the sector approach and the campaign can be completed earlier than 4 days.

The staggering should not be done in a way that the whole district will still be completed within 7 days of the scheduled end date of the campaign. Example if the SIA is scheduled to end 20 February all activities (and areas) should be completed by 27 February. Any area that is not completed within this SIA period is considered missed and is not counted as part of the SIA coverage achievement. However this area should still conduct a vaccination round at the first possible opportunity.

- o Select the best performing vaccination teams and supervisors to work in a limited amount of UCs. It may be necessary to get these quality polio workers from different UCs if not enough local persons are available to provide an adequate number of teams
- o Ideally there should be 3 persons on team which must include a local person to guide the vaccinators if they come from a different UC



- o Additional fixed sites can be set up at strategic points such as vaccinator house site, private practice clinics, community centers or near mosques, etc, These fixed sites could provide other immunizations, soap, micro-nutrients, etc.
- o All line government department staff led by the DC or ADC should be available to lead the efforts in the designated sector campaign
- o Increase transit vaccination teams for the areas leading in and out of high risk security areas

Advantages for this approach:

- (a) Better quality supervision and vaccinator performance
- (b) Can concentrate security in a limited area thus reducing security threat
- (c) Can use a similar methodology to past campaigns

Disadvantages for this approach:

- (a) Complicated vaccination campaign schedule
- (b) Extends the length of the SIA so that it may lose some epidemiological effectiveness
- (c) Possible vaccinator and supervisor fatigue

In between vaccination passages in all the high risk areas try to increase polio plus outreach fixed sites and accelerate other development projects for these under served areas.

In actuality districts may use a mix of approaches where most of the district may be able to conduct the SIA normally while one portion must use a fast track approach or some of the district may be staggered while a normal approach is used in the other part. The mixing of approaches is up to the discretion of the DC and local authorities following the principle of finishing the SIA within 7 days of the scheduled end date!

7.4 Security for Outside the Reservoir and Core Endemic Areas

The same pre campaign planning is necessary as in the priority 1 areas. No vaccination activity should take place until a local security risk assessment and plan is made for the areas. The sector or stagger approach may be necessary for some areas but mostly the activities should be able to be conducted in the usual manner but only after a security component is incorporated into the micro-plan and adequately addressed during the implementation. Again additional fixed vaccination sites should be provided to support the house-to-house work.

7.5 Monitoring

The security plan and arrangements must also be made for all the SIAs' monitors. The independent post campaign monitoring will remain suspended for now. However, market/hospital surveys and LQAS will continue where feasible. The market/hospital surveys will be conducted only at large hospitals and market areas where the DC and DPO have considered the area to be safe and security arrangements have been considered and applied. LQAS areas will be submitted a day in advance for security clearance from the DC's office and the survey will be implemented once proper security arrangements are in place. If the DC and DPO consider an area at security risk to conduct the survey or LQAS then an alternative site will have to be chosen.

Polio Eradication Initiative Pakistan
Emergency Operational and Security Guidelines for 2013
Polio Immunization Activities in Pakistan
(Revised 01 August 2013)

1. Introduction

Pakistan is one of the last three polio endemic countries in the world. The Government of Pakistan has declared a National Emergency to interrupt polio transmission and achieve the goal of eradication. The first National Emergency Action Plan (NEAP) for Polio Eradication was developed and approved in 2011 by the Prime Minister of Pakistan along with all Chief Ministers, the Governor of Khyber Pakhtunkhwa, Prime Minister AJK and representatives of partner agencies, and was subsequently launched by the President of Pakistan. This was followed by a second NEAP for 2012.

The successes achieved in Polio Eradication following the launching of NEAPs in 2011 and 2012 have been mainly due to increased oversight and accountability by leadership at all levels. Oversight and accountability structures/mechanisms were established as a result of the NEAPs, and they oversee implementation of these plans. At the federal level there is the National Task Force for Polio Eradication (chaired by the Prime Minister) with the Prime Ministers Polio Monitoring Cell as its secretariat, at the Provincial level there are the Provincial Task Forces chaired by the Chief Ministers/Chief Secretaries, supported by Provincial Polio Monitoring Cells, and at the District and Union Council levels there are Polio Eradication Committees chaired by the DC and the senior most member of the administration at the Union Council level respectively.

In November 2012 the NEAP for 2013 was adopted following a process of development that took into account the progress made under previous plans, and an intensive review process by national and global technical experts in consultation with all provinces and partner agencies.

However since the development of the 2013 NEAP, a major challenge has been posed by the security situation with Polio workers being targeted and threatened in different parts of the country. To overcome this challenge requires specific planning and improvisation, innovation and creative approaches to reach every eligible child in security sensitive areas. These guidelines have been developed and revised in response to the challenge posed by security risks to the polio programme. They should be regarded as an Annex to the NEAP 2013.

2. The Need for Emergency Operational and Security Guidelines

The killing of 9 health workers during the December 17-19, 2012 polio vaccination campaign and subsequent further killings and security incidents have significantly affected polio campaigns in different parts of the country, and thus the implementation of the NEAP 2013. This resulted in delays and suspensions of campaigns, and a decline in access to children for vaccination, putting at risk the progress towards eradicating polio that had been achieved in 2011 and 2012. *The security situation has been most restrictive in the remaining endemic areas for polio in Pakistan, namely parts of FATA, Khyber Pakhtunkhwa and Karachi, but has also affected other areas. Unless access to children for immunization can be maintained in these areas, the national and global polio eradication goals are at serious risk.*

The tragic events have resulted in an unprecedented outpouring of support from the civil society in Pakistan (a wide range of liberal, secular and religious institutions), political parties across the ideological spectrum, and the provincial and federal governments. Similarly, there has been international condemnation and calls for continued support of the program. Given the national and international outrage on the deaths of health workers and the strongly expressed support for the

program, now is the most opportune time to harness this energy and develop a positive momentum. This will require a number of concerted actions at the UC, district, provincial and national levels.

The guidelines attempt to address the following questions:

- 1) How best to plan for and conduct campaigns in a more secure environment;
- 2) How to build broader and stronger support for the program among the most affected communities

3. Goal of these guidelines:

To ensure that technically sound polio immunization activities are conducted in the safest manner possible while maintaining the momentum and integrity of the 2013 NEAP.

4. General Guidelines and Guiding Principles:

- Since security incidents can occur in any part of the country at any time, *all provinces and districts need a security risk analysis and plan on how to conduct polio immunization activities in the safest manner possible.*
- The decision about security prioritization will be made by local authorities. Areas that are not considered to be a security risk will be able to conduct their activities normally as laid out in the 2013 NEAP.
- In areas considered to be at high security risk areas other special strategies may be involved. It is important to emphasize that all the possible measures have to be utilized to ensure access to all the target children with special focus on the highest security risk areas.
- Provincial Security Coordination Committees chaired by Secretary Home Department will oversee the security issues for polio immunization activities in each province.
- There will be full ownership, commitment, coordination and leadership by the **district administration**. The focus of planning and coordination should be the office of the DC with the full engagement of the District Police Officer (DPO) and other law enforcement agencies in the DPEC.
- Local police authorities will be included in all UPECs and UPEC Chairman and Secretary will ensure coordination with the concerned in-charge police station (SHO) regarding the security risk situation down to vaccination team work area.
- Well planned and managed engagement of local religious and community leaders will be undertaken to build trust and normalize the situation for campaign activities.
- Technically sound micro-plans will be prepared (refer to approved UC micro-planning guidelines) incorporating the security element, community and religious leader support and appropriate communication strategy.
- Flexibility of scheduling and immunization strategies will be ensured according to local conditions. The DPEC will decide how to implement activities (making sure the campaign finishes within 7 days of the scheduled end date).

5. Special Operational Strategy Options for High Risk Security Areas

- 5.1 Before starting polio immunization activities in all districts:

- a) A readiness report including a security risk plan should be provided by the DPO to the DC 5 days before the SIA
- b) DC and DPO make the final decision on whether to implement or defer in all or part of the district depending upon the security assessment
- c) UPEC to establish security coordination and planning protocols with the concerned local police station which will be monitored by polio control rooms
- d) Seek support of the most affected communities for anti-polio campaign activities
- e) Identify and activate all channels of mediation to remove threats to polio vaccination and depoliticize polio and other health services
- f) Ensure the micro-plan involves all line government departments and community influencers
- g) Do not make high profile announcements about polio round vaccination dates
- h) Provincial and District Control Rooms in consultation with the UPECs should relay and share information regarding security issues before, during and after the SIAs

5.2 Options for conducting activities in high security risk areas

In areas where the DC and DPO decide that activities can be conducted, but that there is a security threat requiring modification of the usual strategies and approaches, the following options can be considered.

Option 1: Sector Approach (“Fast Track approach”)

This approach is based on covering a limited area in a short amount of time. In a high risk security area this would involve employing as many vaccination teams and supervisors as necessary to cover all children in a UC within the shortest time possible (1-2 days). The objective is to be able to provide enough security to protect vaccinators in a small area. After the teams complete this area they can move on to another area using the same approach. A return visit to mop-up missed children may be done when the security situation permits.

In order to implement this option:

- Will have to employ additional vaccinators and supervisors from the same community as necessary
- Additional fixed sites can be set up at strategic points such as vaccinator house site, private practice clinics, community centers or near mosques, etc, These fixed sites could provide other immunizations, soap, micro-nutrients, etc.
- All line government department staff led by the DC or ADC should be available to lead the efforts in the designated sector campaign
- Increase transit vaccination teams for the areas leading in and out of high risk security areas

Option 2: Staggering Approach

This approach is similar to the present way of conducting SIA using 4 days but does not cover the entire area at the same time. It is staggered, with some UCs done first, and following completion moving to other UCs. The best vaccination teams and supervisors are selected

for this activity meaning some may come from another UC. Some more vaccination teams may be employed so that it resembles the sector approach and the campaign can be completed earlier than 4 days.

The staggering should be done in a way that the whole district will still be completed within 7 days of the scheduled end date of the campaign (e.g. if the SIA is scheduled to end 20 February all activities and areas should be completed by 27 February). Any area that is not completed within this SIA period is considered missed and is not counted as part of the SIA coverage achievement. However this area should still conduct a vaccination round at the first possible opportunity.

In order to implement this option:

- Select the best performing vaccination teams and supervisors to work in a limited number of UCs. It may be necessary to get these quality polio workers from different UCs if not enough local persons are available to provide an adequate number of teams

- Ideally there should be 2 persons on each team which should seek support of a local person to guide the vaccinators if they come from a different UC

- Additional fixed sites can be set up at strategic points such as vaccinator house site, private practice clinics, community centers or near mosques, etc, These fixed sites could provide other immunizations, soap, micro-nutrients, etc.

- All line government department staff led by the DC or ADC should be available to lead the efforts in the designated sector campaign

- Increase transit vaccination teams for the areas leading in and out of high risk security areas

In between vaccination passages in all the high risk areas try to increase polio plus outreach fixed sites and accelerate other development projects for these underserved areas.

Option 3- Staggering with Fewer Teams over a Longer Period

Another variation on the staggering approach is to use only the best vaccination teams, which may be less in number than the amount necessary for normal activities, therefore more days will be required to complete the activity. This situation may arise due to less security being available or due to fewer teams being appropriate to work in any given area. It could be an advantage if security teams are more familiar with the vaccination teams and understand the demands of the immunization activity. This may potentially result in better quality work than with more teams but less effective security.

Option 4- Continuous vaccination in LHW's own catchment area (No set campaign time)

Some areas are so security compromised that it is not possible to conduct an immunization campaign no matter what length of time. In this case, LHWs could conduct vaccination activities over 15 day intervals in their own catchment areas. The LHW would collect OPV from the local health facility and keep the vaccine at her home either in a vaccine carrier or a refrigerator then can take 1-2 vials with her as she moves through the community to vaccinate children each day without carrying a vaccine carrier. The LHW must be mindful of the OPV VVM and must not use the vaccine if it is in stage 3 or stage 4 despite the wastage of doses. Since she is familiar with the surrounding families and the number of children therefore she does not need to carry an ID badge or other signs of the polio program. She will continue vaccinating up to 15 days until she covers all the children in her area. This

approach will only be used in a few select areas and a consequence will be higher vaccine wastage yet the opportunity of vaccinating children far outweighs the wastage.

Option 5-Lower visibility

It may be necessary depending on the situation to employ lower visibility practices as a precaution for whatever approach that is used. This could include having vaccination teams not move with vaccine carriers, security personnel in plain dress, dropping part or all of house marking, simplifying tally sheets to have no names or identifying numbers, no ID batches or caps for vaccination teams, etc.

Districts may use a mix of approaches in areas that are security compromised, depending on the local circumstances and experience. For example, even if most of the district may be able to conduct the SIA normally, one portion may be covered using a fast track approach, or a staggered approach. The mixing of approaches is up to the discretion of the DC and local authorities following the principle of finishing the SIA within 7 days of the scheduled end date.

5.3. Monitoring

The security plan and arrangements must also be made for all SIA monitors. While independent post campaign monitoring will remain suspended for now in high risk security areas, there are monitoring options available, including:

- market/hospital surveys; these will be conducted only at large hospitals and market areas where the DC and DPO have considered the area to be safe and security arrangements have been considered and applied.
- LQAS; areas for LQAS will be submitted a day in advance for security clearance from the DC's office and the survey will be implemented once proper security arrangements are in place. If the DC and DPO consider an area at security risk to conduct LQAS then an alternative site will have to be chosen.

6. Communications for Emergency Situation in Polio Eradication Initiative

The following can be considered essential communication guidelines to support the National Emergency Operation and Security Guidelines.

- Involve local religious and community leaders in planning for access for vaccinators to communities;
- Focus mass public information efforts on disease education and risk perception, rather than campaign awareness;
- Increase use of content integration and existing editorial space, rather than advertising and marketing approaches;
- Present polio as a part of a broader package of health services for children;
- Avoid the promotion of campaign dates on mass media materials. If local security situations allow, districts may choose to promote dates using ground materials and community outreach;
- Share information about positive environmental samples with affected communities to increase risk perception;

- Integrate communication plans with operational plans

Door to door social mobilization activities should be avoided, except to address refusal clusters

Surveillance for Polioviruses

Preamble

AFP surveillance is one of the four cornerstone strategies of polio eradication. The main purpose of AFP surveillance is to detect the presence of circulating polioviruses. However, the information obtained through surveillance has other essential uses. AFP surveillance is the only tool available as the final measure of a country's progress towards polio eradication and ultimately for polio free certification. It also guides in planning effective strategies for vaccination activities and identifying high risk population groups. A sensitive AFP surveillance system aims at finding all the cases of acute flaccid paralysis (AFP), investigate those and collecting stool specimens to be tested in a WHO accredited laboratory to confirm the presence of polioviruses.

The National Emergency Action Plan (NEAP) so far focused mainly on the immediate priority in Pakistan, that is, improving the overall quality of Supplementary Immunization Activities (SIAs) and depleting remaining poliovirus reservoirs through overarching strategies including rigorous oversight and accountability mechanisms. It has been successful in most of areas as reflected by 71% reduction in polio cases in 2012 compared with to 2011 and wild poliovirus circulation geographically restricted. This annex to the existing NEAP is to ensure adequate monitoring of AFP surveillance by enhancing the oversight and accountability for this important cornerstone strategy through the existing structures at the national, provincial and district levels. It is pertinent to mention that Pakistan's AFP surveillance system is complemented by environmental sampling and a world class laboratory for polioviruses at National Institute of Health Islamabad, which is a WHO Regional Reference Laboratory for Polioviruses.

Key Functioning Mechanisms at the District level

The Provincial Government shall ensure that there is a dedicated and full time District Surveillance Coordinator (DSC) in every district/agency/area/township with essential enabling support (including mobility, computer, etc.). EDO-H/DHO/AS shall be responsible for this and DSC shall be accountable for ensuring following key functions of AFP surveillance system:

1. Building of a surveillance network in coordination with UC MOs/UPEC Chairmen based on a comprehensive list of health care providers in public and private sectors including informal health care providers. A quarterly review of the surveillance network shall be carried out for assessing its appropriateness.
2. Awareness of all busy health care providers (mentioned above) to ensure reporting of all AFP cases.
3. Investigation of all AFP cases within 48 hours of reporting,, using standardized form and ensuring stool specimens collection and shipment to the laboratory maintaining the reverse cold chain.
4. Weekly routine (zero) reporting and its adequate documentation at all levels (health facilities and district office).
5. Active surveillance visits to high priority (busiest) health care providers.
6. Comprehensive documentation including line-listing of AFP cases, AFP case files and records of zero reports and active surveillance.
7. Assist EDO-H/DHO/AS on holding monthly district surveillance review meeting, to review surveillance performance indicators essential for certification and making recommendations for improvement, if required

8. Generating monthly report about surveillance performance indicators any short comings and way forward. EDO-H/DHO/AS shall submit this report to DPEC.

DSC shall be an integral part of the District Polio Control Room established at the Deputy Commissioner's office. WHO Polio Eradication Officer (PEO) will continue providing technical support and oversight to the DSC for AFP surveillance especially in areas of evidence based actions for improvements, if required.

Indicators to be Monitored at the district and Provincial Levels

All essential certification standard AFP surveillance indicators shall be monitored at the district level on monthly basis. These include:

- Non-polio AFP rate (per 100,000 children below 15 years of age)
- Proportion of AFP cases with adequate stool specimens
- Timeliness of Routine/Zero Reporting
- Completeness of Routine/Zero Reporting
- Percent Active surveillance visits conducted
- Percent AFP cases investigated within 48 hours of notification
- Percent AFP cases followed up at 60 days after the onset of paralysis
- Percent stool specimens with non-polio entero-virus isolation

Monitoring Mechanisms

District level

- The district polio control rooms will have all the necessary information displayed regarding AFP surveillance including:
 - a) Names of all the health facilities / healthcare providers included in the surveillance network by classification of routine/zero reporting and active surveillance; and a spot map of the same
 - b) Monthly work plan for active surveillance, surveillance related activities like trainings and orientation of healthcare providers etc.
 - c) Updated line list and map of AFP cases for the current year
 - d) Status of key surveillance indicators by tehsil
 - e) Trend of routine/zero reporting timeliness and completeness (by health facilities and by tehsil) till the previous month
 - f) Trend of active surveillance conduct (by health facilities and by tehsil) till the previous month
- The district polio control room will ensure presenting the AFP surveillance indicators (minimum the ones mentioned above) during the DPEC meeting to the DC/DCO/PA.
- In case of sub-optimal functioning, the DPEC will analyze the situation in consultation with the technical partners and advise accordingly.

- Minutes of meeting reflecting review of surveillance activities shall be maintained and special reports / actions reflecting utilization of data shall also be maintained.

Provincial level

- The provincial polio control room (at the Chief Secretary's office) will have all the necessary information displayed regarding AFP surveillance including:
 - a) Number and proportion of districts with designated full time DSC
 - b) Number and proportion of districts where DSCs are provided with enabling support for surveillance activities (e.g. dedicated vehicle, fuel cost, computer etc.)
 - c) Status of key surveillance indicators (mentioned above) by districts
 - d) Trend of routine/zero reporting timeliness and completeness by district till the previous month
 - e) Trend of active surveillance conduct by district till the previous month
 - f) Minutes of DPEC meetings from districts (including notes on AFP surveillance discussions) and special reports reflecting AFP surveillance performance review and action(s).
- The provincial polio control room will ensure presenting the AFP surveillance indicators/information (minimum the ones mentioned above) during the meeting of the provincial task force.
- In case of sub-optimal performance, the provincial task force will ensure investigating the causes taking/advising appropriate response (including the accountability measures).
- The provincial control room will organize periodic targeted surveillance reviews in the light of the ongoing surveillance data analysis in consultation with WHO.

Optimizing the contribution of the Polio
Eradication Initiative to broader
immunization and disease control goals
in Pakistan

[Type the author name]
05/08/2013

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Background

The World Health Assembly (WHA) resolved to eradicate Poliomyelitis for the past 25 years and concerns have been raised on the polio program for not doing enough to contribute to broader immunization goals. On the contrary, the polio staff at different levels has de facto contributed to the EPI in several ways since the start of the eradication program. Nevertheless, this contribution has often been seen as being of variable intensity, unsystematic, often reactive and insufficiently coordinated.

Today polio is closer to being eradicated than ever before. The global goal for interrupting the circulation of wild polio virus is 2014 and the program is on track towards achieving it. To sustain the gains made towards Polio eradication, there is a critical need for strengthening routine immunization. In the absence of strong routine immunization program and high immunization coverage, any reintroduction of the virus would inevitably lead to a catastrophic and rapid spread. To reiterate the need of strengthening the routine immunization, WHA at its May 2013 meeting endorsed the 2013-2018 Polio Eradication End Game Strategic plan with one of its key objectives (Objective 2) highlighting the importance of stronger routine immunization program.

Pakistan context

Substantial achievement has recently been made in Pakistan in terms of polio eradication with a drastic fall in the number of cases and positive environmental samples. Poliovirus circulation is now restricted to very few reservoirs. The determinants of this major achievement are the government ownership and strong oversight and accountability mechanism that were recently put in place, as well as the development and implementation of a National Emergency Action Plan (NEAP), in addition to the strong technical, logistical and financial support of the Global Polio Eradication Initiative (GPEI).

However, the landscape for routine immunization remains bleak with coverage of all antigens persisting at much lower levels than desired. An example of the weakening system being the recent measles epidemic in the country resulting in more than 25,000 cases and more than 500 deaths in 2012-2013. Realizing the Routine immunization – Polio dilemma, international bodies like the Strategic Advisory Group of Experts (SAGE), the Global Vaccine Summit and the World Health Assembly, have made clear recommendations to the five GPEI partners in particular, to help countries effectively utilize the polio eradication assets to improve their immunization system. This has led to the inclusion of the component on improving routine immunization in the 2013-2018 global polio eradication end-game strategic plan and the Global Vaccine Action Plan (GVAP).

To translate this plan into action, the Regional Director, WHO/EMRO and Ministry of National Health Service, Regulation and Coordination called a high level multi-partners meeting on 4 – 5 July 2013, to reach a consensus among different partners, including the Government of Pakistan, on the main strategic directions to use polio assets in Pakistan to improve routine EPI. In preparation of this Multi-partners' meeting in July, a WHO mission comprising of PEI and EPI experts from HQ and EMRO visited Islamabad during 1 – 4 June 2013 to develop consensus among partners and Government of Pakistan on a broad strategic direction to sustain polio achievement through strengthening routine immunization as well a legacy plan to improve the country immunization system.

The mission had several rounds of discussion around the current situation of PEI and EPI in Pakistan; available resources of PEI and its distribution; and priority areas to use these PEI assets for strengthening RI with PEI and EPI staff in WHO and UNICEF country offices with other immunization partners (WB, DFID, USAID, Aus Aid, JICA, Rotary Int.) including the national and provincial EPI program managers and PEI/EPI staff from provinces. Later this concept was endorsed in the Multi-partners' meeting for improving immunization program in Pakistan held in July 2013 in Islamabad.

PEI assets in Pakistan

- **Human resources:** The PEI has built and deployed a large number of competent staff at national, provincial, district and UC level across the country.
- **Physical assets:** PEI finances large fleets of vehicles, communication and information technology equipment which operate in well-functioning work offices.
- **Operations systems:** The PEI has established a well-functioning AFP surveillance system relying on a highly performing national laboratory. It has also effectively facilitated coordination of partners' efforts and accountability of all stakeholders for their agreed contribution to the effort.
- **Knowledge:** Last, but not least, the PEI has acquired a valuable experience and expertise on public health issues.

Consensus on way forward

Discussions and deliberations between the relevant immunization stakeholders including the partners and government spanning over a period of four days helped in the consensus building around a set of guiding principles and areas of contribution of PEI assets to sustain the gains interrupting polio virus transmission and broader immunization goals. During 4-5 July 2013, a multi-partners' meeting was held in Islamabad to develop a consensus on strategies to improve routine immunization program in Pakistan especially scope of utilizing PEI assets in improving routine immunization. The meeting was participated by a wide range of Polio-EPI partners and experts. A general consensus was reached among all participants on adopting this strategy as a way forward to use PEI assets in support of routine

immunization. As a follow-up another WHO mission visited country during the 1st week of August and develop an action plan for the priority 16 districts for a period till December 2013 and identified specific deliverables (sub-annex 5).

Guiding principles

1. Develop flexible 'packages'
 - Representatives of the different partners agreed on developing flexible 'packages' of potential support interventions that polio-EPI teams can use to plan, based on available assets, experience and areas of expertise at different provinces.
2. Alignment with existing plans
 - Existing annual/multi-year plans will serve as a guide and harmonize the proposed activities to improve routine immunization.
 - Elements of the “packages” will be chosen and implemented in alignment with national context & priorities.
3. Focused intervention at the initial stage
 - Taking into consideration the polio eradication priorities as well as the availability of polio assets, there was a consensus on starting implementing this package in 16 Priority 2 districts (districts with intermediate risk for polio transmission. List of the selected 16 districts is in sub-annex 1). Districts were selected by provincial governments in consultation with WHO and UNICEF. Over the course of time with building capacity and lesser PEI activities, more districts will be included for support.
 - Based on strong recommendation from some of the provincial level government representatives, it was agreed that the polio eradication operation rooms and accountability process be used beyond the initial intervention districts, based on provincial and district governments decision.

Priority areas of contribution of PEI for routine immunization

1. Integrated district micro-plan

Due to limited number of functioning health facility in Pakistan, routine immunization service delivery is mostly dependent on outreach strategy. For successful implementation of outreach strategy, a good micro-plan is crucial. Unfortunately, in most of the districts either this micro-plan is not developed/updated or not adequate. Resultantly, outreach vaccination activity in most of the districts is either non-existent or irregular leading to poor access to immunization service for the community. PEI helped in developing extensive Polio SIA micro-plan for every UC identifying every community, their target, vulnerability, vaccine and logistics distribution, transportation, supervision and monitoring. This information from the Polio SIA micro-plan can

be effectively used to develop a good routine immunization micro-plan for every UC. Moreover, the Polio SIA schedule can also be considered during developing the routine immunization micro-plan.

The routine immunization micro-plan is to be developed at UC level by the UC immunization team headed by UCMO. The local vaccinator, LHV, LHSs, Nutrition supervisor, CDC supervisor, Sanitary Petrol and other local immunization staff will form the team to develop this micro-plan. UCPWs and UCOs will facilitate and support in this exercise providing information from Polio SIA micro-plan. District level Polio staff may also provide technical support wherever necessary.

The first step of developing UC micro-plan will be to draw a UC map showing all health facilities, functioning EPI centers, community/villages with their tentative monthly target for <1 yr children, major geographical landmarks e.g. river, canal, roads etc. Existing Polio SIA micro-plan map can be used for this purpose.

The second step will be to identify the catchment area of the existing EPI fixed center on the map. This can be done by demarcating an area 3 km radius or 30 minutes travel distance around the fixed center(s). Normal mode of transport for local people should be considered for measuring travel distance.

The third step will be dividing the rest of the area of the UC (excluding the fixed center catchment area identified in step 2) into 15 – 18 blocks. Boundary of village/community, major landmark e.g. river, canal, roads, target children etc. to be considered for identifying these blocks. Each block is to be assigned for an outreach team for one day. Location of vaccination sites for outreach services in the blocks will be identified in the micro-plan and local community will be informed about its location and date/day when the vaccinator will be visiting.

The fourth step will be assigning specific date for conduction of outreach session in each of these blocks. Name of the immunization staff who will conduct the vaccination session on that particular date also has to be specified in the micro-plan. Depending on number of immunization staff available in the UC, more than one outreach vaccination session can be planned on any given day. If there is no SIA scheduled in any particular month, then the required number of days dedicated to routine immunization outreach service can be increased in that month. If there are one or more SIAs in a month then a lesser number of outreach sessions will be held in that month. Attempts are to be made so outreach sessions are conducted in blocks having maximum number of target children in such months.

The fifth step will be developing vaccine and logistics distribution, transportation and supervision plan for each outreach vaccination session.

UC should develop the micro-plan for at least for one quarter (3 months) at a time and copy of that micro-plan to be kept at Tehsil/Taluka and district level. The session plan should consider/integrate Polio SIAs (as well as other vaccination campaigns e.g. measles) as well.

2. Integrated communication

For a successful and sustainable immunization programme, especially to sustain the gains of polio eradication efforts, it is extremely critical that advocacy, communication and social mobilization strategy should be developed. This communications strategy should be applied in such a manner that it not merely informs the masses to eliminate polio disease (wild and vaccine-related) but also underscores the importance of strengthening routine immunization systems to achieve higher coverage rates for all antigens and reductions in missed opportunities, unreached children, and drop-out rates. This can lead to a reduction of morbidity and mortality due to vaccine-preventable diseases by facilitating community awareness of immunization as a public health priority and by ensuring commitment and participation in immunization services and disease detection and reporting.

KEY APPROACHES

The critical asset for communication and social mobilization is the human resource available in the form of UNICEF's work force of the Polio social mobilizers – COMNet staff. In order to improve outreach to communities, UNICEF shifted efforts from national-level communication interventions to efforts strongly focused on the Union Council and community level, with a specific emphasis on high-risk groups and localities. Starting with the front line workers at the community level, the structure features three key staff position levels:

Social Mobilizers (SMs) are responsible for the implementation of community-based activities alongside local partners and are already responsible for the distribution and placement of communication materials at the community level. They regularly visit households in their assigned areas and use inter-personal communication (IPC) techniques with caregivers in order to encourage them to immunize children their children against the nine vaccine preventable diseases in addition to the provision of the communication support to vaccinators and other outreach workers, especially in case of refusals.

Union Council Communication Officers (UCOs) support the highest quality of micro planning possible through the Union Council Polio Eradication Committee (UPEC) and oversee and

support social mobilization. They also provide UC Information Education and Communication (IEC) material distribution plans, strengthen local partnerships and ensure inclusion of and access to mobile and migrant populations in polio eradication activities.

District Health Communication Support Officers (DHCSOs) develop district level communication and IEC distribution plans, working through the District Polio Eradication Committee (DPEC) and provide overall supervision and training support to workers and partners at the Union Council and community levels. They serve as district communication team leaders, leading their respective teams and working closely with partners in the field.

For communication and community engagement; UNICEF Country Office has already initiated the process of converging Polio and EPI with the development of Integrated Advocacy, Social mobilization and Communication Strategic plan for Routine immunization including Polio and new vaccines (PCV-10). The strategic plan has behaviour change communication strategy with clearly set behavioural objectives, key messages around routine immunization including polio and target audience specified at primary, secondary and tertiary level. Moreover, during the next six months, in the selected districts, the Polio COMNet staff shall be oriented on the integration of messages around Polio and routine immunization with the distribution of the pictorial, easy-to-use information, education, and communication material which could be integrated into their existing toolkits.

KEY ACTIVITIES

- i. Master Trainers training on routine immunization for all DHCSOs/UCOs of pilot districts in-line with the planning for regular trainings;
- ii. Production and distribution of revised community counselling cards on polio in addition to the routine immunization card;
- iii. Trickle down trainings by DHCSOs, supported by UCOs to all COMNet staff in the pilot districts
- iv. Mobilization sessions by COMNet staff in their catchment areas, staff to cover 60/70 households.

The communication strategy will take advantage of credible influencers and will also ensure that measures are taken to deliver culturally-appropriate messages in the right language and dialect for the target communities. Special measures will also be undertaken to identify and address the refusals, due and defaulters of the routine immunization. A detailed social map will be developed for every UC focusing on high risk populations. In UCs where such social maps already exist, at least 10% will be validated by district level partners' staff (UNICEF). The focus of social

mapping will be to identify and list all credible influencers in the communities, mosque Imams and the local health care providers.

Moreover; the Polio COMNet staff shall organize the communities to establish “community coalitions” comprising of the community based bodies, religious leaders, key influencers and health care providers (Lady Health Worker, Lady Health Visitor, Lady Health Supervisor, Vaccinator, social mobilizer or a medical officer). Such platforms would influence the demand for routine immunization among the common people on an on-going basis and is sustainable in the long run. Community coalitions comprising of the appropriate gender balanced representations of the Community Based Organizations (CBOs), religious leaders, key influencers, media representatives shall also steward and monitor the process of social mobilization.

Inter-personal communication (IPC)

Interpersonal communication skills are considered critical in raising demand for immunization services. Health care providers of the first and second level health care facilities, vaccinators, LHWs and LHSs of the National Programme, representatives of the Civil Society Organizations (CSOs), Community Based Organizations (CBOs) and COMNet staff will be trained on IPC to support the ACSM activities. This would enable them to work effectively with the parents and communities to increase demand for immunization services for protecting their children against nine vaccine preventable diseases. Special focus shall be kept on the social, cultural and political context of each high risk area, down to the union council level.

Moreover, the COMNet staff of Polio and local media shall also be engaged in the monitoring of the ACSM activities. Increasingly, this valuable human resource will be used to support routine immunization, as well as for training vaccinators and other frontline workers in Interpersonal Communications. Mechanisms shall be devised to link these COMNet staff with the fixed centres so that the EPI programme can organize outreach services to vaccinate unvaccinated children; hence improving the coverage and immunization outcomes.

3. Capacity building of frontline workers and Polio staff

Technical Polio staff (PEO, UCPW) and UCMOs are adept at the basic immunization knowledge and skills required for maintaining and administering OPV, however, in most cases they will need capacity building on routine immunization, which has additional complexities, challenges and a different orientation. In order for technical polio staff to function as monitors and supervisors for routine immunization and supplementary immunization activities involving injections they will have to be better trained. These trainings will include:

- I. Orientation to the Routine Immunization Monitoring Checklist that focuses on 7 questions/observations covering session implementation, defaulter tracking, vaccine supply, cold chain maintenance, injection safety, AEFI and providing information to mothers
- II. To ensure all technical workers have basic skills about EPI and will be able to adequately monitor and supervise implementation, the polio technical staff and UCMOs should receive training on WHO's Immunization in Practice. The topics to be covered are:
 - Vaccine Preventable Target Diseases
 - EPI Vaccines used in Pakistan
 - Cold Chain
 - Ensuring Safe Injections
 - Planning Immunization Sessions to Reach Every Infant
 - Holding an Immunization Session
 - Monitoring and Using Your Data
 - Building Community Support for Immunization

The training for these modules can be done over a 2-3 day period or can be given on a rolling basis with 1-2 topics per time during routine meetings, whichever is more appropriate for the program.

- III. Polio technical staff and UCMOs will also require refresher/orientation training for routine immunization planning. Micro-planning for routine immunization sessions follows the same basic concepts as what is done for polio SIAs, although the micro-planning for routine immunization has to be also coordinated with the conduct of frequent SIAs and has to include both a fixed site and outreach component. The guidance for micro-planning should come from the concepts of WHO's Reaching Every District/Reaching Every Community". The components of this micro-planning exercise will include:
 - Quantitative analysis of local immunization data
 - Preparing and reviewing an operational map
 - Identifying special activities for high risk and hard to reach areas
 - Preparing a health facility plan
 - Problem solving using the RED strategy
 - Making a work-plan for one quarter
 - Using the monitoring chart
 - Working with the community and tracking defaulters
 - Managing supplies
 - Giving feedback to the control room and making monthly reports

This orientation for routine immunization micro-planning can be facilitated by comparing the similarities and additional requirements to polio campaign micro-plans, especially the fact there will not be house-to-house immunization activity and fewer teams involved.

IV. PEOs, UCMOs and UCPWs are aware of AFP surveillance system but it will be necessary for them to receive training on how the integrated vaccine preventable disease surveillance system is arranged and how to coordinate with the District Surveillance Coordinator. In addition they will need to be provided technical information on signs and symptoms, case investigation forms, line list requirements, types of samples to be collected and reporting mechanism, and potential outbreak response actions, especially for:

- Measles
- Neonatal Tetanus
- Diphtheria
- Pertussis

V. Communications to create demand for Routine Immunization.

In the longer term it may be useful for PEO and UCMOs to receive EPI Mid-level Managers Training.

4. Routine EPI monitoring

Monitoring of actual vaccination sessions is essential to improve the EPI program by assessing what needs to be improved and to provide feedback to the Union Council and District Polio Eradication Committees. Monitoring will also motivate vaccinators and supervisors to improve their performance and be more accountable if they know they are being observed. Therefore a simple checklist will be developed to guide District Surveillance Coordinator (DSC)/EPI Focal person, other district/sub-district level health staff, Polio Eradication Officers, UC Medical Officers and UC Polio Workers with their observations and provide data to analyze the routine immunization performance. This checklist will focus on basic EPI functions and can be expanded as the program and skills of the monitors improve. The checklist will assess the following:

- a) Is the planned session conducted? (It is fundamental that if a vaccination session is not being conducted then the monitor will not proceed further with the checklist since there is nothing more to assess, and more importantly the service is not being delivered).
- b) Does the vaccinator have an updated defaulter list for following up children requiring scheduled EPI antigens? (This is to monitor if vaccinators are tracking children who have not completed their full course of antigens).

- c) Does the vaccinator have a standard vaccine carrier with 4 ice packs and foam pad? (This is to monitor if basic cold chain is maintained during the vaccination session).
- d) What vaccines are available for the vaccination session?
 - BCG (list number of vials)
 - OPV (list number of vials)
 - Pentavalent, DTP-HepB-HiB (list number of vials)
 - PCV10 (list number of vials)
 - Measles (list number of vials)
 - Tetanus Toxoid (list number of vials)
- e) Is a safety box is being used for disposing used syringes? (This is to monitor if basic injection safety is maintained during the vaccination session).
- f) Does the vaccinator provide information to mothers about common Adverse Events Following Immunization (AEFIs) such as fever or pain after injection? (This is to monitor if vaccinators are attempting to allay mother's concerns about fever and pain, which are often reasons for child drop-out).
- g) Does the vaccinator inform the mother about the next visit? (Measures if the vaccinator is interacting with the mother so she is aware of EPI sessions and will know the importance of bringing her child again to complete full course of immunization).

The checklists will be collated and analyzed by the district polio control rooms which will in turn share the information with the UC and District committees for discussion and action.

Beside the checklist data, DHT will share following indicators in every DPEC meeting. These indicators to be followed in all districts beyond the primary intervention districts.

- a) Whether monthly EPI review meeting with all UCMOs at district level and with all vaccinators at Tehsil/Taluka level held or not. (Minutes of meetings are to be shared with DCO).
- b) Number of outreach vaccination session planned according to the micro-plan and number of outreach vaccination session actually held during the previous month.
- c) Number of health facilities providing regular routine immunization service among the total functioning health facilities in the district.
- d) Information on every routine and SIA antigens:
 - i. Number of doses in stock at the beginning of the previous month

- ii. Number of doses received during the previous month
 - iii. Number of doses balance at the end of previous month
 - iv. Number of children vaccinated with this vaccine
- e) Trend of number of zero dose children in the district identified during past Polio SIAs (a line graph showing number of zero dose children in past SIA conducted in the district).

5. Supporting strengthening VPD surveillance

Integrated VPD surveillance including case based measles surveillance is introduced throughout the country since 2009. This surveillance system is based on original VPD surveillance system modified with inclusion of lab component and making it weekly reporting instead of monthly. Pre-existing Health facility reporting form was revised and Case Investigation Form (CIF) for suspected measles case was added.

Though there has been significant improvement in functioning of this surveillance system in some provinces especially in terms of timeliness and completeness but it is still not optimum. Wide variation in performance exists among the districts and provinces. District level PEI staff has scope to support in strengthening this surveillance system in the following ways,

- Regular monitoring of timeliness and completeness of the weekly reporting from health facilities at district level and share the indicators in DPEC meeting through Polio Control room
- Encouraging health facility in-charges and other service providers for sending weekly report during their routine visits to the health facilities
- Providing technical guidance to the health-facility in-charge or service providers explaining the surveillance system, their action point and its importance during their routine visit
- Technical support to the District Surveillance Coordinator in compiling data and use of data to monitor basic surveillance indicators
- Assist in outbreak response investigation

6. Accountability and oversight

The National Emergency Action Plan (NEAP) for polio eradication has proven to be quite an effective tool in ensuring the rigorous monitoring and accountability mechanisms with the establishment of the oversight bodies under the chairmanship of the Prime Minister of Pakistan

and Chief Ministers and Governors of the provinces/regions; hence immensely raising the profile of the program and fast-tracked implementation of the strategies. One of the major features of the augmented NEAP 2012 was to give the lead to the Deputy Commissioners/District Coordination Officers/Political Agents (DCs/DCOs/PAs) and hold them accountable for quality of polio eradication activities at the district and UC levels. Engagement of the DCs/DCOs/PAs strengthened the district and UC Polio Eradication Committees (DPEC and UPEC). The augmented NEAP also strengthened further the provincial level task forces with more involvement of the Chief Secretaries and formation of the polio cells in the offices of the provincial Chief Ministers. Prime Minister's Polio Monitoring and Coordination Cell provided a strong oversight from the national level. Regular provincial and district level program reviews were held with the provincial administrative and health leadership as well as the DCs/DCOs/PAs after every supplementary immunization activities (SIAs) to appraise the performance, identify gaps and appropriate remedial measures.

The specialized task forces and committees; from the national up to the UC level have proven instrumental to ensure the implementation of the NEAP and achieving the progress over the year 2012. All these task forces and committees were headed by the top political and/or administrative leadership empowered by these bodies to take adequate decisions, track the implementation and apply accountability when required. Moreover, the Prime Minister's National Task Force meets quarterly to assess the program progress. Prime Minister's Focal Person for Polio Eradication was regularly briefing the Prime Minister's Office about the program status and seeking necessary help when required. The milestones and indicators mentioned in the NEAP are being regularly tracked and assessed and presented to the National Task Force during its meetings. The national steering committee headed by the relevant Ministry (previously Ministry of IPC and now Ministry of NHSRC) assesses the situation of ongoing operations and keeps a close liaison with the provincial programs through a feedback mechanism.

In addition to a control room at the national level, the NEAP advises a provincial control room in the office of the Chief Secretary led by a senior officer in his office. The control rooms are supposed to gather and collate the reported (administrative) data during the pre-campaign preparation and the campaign implementation phases along with actionable information transmitted in a timely fashion to the next level.

The Provincial Task Force for polio eradication is to be led by the Chief Secretary and is supposed to fast-track implementation of the National Emergency Action Plan. A senior full time government officer (Additional Secretary level) is to be designated in each province and in FATA;

to manage the provincial Polio Control Room with the assistance of partners. The incumbent is a member of the Provincial Task Force and reports directly to the Chief Secretary (and Additional Chief Secretary in FATA).

At the district level, the DC/DCO/PA as Chairman of the DPEC/APEC is supposed to designate a full time government officer (Additional Deputy Commissioner / Assistant Commissioner & APA for FATA) to ensure accountability for implementation of the District Emergency Action Plan. This official manages the district control room and is responsible for ensuring the collection of data on the indicators for preparation and implementation of SIAs, and for presenting this information to the DPEC for appropriate actions. The concerned authorities in the Provincial Governments and Peoples' Primary Healthcare Initiative (PPHI) have to ensure availability of a Medical Officer in every UC (UC MO) particularly in the high risk UCs; who have to function as the UPEC Chairman.

The DPEC headed by the DC/DCO/PA meets 10 days before the campaign to review the status of preparations and the results of UPEC meetings (completeness and timeliness) and considers specific requests from the UPECs and any interventions required to make corrections at the UC level. A sub-committee meeting is held 5 days prior to the campaign to make a final assessment of the implementation of key recommendations, and to decide on implementation or deferment of implementation UC by UC on the basis of preparation indicators. The DPEC is assisted by the DDHO for managing its functions at the tehsil level.

Functionality of the UPEC is ensured by the DC's office (in coordination with the concerned EDO-H) with designation of the full time Union Council Medical Officer as Chairman and Secretary UC as co-chair of the Committee with binding membership of important UC level stake holders. The meeting of the UPEC is supposed to be conducted 15 days before the campaign with an agenda including: a) review of implementation status of the last meeting's decisions; b) review and endorsement of the integrated micro-plans including composition and quality of vaccination teams and engagement of the community influencers for information and motivation of the community; and c) plans for quality training, supervision and real time process data transmission on daily basis.

This oversight structure for PEI will be effectively utilized for establishing accountability and program performance monitoring for routine EPI and other disease control activities. Data collected by the PEI staff through checklist and district control room data derived through DHT and Polio SIA as described earlier will be shared in the DPEC and UPEC meetings. These indicators will be regularly followed by the respective oversight structures and will be reported to the higher level. Appropriate remedial measures and actions will be ensured through these

oversight structures at different levels for proper functioning of routine immunization and other disease control activities.

PEI contribution in disease control activities

Presently, Pakistan is passing through a devastating measles epidemic. The epidemic became explosive since the last quarter of 2012 and since then over 25,000 suspected measles cases have been reported with over 500 deaths. This called for the recommendation by the joint WHO-UNICEF-GAVI mission to conduct a nationwide Measles Supplementary Immunization Activities(SIA) targeting all children aged 09 months to <10 years. The mission further recommended increasing routine measles coverage for both doses through strengthening routine EPI to sustain the population immunity gained through the SIA.

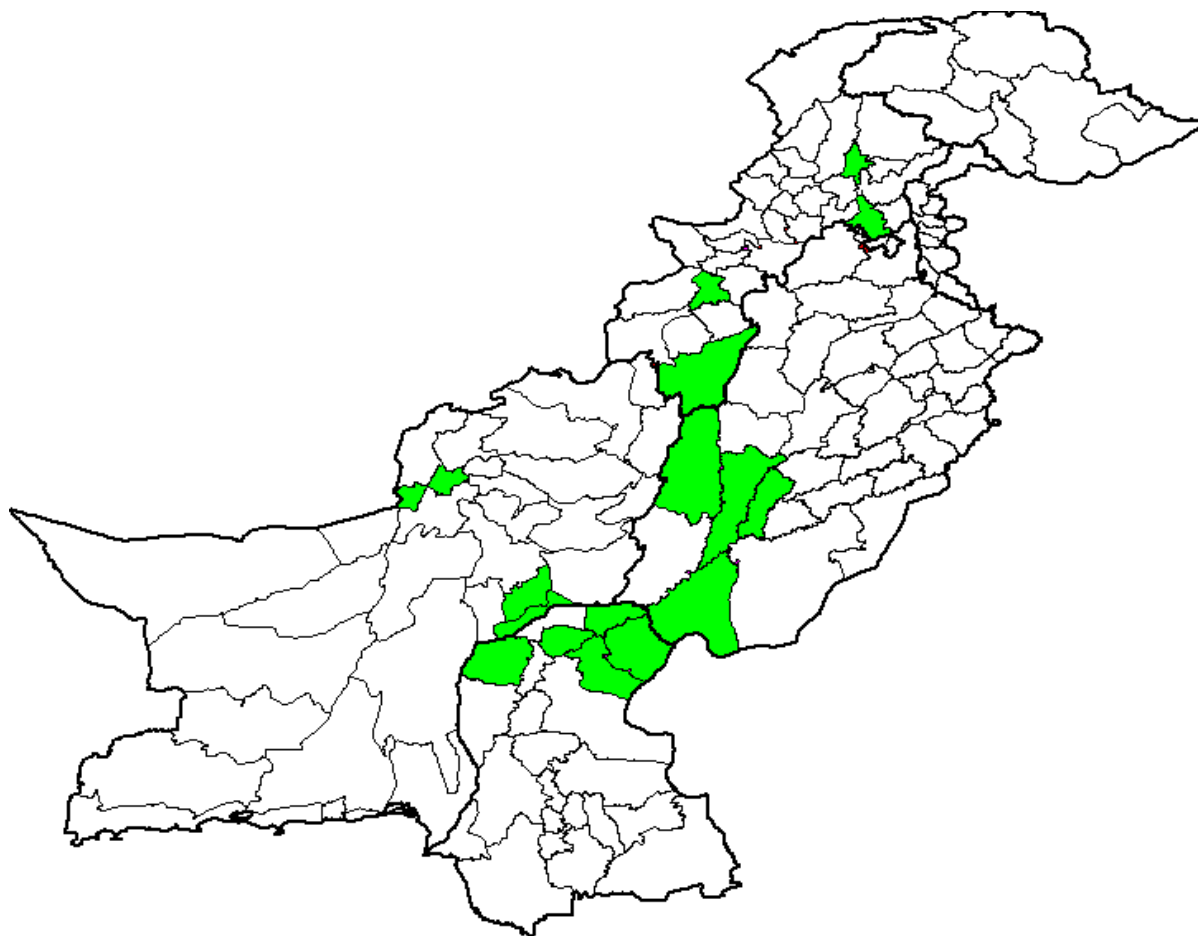
Government of Pakistan decided to conduct the SIA in November 2013 with assistance from donors (GAVI, MRI, WHO and UNICEF) and using its own resources. It has been further decided to integrate the SIA with Polio NID scheduled in the same month. There is a good opportunity for the Polio team to contribute in this integrated Polio-Measles SIA in terms of preparation, implementation and monitoring. The Polio oversight structure at national, provincial, district and UC level also have immense scope of ensuring a good quality SIA through its oversight mechanism.

National and provincial level polio staff may contribute in planning, strategy setting, developing guidelines, and tools. They may also help in preparation for training and orientation of the master trainers of the districts. Building ownership among the political and administrative hierarchy through advocacy is another important area where the Polio team may play a significant role.

District and UC level PEI staff may provide technical assistance and monitor development of micro-plan, training and orientation of health workers, cold chain and vaccine-logistics management and other preparatory activities. Preparedness of the districts for the SIA can be closely monitored by these grass root level PEI staff. The monitoring of the SIA implementation will use a checklist and evaluation through RCA and LQAS.

Sub-annex 1

Districts for Primary Intervention in 2013



Province / District
PUNJAB
DGKhan
Multan
Muzaffargarh
RYKhan
SINDH
Kamber
Ghotki
Kashmore
Shikarpur
Sukkur
KHYBER PAKHTUNKHWA
Bannu
DIKhan
Haripur
Shangla
BALUCHISTAN
Jafarabad
Nasirabad
Quetta

Routine Immunization Vaccination Session Monitoring Checklist

Name of the monitor:

Date:

Designation:

UC:

Tehsil/Taluka:

District:

Type of Vaccination center:

Fixed

Outreach

1. Session conducted?	Yes	No
2. Does the vaccinator have an updated defaulter list for following up children requiring scheduled EPI antigens?	Yes	No
3. Does the vaccinator have a standard vaccine carrier with 4 ice packs and foam pad?	Yes	No
4. What vaccines are available for the vaccination session?		
Antigen	# of vials	
BCG		
OPV		
Penta (DTP-HepB-Hib)		
PCV10		
Measles		
TT		
5. Whether a safety box is being used or not for disposing used syringes?	Yes	No
6. Does the vaccinator provide information to mothers about possible common adverse events following immunization (AEFIs) such as fever or pain after injection?	Yes	No
7. Does the vaccinator inform the mother about the next visit?	Yes	No

Routine immunization indicators to be shared by the District Polio Control room in DPEC meeting

1. What percentage of UCs in the district developed an integrated microplan for outreach vaccination session	%
2. Number of vaccination sessions at EPI fixed center were monitored in the district by PEI staff	#
3. Number of vaccination sessions at EPI fixed center were monitored in the district by UCMOs and other Health department staff	#
4. Number of outreach vaccination sessions monitored in the district by PEI staff according to micro-plan	#
5. Number of outreach vaccination sessions monitored in the district by UCMOs and other Health department staff according to micro-plan	#
6. Total number of monitored outreach vaccination sessions were actually found held according to micro-plan	# (%)
7. Total number of monitored outreach vaccination teams found having updated defaulter list	# (%)
8. Total number of monitored vaccination teams (fixed and outreach) were found using a standard vaccine carrier with four icepacks and foam pad	# (%)
9.a. Number of monitored outreach vaccination sessions were found with no or inadequate tOPV	# (%)
9.b. Number of monitored outreach vaccination sessions were found with no or inadequate Pentavalent vaccine	# (%)
9.c. Number of monitored outreach vaccination sessions were found with no or inadequate PCV10 vaccine	# (%)
9.d. Number of monitored outreach vaccination sessions were found with no or inadequate measles vaccine	# (%)
9.e. Number of monitored outreach vaccination sessions were found with no or inadequate TT vaccine	# (%)
10. Number of monitored vaccination teams (fixed and outreach) were found using safety box	# (%)
11. Number of monitored vaccination teams (fixed and outreach) were found giving message to the mother/care giver about expected AEFI relevant to the antigen(s) administered	# (%)
12. Number of monitored vaccination teams (fixed and outreach) were found giving message to the mother/care giver about date and importance of next visit when applicable	# (%)
13. Whether the monthly EPI review meeting held at district level with all UCMOs under the chairmanship of EDO (Health)/DHO/Agency Surgeon in this month or not. (minutes of the meeting to be shared with the DPEC chairman to consider the meeting was actually held)	Yes/No
14. How many monthly EPI review meeting held at tehsil/taluka level with respective vaccinators under the chairmanship of DDHO in this month? (minutes of the meetings to be shared with the DPEC chairman to consider the meetings were actually held)	#
15. Vaccine stock and utilization information in the district for the immediate past month	

Antigen	Stock at the beginning of the last month (in doses)	Received during the last month (in doses)	Number of children/women vaccinated					Stock at the end of the last month (in doses)
			0 dose	1 st dose	2 nd dose	3 rd dose	4 th dose	
Routine immunization								
BCG								
OPV								
Penta								
PCV10								
Measles								
TT								
SIA								
OPV								
Others								
16. Trend of number of zero dose children identified through last 4 Polio SIAs held in the district								
Polio SIA (NID, SNID, SIAD, Mop-up activities)				Number of zero dose children identified				
1 st SIA								
2 nd SIA								
3 rd SIA								
4 th SIA								
17. Timeliness and completeness of integrated weekly VPD surveillance system (both indicators should be at least 80%)								
(a) How many health facilities are in the integrated VPD surveillance network in the districts?								
(b) How many total weekly VPD surveillance report received in the district within due date from health facilities till last week since beginning of the year				Timeliness: $(b \div a \times \text{Last Epi wk number}) \times 100$				
(c) How many total weekly VPD surveillance report received in the district from health facilities till last week since beginning of the year				Completeness: $(c \div a \times \text{Last Epi wk number}) \times 100$				

Routine immunization indicators to be monitored by the Provincial Task Force

1. Basic indicators

Total number of BHU and above level health facilities in the province and out of them number of health facilities provide regular vaccination service (give a district wise break up of such health facilities)	
Number of UC without any EPI center in the province	
Total number of vaccinators in the province and number of UC without any vaccinator	
Total number of Union Council without any comprehensive quarterly microplan for outreach vaccination service (give district wise breakup)	
Total number of trained LHWs available in the province and how many of them are involved in provision of immunization service independently in their catchment area	
Number of districts achieved cumulative Penta 3 coverage above 80% till last month	
Number of districts achieved Penta 1 to Penta 3 cumulative dropout rate below 10% till last month	
Number of districts had monthly outreach vaccination session dropout rate above 5% during the past months since the last Task Force meeting held	
Number of districts achieved 80% or more timeliness for weekly VPD surveillance reporting till last epidemiological week	
Number of districts achieved 80% or more completeness for weekly VPD surveillance reporting till last epidemiological week	

2. Trend of number of zero dose children identified through last 4 Polio SIAs held in the province

Polio SIA (NID, SNID, SIAD, Mop-up activities)	Number of zero dose children identified
1 st SIA	
2 nd SIA	
3 rd SIA	
4 th SIA	

3. Routine OPV3 coverage among the Non-Polio AFP cases reported in this year in the province

4. Vaccine stock and utilization information in the province for the immediate past quarter

Antigen	Stock at the beginning of the last month (in doses)	Received during the last month (in doses)	Number of children/women vaccinated					Stock at the end of the last month (in doses)
			0 dose	1 st dose	2 nd dose	3 rd dose	4 th dose	
Routine immunization								

BCG									
OPV									
Penta									
PCV10									
Measles									
TT									
SIA									
OPV									
Others									

5. Number of primary intervention districts started reporting on the district level monitoring

Work plan for Optimizing the contribution of PEI to broader immunization and disease control goals in Pakistan

Activity	Responsibility	Time frame (2013)
Development of training curriculum and training materials	Quamrul Hasan Keith Feldon	30 August
Briefing to the National Task Force (NTF)		1 st week of September
Provincial Workshops (1 x 4 province) <ul style="list-style-type: none"> • Provincial EPI (2) • District (3 x 16 districts) • DCO (only for 1st day of the workshop) 	<u>Facilitators</u> <ul style="list-style-type: none"> • WHO/UNICEF provincial/district team 	3 rd week of September
District Workshops (in every district) <ul style="list-style-type: none"> • USMOs • UCPWs • UCCOs • DSV • DCSO • LHW Coordinator • DDHOs • Vaccinators (??) (in batches of around 25 participants per batch)	<u>Facilitators</u> <ul style="list-style-type: none"> • WHO/UNICEF provincial/district team 	2 nd week of October
Briefing to the Provincial Task Force (PTF)		1 st meeting after the NFC meeting or by end of October

Deliverables

Indicator	Target	Timeline
Integrated micro-plan developed	50% UC in each district	2 nd week of November
	100% UC in each district	2 nd week of December
Commencement of RI Monitoring by PEI staff	50% UC in each district	4 th week of November
	100% UC in each district	4 th week of December
District report to DPEC – on progress on micro-planning	100% districts reporting on progress on micro-plan development	4 th week of November
District report to DPEC – on progress on monitoring of RI indicators by PEI staff	100% districts reporting on monitoring of RI indicators by PEI staff	4 th week of December
DPEC report to Provincial Task Force	100% DPECs are reporting to PTF	4 th week of December