

Augmenting the  
**NATIONAL EMERGENCY  
ACTION PLAN**

*For*  
Polio Eradication in 2012



Government of Islamic Republic of Pakistan  
January 2012

## Foreword

Pakistan is passing through a very critical situation with regard to Polio Eradication with the country reporting the highest number of polio cases among all endemic countries.

A National Emergency Action Plan was implemented in 2011 providing for a new infrastructure of oversight, monitoring and accountability at the Federal, Provincial and district levels.

On 24th November, 2011, the Honourable Prime Minister Chaired a meeting of the National Task Force on Polio Eradication with Chief Ministers, Governor Khyber Pakhtunkhwa and Prime Minister Azad Jammu & Kashmir attending. The meeting endorsed the Augmentation of the National Emergency Action Plan to make it more effective to achieve the goal of Polio Eradication in 2012.

The augmentation of the National Emergency Action Plan was completed after a meticulous consultative process involving the Provincial Governments, the partner organizations, international experts and the independent academia. The augmented strategies for the National Emergency Action Plan 2012 have been detailed in a document which must be implemented in conjunction with the existing National Emergency Action plan, which remains in force. The document featuring the augmentation of the National Emergency Action Plan is issued for vigorous follow up.

It is mandatory to make sure every strategy mentioned in the National Emergency Action Plan and its augmentation is implemented with full force especially at the Union Council (UC) level in each district.

Proper implementation of the National Emergency Action Plan and the strategies outlined in the Augmentation Document by provincial and district level administrative and political leadership; is the key to make 2012 different and to get Pakistan in the line of Polio Free Countries by the end of 2012.



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# Table of Contents

## **A) Executive summary**

## **B) Context**

- i. Developments in 2011 and the rationale for augmenting the National Emergency Action Plan
- ii. Epidemiology and risks of continued transmission

## **C) The Augmented National Emergency Action Plan 2012**

- i. Goal
- ii. Milestones
- iii. Objectives
- iv. Augmentation Strategies
  1. Augmenting national management and oversight
  2. Intensifying oversight in Provinces
  3. Enhancing oversight and accountability at the district level
  4. Enhancing performance of district and sub-district level committees to oversee campaign operations
  5. Deferment of scheduled campaigns in case of inadequate preparations
  6. Additional Innovative Strategies
  7. Enhancing post campaign monitoring and evaluation
  8. Capacity building by Partner Organizations
  9. Improvement of national communication strategies

## **D) Conclusion**

## **E) Annexes**

- i. Annex I: List of Acronyms
- ii. Annex II: DPEC (functions and Composition)
- iii. Annex III: UPEC (functions and Composition)
- iv. Annex IV: proposed schedule of the SIAs in 2012
- v. Annex V: List & map of High Risk Districts
- vi. Annex VI: Indicators for DPEC, UPEC and Campaign Deferment

## A) Executive summary

***Rationale for augmenting the NEAP:*** The National Emergency Action Plan (NEAP) for Polio Eradication had the goal of interrupting all poliovirus transmission in Pakistan by the end of 2011. It is now clear that this goal will not be achieved. In 2011 Pakistan has the highest number of cases in the world. The main reason for the failure to achieve the goal is inadequate implementation of strategies especially in key high risk areas. The Independent Monitoring Board for the Global Polio Eradication Initiative (IMB) in September 2011 expressed serious concerns and recommended a fundamental re-think of the NEAP and focusing on enhancing meaningful accountability.

***Review of the NEAP:*** In response, a critical review of the NEAP was conducted in November 2011 by the Government of Pakistan, Provincial Governments, partners and academia as well as independent policy and strategy development and oversight institutions. Key actions for augmenting implementation of the NEAP were identified, intended to significantly improve accountability and implementation. *The augmented strategies for the NEAP 2012 detailed in this plan should be implemented in conjunction with existing NEAP strategies, which remain in force.*

***The Goal of the Augmented Emergency Action Plan:*** To interrupt transmission of poliovirus in Pakistan by the end of 2012.

***Elements of the augmented NEAP:*** Key milestones along the road to achieving this goal are detailed in the augmented plan, as are augmented strategies, some of which are enhancements of strategies already included in the NEAP, and some of which are new and innovative approaches.

### ***The new elements that the augmented plan brings are:***

- Re-defining polio as a national emergency that must be urgently addressed, and ensuring that all arms of Government are engaged in eradicating polio
- Achieving oversight at district, province, and national level through National Task Force presided by the Prime Minister with wide representation of stakeholders including community leadership. Shifting emphasis to implementation of 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
- ***Reviewing implementation:*** The implementation of the augmented NEAP 2012 will be reviewed by the Prime Minister's Task Force for Polio Eradication every three months, Provincial Task Forces chaired by the Chief Minister every month (Governor Khyber Pakhtunkhwa for FATA). A dedicated full time senior officer in the Prime Minister and Chief Minister (CM) Secretariats will be in place by

January 2012 for coordination for the smooth implementation of the Plan and a report to the Prime Minister and Chief Minister fortnightly. As per advice of the Prime Minister, performance of Deputy Commissioner / District Coordination Officer / Political Agents and Executive District Officer Health based on the performance indicators in the augmented NEAP is to be reflected in their Annual Confidential Reports.

## ***B) Context***

### **i. Developments in 2011 and rationale for Augmenting the NEAP**

The Government of Pakistan launched the National Emergency Action Plan (NEAP) for Polio Eradication in January 2011, with the goal of interrupting all poliovirus transmission in Pakistan by the end of 2011. **It is now clear that this goal will not be achieved.** Despite the launch of the Emergency Plan, as at 21 November the number of polio cases in 2011 (154) has already exceeded the total number reported last year. Not only has Pakistan reported more cases than the other three endemic countries (Afghanistan, India, Nigeria) put together, but **Pakistan now has the highest number of cases in the world in 2011.**

**The main reason for the failure to achieve the goal is inadequate implementation of NEAP strategies especially in key high risk areas.** Intense transmission in Balochistan, in particular in Quetta, Killa Abdullah, and Pishin, and in southern Sindh, in particular in key high risk areas of Karachi, accounts for nearly two-thirds of all polio cases reported in Pakistan; **indeed more than 70% of all cases nationally, including most polio cases outside Baluchistan and Sindh, are due to viruses coming from these areas; virus from these areas has also been exported internationally to Afghanistan and China.** Transmission in SIA-access compromised areas of FATA and neighbouring accessible areas in FATA and KP

is continuing, but at a lower rate than in 2010. Recent significant outbreaks in southern FATA are due to virus coming from southern Sindh, but they demonstrate continued failures to reach children with immunization in these high risk agencies.

**In the past two years, performance in key high risk areas in Balochistan and Sindh has been persistently poor.** Failure of management and accountability results in 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) no punishment for sub-optimal performance. Interventions at the district and sub-district levels and coordinated efforts through political and administrative leadership, if any, have been weak and, thus, so far failed to improve the situation.

Reflecting on this situation, the Independent Monitoring Board for the Global Polio Eradication Initiative (IMB) in its 3<sup>rd</sup> Meeting in September 2011 expressed serious concerns about Pakistan's polio eradication program. The IMB noted that although the NEAP is sound, it is not being meaningfully translated into action, and recommended that the Pakistan programme *fundamentally re-think* the NEAP, focusing on what can be done to *enhance meaningful accountability*.

In response to the IMB report, a critical review of the NEAP was conducted in November 2011 by the Government of Pakistan and Provincial Governments in collaboration with WHO, UNICEF, Rotary International, Bill & Melinda Gates Foundation and other partners. Consultations were made with the independent academia and policy-strategy development institutions. Progress against the NEAP was appraised and key actions for augmenting implementation of the NEAP strategies were identified, and intended to significantly improve accountability and



implementation. **This document incorporates actions to augment implementation of NEAP strategies in 2012.**

## **ii. Epidemiology and risks of continued transmission**

As noted above, as at 21 November Pakistan has reported 154 cases of polio in 2011, already more than the 2010 total, and the highest number of cases reported by any country in the world. The epidemiological pattern in 2011 is summarized below:

- Nearly three out of every four cases (72%) are from key transmission zones in Baluchistan and Sindh, or directly related to transmission in these zones.
- The bulk of polio (more than 75% of cases) is from known persistent transmission and high risk districts in the known major transmission zones.
- Transmission in both FATA and KP is down from 2010 levels by 30%.
- In Balochistan, the reason for explosive polio transmission is sub-optimal quality of implementation due to poor programme management. Cross border population movement, pockets of insecurity and vaccination refusal are further factors.
- Karachi has large numbers of migrant, underserved and minority populations. Weak management and implementation of immunization campaigns in key areas of the city with large migrant populations allows continued transmission and spread to the rest of the country.
- The major risks for continued transmission in FATA and KP continue to be compromised access to children due to insecurity, and gaps in management and quality of campaign implementation.
- In other areas mobile and migrant populations and poorly covered areas constitute the greatest risk of re-introduction of WPV and of local transmission.

## **C) The Augmented National Emergency Action Plan 2012**

### **i. GOAL**

**The goal of the Emergency Action Plan for Polio Eradication is to stop wild poliovirus transmission throughout Pakistan by the end of 2012**

### **ii. MILESTONES**

By January 2012

- Data on preparation and implementation indicators for SIAs available at district, province, and national level
- Enhanced partnership implementation of SIAs introduced in persistently under-performing areas

- A media campaign will be launched to mobilize wide-spread national and localized support for the eradication effort

By March 2012

- Minimum 90% of all LQAS lots in key under-performing districts (Quetta, Killa Abdullah, Pishin in Baluchistan; Gulshan Iqbal, Gadap, and Baldia in Karachi; Thatta in Sindh) will be accepted at greater than 90% coverage
- Poliovirus transmission interrupted in Punjab and northern Sindh

By July 2012

- Minimum 80% of all LQAS lots assessed nationally in every SIA accepted at greater than 95% coverage
- Poliovirus transmission interrupted in KP, all accessible areas in FATA, and southern Sindh (except Karachi)
- WPV3 transmission interrupted nationally
- Refusals in KP, FATA and southern Sindh are <5% of missed children
- At least 85% of caregivers in key under-performing districts of Balochistan (Quetta, Killa Abdullah, Pishin) and Sindh (Gulshan Iqbal, Gadap, and Baldia in Karachi; Thatta in Sindh) believe that OPV is safe

By October 2012

- Poliovirus transmission interrupted in Karachi and in Quetta block
- Mechanisms in place to access > 90% of children in SIAs in FATA
- Environmental and AFP surveillance demonstrate both genetic and geographical restriction of WPV1 in the high transmission season
- Refusals in Quetta Block and Karachi are <5% of missed children

By December 2012

- Cessation of all wild poliovirus transmission in Pakistan

### **iii. OBJECTIVES**

- a) Achieve consistent government oversight, ownership, and accountability of polio programme performance at each administrative level in Pakistan
- b) Ensure highest quality polio vaccination in the high risk districts/ agencies and populations that suffer from persistent transmission of poliovirus or recurrent re-introductions of poliovirus through improved quality and innovative approaches
- c) Ensure consistent access to children in security compromised areas especially in FATA and Khyber Pakhtunkwa

iv. **STRATEGIES TO AUGMENT IMPLEMENTATION OF THE STRATEGIC PLAN**

**These strategies should be taken in conjunction with the existing strategies delineated in the NEAP for 2011. The existing strategies should also be fully implemented in 2012.**

1. *Augmenting national management and oversight of the NEAP*

- a) The Prime Minister's National Task Force is responsible for fast-tracking implementation of the augmented National Emergency Action Plan. A senior Focal Point for polio eradication has been appointed by the Prime Minister to oversee implementation of the Plan, and will liaise 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 provide 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 2012 and be responsible for coordinating between the PM Secretariat and secretariats of the Governors and Chief Ministers, Provincial Steering Committees, and PEI partners. The Focal Point 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.
- b) The Monitoring and Coordination Cell in the PM Secretariat will support the National Focal Point 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. In the post-devolution period, the Inter-provincial Coordination Ministry is currently the 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 shape of Provincial, District and UC-level "**progress report cards**" against the NEAP indicators for each SIA.
- c) **The Polio Control room** will be functionalized and streamlined at the **national** level within the Polio Monitoring and Coordination Cell to receive the collated reported (administrative) data during the pre-campaign preparation and the campaign implementation phases. Polio Control Rooms will be functionalized at the **provincial level** in the offices of the Provincial EPI Managers and at the district level in the DCOs' 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 to be transmitted timely to the next level. The Polio Control Room should also

coordinate collection of real-time information from the field for all operational activities.

- d) 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 ad 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. Intensifying oversight in Provinces for urgent augmented efforts to implement the emergency plan.***

- a) **A senior full time government officer will be designated in each province** and in FATA by January 2012 to coordinate implementation of the NEAP at provincial level. The officer will report directly to the Chief Minister (and Governor KP/FATA) and will coordinate with the office of the Minister for Health, the Chief Secretary, 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. The incumbent will be a member of the Provincial Task Force / Steering Committee, and will report directly the Chief Minister fortnightly.

## ***3. Enhancing oversight and accountability at the district level***

- a) In the persistent transmission and repeatedly infected districts (see Annex V), the Chief Secretary of the province will ensure appointment of **proficient DCOs/DCs/ PAs/TMOs and EDOs-H** having proven capabilities of management and a good track record by January 2012. 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. As a program of the highest national priority, the NEAP recognizes the immense importance of the DC’s role and relates the success and the failure of the NEAP at the district and union council levels to the DC’s performance in this respect. Appropriate actions of reward and accountability for the DC’s performance must be initiated and 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 % UCs achieving the target of 95% finger marking coverage by independent monitoring and LQAS).***

- b) In the NIPA training, a specific component on polio eradication will be added to orient the administrative cadre on running polio operations in the district.
- c) The national programme will immediately (by January 2012) prepare and disseminate a revised set of indicators to assess the quality of the preparations for the SIAs at the district and the UC levels; These indicators will take into account the existing NEAP indicators, and others based on the experience of the previous 12 months; the indicators for the implementation phase essentially remain the same. ***These indicators will be the basis for the Provincial Task Force / Provincial Steering Committee and the DPEC for assessment of preparation and performance by UCs and districts.***
- d) The Deputy Commissioner (DC) / District Coordination Officer (DCO) / Town Municipal Officer (TMO) / Political Agent (PA) as Chairman of the DPEC / TPEC / APEC, will designate a **Government-paid full time officer** to ensure accountability for implementation of the district Emergency Action Plan by January 2012. ***This official will be responsible for ensuring the collection of data on the indicators for preparation and implementation of SIAs referred to above, and presenting this information to the DPEC, and will report to the DCO as chair of the DPEC.***
- e) The Provincial Governments (Chief Secretary, Secretary Health and Deputy Commissioner/DCO/PA) will ensure availability of a **qualified medical officer in every UC (UC Medical Officer)** who will function as the UPEC Chairman (please refer to section below on UPEC and the annex- III) 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 and UC MO. In addition to tasks mentioned under UPEC, the 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 given by the EDO-H in pre-SIA, during and post campaign phases. The UC MO will work closely and coordinate with the UCPW and UCO recruited by partners where available, in ensuring vaccination of every child in the UC especially those from the highest risk UCs. ***The DCO will ensure that the UC Medical Officer is posted permanently (with no or minimum turnover) to follow up the issues properly. His performance will be evaluated by the EDO-H (in consultation with the DCO) after every campaign followed by necessary actions.*** Partners will support training of UC MOs to enable them to perform their functions by January 2012. The activities planning and implementation of the UCPWs and UCOs through their district supervisors will be coordinated through Area Coordinator at the sub-provincial level.

#### **4. Enhancing performance of District and Sub-District level committees to oversee campaign operations (preparation and implementation)**

##### **a) District Polio Eradication Committee**

The DPEC meeting will be convened by the **DCO**; and **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:

- EDO Education, Community Development
- EDO Revenue departments District Police 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. PPHI, NCHD, HANDS, Rural Support Programs, etc.
- Active medical professional organizations e.g Pakistan Medical Association and Pakistan Pediatrics Association etc.
- Members of parliament (MNAs, MPAs, Senators); One Public Representative (MNA and / or MPA) will represent the parliament in the DPEC in each district (*The office of the DC/DCO/PA/TMO/ and EDO (H) will ensure timely information sharing with the parliamentarians in regards to dates of the meeting*).
- Local representatives of the partner organizations - WHO, UNICEF and Rotary International
- Any other relevant notables.

*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.*

The parliamentarians 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.

A full meeting of the DPEC will be held at least 10 days before the campaign to review the status of preparations and the results of UPEC meetings (completeness and timeliness) and to consider specific requests from the UPECs and any interventions required to make corrections at the UC level. 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. He/she will be responsible to share with the

DPEC the UC wise information/data of the tehsil of his assignment. The meeting of the DPEC must have in its agenda:

- 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
- 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
- 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 4 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 DPEC chairman (DCO/DC) and the Secretary (EDO-H) will ensure **establishment of a polio control/operations** room at the district level to receive real time data/information on indicators disseminated by the national programme for preparation and implementation at UC level, including the functioning of the UPECs on set dates (15 days and 4 days before the campaign) and on a daily basis during the campaign, and to transmit this information further to the provincial level (office of the provincial EPI manager). **A focal person will be assigned in the district control/operations room** (preferably a Medical Officer/senior official like District Superintendent for Vaccination etc.) to lead the data receiving and transmission and; necessary technical support may be provided by the partners. *The assessment of the functionality of the DPEC will be based on a set of indicators that is annexed (Annex VI).*

*b) Ensuring correct functioning of Union Council Polio Eradication Committees (UPEC)*

The UPEC composition **should be (re)notified** with designation of the Union Council Medical Officer as Chairman and Secretary UC as Secretary of the Committee. A mandatory membership includes:

- Principal / Headmaster of school (the senior most)
- Lady Health Supervisor
- representative(s) of UC level NGO(s);
- community member's representatives such as notables, public representatives and religious leaders
- partner agency UC Polio Worker (UCPW) and UC Communication Officer (UCO), where present.

The meeting of the UPEC will be conducted **15 days before the campaign** with an agenda including:

- review of implementation status of the last meeting's decisions
- review and endorsement of the micro-plans including composition and quality of vaccination teams and engagement of the community influencers for information and motivation of the community
- plans for quality training, supervision and real time process data transmission on daily basis.

#### 5. *Deferment of scheduled campaigns in case of inadequate preparations*

Monitoring of the preparatory phase of SIAs will be significantly enhanced 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) 4 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.*

#### 6. *Additional Innovative Strategies*

##### a) *Expanding Partnerships for implementation of campaigns in areas with persistent failure to conduct campaign of desired quality*

If there is consistent evidence of poor performance through IM data, LQAS data, or field evaluation, or if a campaign is suspended twice in any area (see above section on UPEC), forming implementation **partnerships with other Government or non-government organizations** for enhancing implementation of the campaign will be explored. Areas (**Quetta, Pishin, Killa Abdullah; and high risk areas in Karachi**) which already failed to achieve desired results despite repeated efforts and interventions qualify for this approach immediately (i.e. from January 2012 and onwards).



- b) *Special approaches for key areas e.g FATA*
  - i) Immunization plus; periodic establishment of medical camps by the Department of Health (DoH) offering immunization services in addition to basic curative services. The medical camps should be established in key locations covering populations from areas which cannot be accessed by vaccination teams due to insecurity. The community may be offered incentives in the form of basic necessities e.g. soap, combs, towels etc. (supported by partner organizations) to motivate and create demand.
  - ii) Strengthening routine immunization through enhanced outreach activities: with add on of OPV for children aged less than 5 years. Since; there is demand for routine immunization (supposedly due to injections) in areas of FATA; there is likelihood that the OPV add-on will be readily accepted during such operations.
  - iii) Community based initiatives like Basic Development Need (BDN) should be utilized for promoting the vaccination (both routine immunization and the SIAs) and achieving the desired coverage by involving the community.
- c) Direct disbursement mechanism of payment to grass root level polio eradication campaign workers to reduce the risks of non-payment or late payment, and enhance selection of appropriate vaccination team members and supervisors.
- d) Short Interval Additional Dose Strategy will continue to be utilized to rapidly build the immunity of the un-immunized or under-immunized populations; e.g. during windows of opportunity in the areas with longstanding inaccessibility due to insecurity; and areas with longstanding under-performance during vaccination campaigns

#### **7. Enhancing post campaign monitoring and evaluation**

Independent monitoring data clearly is not providing accurate data in all areas. LQAS data appears to be more accurate in key high risk areas (and often shows significant quality problems) but cannot be expanded to cover all areas without also being compromised in quality. Following key steps can be taken to improve monitoring.

- i) The independent monitoring process will be reviewed by end January 2012 and any key changes in process will be implemented by the March SIA round.
- ii) The possibility of using expanded partnerships with NGOs, Universities, and other competent groups to monitor in key high risk areas will be explored, as will the potential for completely outsourcing monitoring activities in given areas with significant data problems.
- iii) LQAS will be carried out 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.

#### **8. Capacity Building by Partner Organizations**

Partner organizations in coordination with the provincial and district Governments will assist in building capacity of the staff of the Department of Health (DoH).

- i) Orientation sessions will be conducted for the DCOs to familiarize them with the Polio Eradication operations and their critical role in leading the district and keeping the accountability; by January 2012.
- ii) UC Medical officers will be trained by the Area Coordinators, Polio Eradication Officers, District Health Communication Support Officers and the C4D officers, on a consistent basis through to the end of December 2012.

#### **9. Improved national communication strategy to enhance vaccine acceptance and create demand for vaccination, with special emphasis on the areas of persistent transmission (KP/FATA, Quetta Block and Karachi)**

It is critical that ownership and accountability for polio eradication in Pakistan extend beyond the political realm. Strengthening community trust and demand for OPV, particularly among known population pockets that have expressed resistance to vaccination, must be facilitated through active engagement with social institutions and structures that underpin social norms and public opinion. Pakistan's rich civil society and political leadership, together with its influential media, must collectively work together to ensure every parent understands the importance of polio vaccination, and demands it for the improved health of their child.

Accountability for polio eradication must extend across the broad spectrum of society: from the highest political levels, to the social, professional and religious infrastructure.

- i. **To ensure the public understands and shares public accountabilities towards the eradication goal**, the following activities will be undertaken
  - High-level Polio ambassador shall participate at high-level Polio campaign launches and advocacy events once every quarter.
  - Prime Minister's and Chief Ministers' offices will identify federal and provincial PEI spokesperson that shall be accountable for systematic engagement with mass media and the public on behalf of the PEI programme.
  - A large-scale mass media campaign will be launched to mobilize widespread support and commitment towards polio eradication in Pakistan. Government owned media channels and print outlets will leverage own resources to provide pro-bono airtime and space for public

service announcements (at least ten insertions, total of five days) in addition to publicizing Polio Control Cell phone number for every NID.

- A series of high-level inter-sectoral orientation meetings will take place with key provincial stakeholders to communicate the revised NEAP strategy, and to clarify roles and accountabilities expected at all levels.
- The media shall be proactively engaged as a key partner to publically communicate progress and setbacks towards the eradication goal.
- For 2012 polio campaigns influential celebrities shall be engaged as Polio advocates at the National and Provincial level to forge wide public support for Polio eradication in Pakistan.
- Key editors, health journalists and prominent TV anchors at federal and provincial level will be engaged for enhancing public momentum through periodic media briefings, journalist trainings, media fellowships and facilitated field visits.
- Pakistan Polio Eradication Initiative website will be set up to make critical information about the programme and implementation of NEAP available to the public.

ii. **Social commitment to OPV in areas of insecurity**

Ensuring social commitment for polio eradication requires specific strategies in areas of insecurity. Awareness of polio campaigns in Pakistan are among the lowest in the world, but knowledge of polio and polio campaigns is even lower in areas of insecurity. On average, 44% of caregivers in Balochistan reported knowing about campaign dates in 2011, compared to 64% nationally. Twenty-eight percent of caregivers in select districts of KPK and FATA did not know if OPV was safe, compared to only 5% in Punjab. It is less likely that caregivers with low knowledge about the polio programme will open their door when vaccination teams – who are often unknown to them - arrive to vaccinate children against a disease they know little about, with a vaccine they may not trust.

iii. To ensure that **parents and influential gate-keepers in insecure areas demand OPV as a key health service for children <5**, the following activities will be undertaken:

- Interactive and in-depth radio content such as serials, short documentaries, news programmes will be developed to incorporate key polio messages. These programmes will be aired on credible radio channels. Government owned radio channels will leverage own resources provide pro-bono air time for such programming.
- Key religious and social leaders will be mapped in each district of KPK, FATA , Balochistan and Karachi by January 2012. Partnerships will be

established to mobilize social support for OPV through fatwa's, campaign inaugurations, media publicity, mobilization of vaccination teams from local constituencies, and any other appropriate strategies.

- Endorsements on OPV safety will be acquired from influential medical and religious bodies and publicized in local and national media. At least one national level endorsement/statement from the Pakistan Pediatrics Association will be publicized by February 2012.
- Community and traditional influencers will be engaged through jirga's and hujrah's to promote support for the polio programme, and the safety of OPV.

iv. **Reaching the highest risk communities**

AFP surveillance (epidemiological and monitoring data) and social data has helped to identify specific areas and populations that are most at risk to the poliovirus. The highest risk Union Councils, and the populations in these areas who are most vulnerable have recently been identified in order to focus limited resources. These high risk areas and communities require special strategies to ensure vaccination services are tailored to their language, cultural context, and migration patterns.

v. **To ensure that populations at highest risk for polio demand OPV and vaccinate their <5 year old children each time it's offered**, the following interventions will take place in the 33 highest risk districts:

- Targeted messages, using the appropriate communication channels, language and influencers, will be disseminated at least 10 days before each campaign.
- Traditional and religious leaders who have influence with underserved and high risk groups will be identified, mobilized, and included in microplans. These influencers will be called upon to engage with households refusing to give their children OPV.
- Enhanced Pakistan-Afghanistan cross border coordination with quarterly meetings at regional and provincial levels. Ensuring that border vaccination posts at Torkham and Spin Buldek are co-branded to project a coherent image of Polio immunization across borders.
- High-risk group communication strategy will be put in place to cater to specific needs of mobile and migrant populations.

## **Conclusion**

It is vital to finish polio eradication in Pakistan, for the health of the nation, and for the whole global community. The highest levels of Government have committed to

finishing this job as a national responsibility. The augmented National Emergency Action Plan is intended to rapidly and dramatically increase oversight and accountability in Government at all levels, to introduce effective innovations, and to ensure that all children will be reached with vaccine, no matter what geographical area of the country or what community they come from. The children of Pakistan, and of the world, can and should be free of the threat of polio forever.

**Annexure attached**

## Annex – I: Acronyms & Abbreviations

<b>AFP</b>	Acute Flaccid Paralysis
<b>APEC</b>	Agency Polio Eradication committee
<b>CM</b>	Chief Minister
<b>DC</b>	Deputy Commissioner
<b>DCO</b>	District Coordination Officer
<b>DHCSO</b>	District Health Communication Support Officer
<b>DPEC</b>	District Polio Eradication Committee
<b>EDO</b>	Executive District Officer
<b>EPI</b>	Expanded Program on Immunization
<b>FATA</b>	Federally Administered Tribal Areas
<b>IM</b>	Independent Monitoring
<b>IMB</b>	Independent Monitoring Board
<b>KP</b>	Khyber Pakhtunkhwa
<b>LQAS</b>	Lot Quality Assurance Sampling
<b>MO</b>	Medical Officer
<b>NEAP</b>	National Emergency Action Plan
<b>NIPA</b>	National Institute of Public Administration
<b>OPV</b>	Oral Polio Vaccine
<b>PA</b>	Political Agent
<b>PEI</b>	Polio Eradication Initiative
<b>PEO</b>	Polio Eradication Officer
<b>PM</b>	Prime Minister
<b>SIAs</b>	Supplementary Immunization Activities
<b>TMO</b>	Town Municipal Officer
<b>UC</b>	Union Council
<b>UCO</b>	Union Council Communication Officer
<b>UCPW</b>	Union Council Polio Worker
<b>UPEC</b>	Union Council Polio Eradication Committee
<b>WPV</b>	Wild Poliovirus

## ***Annexure II: District Polio Eradication Committee (DPEC)***

Each district/agency/town will have a Polio Eradication Committee (DPEC) 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 have been updated before each campaign. Each plan should be endorsed by the designated MO and the designated official by the DC/DCO/PA/TMO (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
- 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 Police Officer
- 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. PPHI, NCHD, HANDS, Rural Support Programs, etc.
- 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 – WHO (PEO), 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



### ***Annexure 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 DEPC 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 4 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 Medical Officer and the UC Secretary officially designated by the offices of the EDO-H and the DC/DCO/PA/TMO 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 4 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
- 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
- UC Secretary/official designated by the DC/DCO/PA/TMO (from outside the health department)
- Area In- Charge/s of the UC
- Lady Health Supervisor
- Community member's 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 2012

Month	Dates	Campaign	Type of vaccine	Interval b/w SIAs (weeks)	Interval b/w NIDs (weeks)
January**	30th Jan-1st Feb	NIDs	bOPV	6	14
March**	12 - 14	SNIDs	bOPV	6	
April**	23 - 25	NIDs	tOPV	6	12
June	4 - 6	SNIDs	bOPV	6	
July	16 - 18	NIDs	bOPV	6	12
September	10 - 12	SNIDs	bOPV	8	
October**	22 - 24	NIDs	tOPV	6	14
December**	10 - 12	SNIDs	bOPV	7	

\*\* followed by second passage in the high risk UCs

### Islamic holidays\*

Eid Mila-un-Nabi	7th February
Ramzan	22 July - 20 August
Eid-ul-Fitar	21-23 August
Eid-ul-Adha	30 Oct - 1st Nov
Youm-e-Ashoora	29-30 November

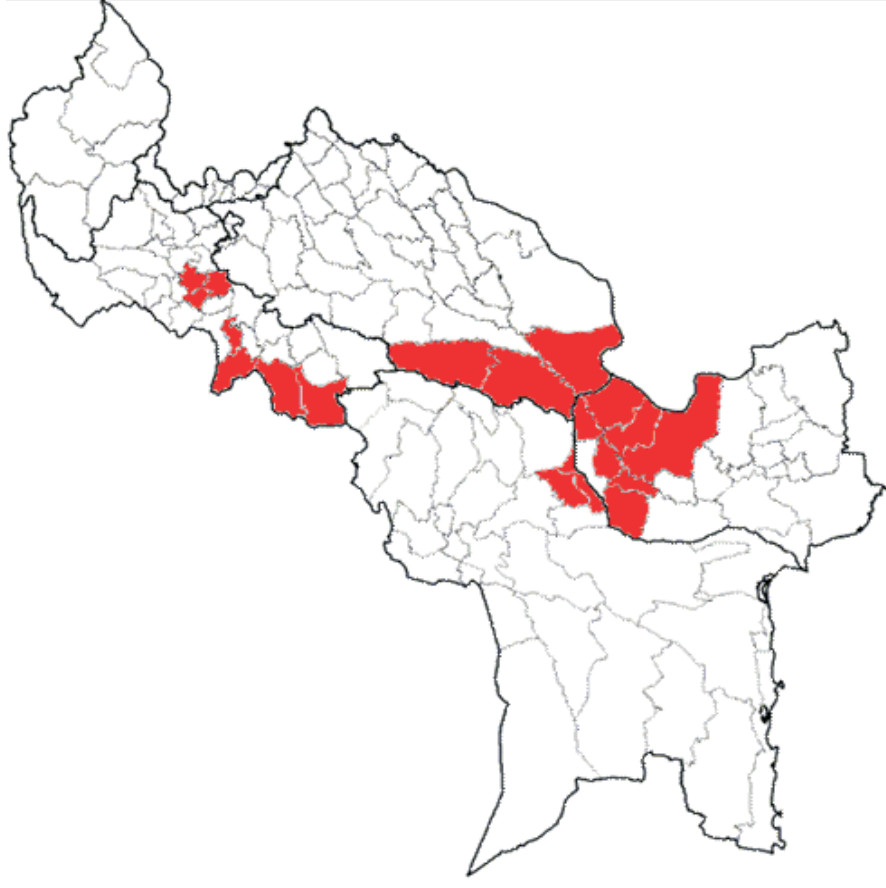
\* Subject to sighting of the moon

### Public holidays

Kashmir Day	5th February
Pakistan Day	23rd March
Labour Day	1st May
Independence Day	14th August
Allama Iqbal Day	9th November
Quaid-e-Azam Day	25th December

# Annex V: High Risk Districts

PROVINCE	High risk districts
<b>PUNJAB</b>	MULTAN
	DGKHAN
	RAJANPUR
	RYKHAN
	MUZFARGARH
	HYDERABAD
	KAMBAR
	GHOTKI
	KASHMORE
	KHAIRPUR
<b>SINDH</b>	LARKANA
	SHIKARPUR
	SUKKUR
	JACOBABAD
	KHIBALDIA
	KHIGADAP
	KHIGIQBAL
	PESHAWAR
	MARDAN
	NOWSHERA
<b>KP</b>	CHARSADA
	BAJOUR
	ORAKZAI
	WAZIR-N
	WAZIR-S
	KURRAM
	KHYBER
	MOHMAND
	KABDULAH
	PISHIN
<b>BALOCHISTAN</b>	JAFARABAD
	NSIRABAD
	QUETTA



■ High risk districts (33)

## **Annex VI:**

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

*(To be used by the Provincial Task Force / steering committee, 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 meeting to be considered valid if chaired by the DCO and attended by the EDO-H)
2. % of the DPEC meetings sharing the minutes (mentioning decisions and actions taken) with the provincial 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 with EDOs-H presenting 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. % of the UCs that met the targets of all the indicators assessed for the UCs / UPECs

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

##### **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. % UPECs chaired by the UC Medical Officer / designated senior health official (UPEC meeting to be considered valid if chaired by the UC Medical Officer and attended 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 validated by the UC level supervisory staff (UC MO, UCPW, UCO) for:
  - a. inclusion of all the components as per the national guidelines including names of the team members, area maps and teams assignment maps
  - b. field validation
5. % of UCs with at least 70% micro-plans field validated by the district level staff including the EPI Coordinator, EPI focal person, DSV and his staff, PEO, DHCSO etc.
6. % UCs with all the mobile teams having all team members over 18 years of age
7. % UCs with at least 80% mobile teams having one local member (suited to local norms and culture)
8. % UCs with at least 95% 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.)

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 (migrants, multifamily dwellings etc.) and their influencers 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%)*

**In addition to the above; the below indicators are to be assessed 4 days before the campaign**

1. *% of AICs trained using standardized, national module including IPC module (target: 95%)*
2. *% of the team members trained using standardized, national module including IPC module (target: 95%)*
3. *% of UCs with all the refusal families reached with IPC before the campaign*
4. *% UCs with all the identified mosques (in the micro-plans) demonstrating highly visible support (through banners/posters & mosque flyers) to polio campaigns*
5. *% UCs with all the identified schools (in the micro-plans) demonstrating highly visible support (through banners/posters & school flyers) to polio campaigns*

**“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 validated by the UC level supervisory staff (UC MO, UCPW, UCO) for:*
  - a. *inclusion of all the components as per the national guidelines including names of the team members, area maps and teams assignment maps*
  - a. *field validation*
2. *At least 70% micro-plans 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*

## **Salient Features of the Augmentation of the NEAP**

*(The augmented strategies for the NEAP 2012 detailed should be implemented in conjunction with existing NEAP strategies, which remain in force)*

### **National Level**

1. A **senior Focal Point** for polio eradication has been appointed by the Prime Minister to oversee implementation of the Plan, and will liaise 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 provide an oversight to implementation of the Augmented NEAP and coordinate with the provinces on behalf of the Prime Minister.
2. A **senior full time t officer** will be designated by January 2012 and be responsible for coordinating between the PM Secretariat and secretariats of the Governors and Chief Ministers, Provincial Steering Committees, and PEI partners. The Focal Point 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.

### **Provincial Level**

1. A **senior full time government officer will be designated in each province** and in FATA by January 2012 to coordinate implementation of the NEAP at provincial level. The officer will report directly to the Chief Minister (and Governor KP/FATA) and will coordinate with the office of the Minister for Health, the Chief Secretary, 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. The incumbent will be a member of the Provincial Task Force / Steering Committee, and will report directly the Chief Minister fortnightly.
2. Chief Minister's/Chief Secretary's monthly review meeting
3. Polio Control Rooms based in the office of the Provincial EPI Managers at the provincial level and at in the DCOs' office at the district level; to 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.

### **District Level**

1. DC / DCO / TMO / PA to be authorized and held accountable for the campaign quality at the district/town/agency and UC level
2. The DC will appoint a focal point at the district level for Polio Eradication.
3. 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. He/she will be responsible to share with the DPEC the UC wise information/data of the tehsil of his assignment.
4. Enhanced role of the DPEC in assessing the preparation of the campaign and deferring the campaign in case of inadequate preparations
5. Functionalize the Polio Control Room in each district at the DCO office with proper ownership by the Government

### **UC Level**

1. Nomination of the UC Medical Officer / Senior Health Official in every UC / Area; to lead the polio eradication in the UC
  - a. Zonal Supervisors to be abolished
2. Functionalize the UPEC in every UC and ensure its adequate composition (including community, religious leadership and members nominated by the member of the parliament from the district) and efficient functioning; with special focus on preparatory phase
3. Involvement of the community to fully participate in campaign activities, especially in high risk areas
4. Empowering the UPEC to recommend deferment of the campaign in the UC in case of sub-optimal level of preparations

### **Role of the Parliamentarians**

1. 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. The office of the DC/DCO/PA/TMO/ and EDO (H) will ensure timely information sharing with the parliamentarians in regards to dates of the meeting.
2. All the parliamentarians will assign a nominee in each UC in their constituencies to be part of the UPEC and support the operations at the UC level. The 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 of the areas during DPEC at the district level and by the Secretary / provincial Focal Person with the Chief Minister / Chief Secretary at the provincial level.*
3. The parliamentarians will participate at the UC level (in their constituencies) inaugurations before each campaign.

### **Important Timelines**

1. UPEC will be held 15 days before each campaign
  - a. Summary of the UPEC meeting / data to be relayed to the DCO's office before the DPEC meeting
  - b. Final Readiness to be shared with the DCO's office 4 days before the campaign
2. DPEC will be held 10 days before the campaign
  - a. Summary of the DPEC meeting will be shared with the provincial task force 8-10 days before the campaign
  - b. Final districts readiness report will be shared with the provincial task force; 4 days before the campaign

### **Innovative Strategies**

1. Expanding partnerships for implementation of the campaign in areas with persistent failure
2. Expansion of existing strategies to rapidly raise immunity among children (SAID)
3. Special approaches for areas like FATA; e.g. Immunization Plus, community based initiatives, enhance routine immunization outreach activities
4. Direct disbursement mechanism for the vaccination teams



5. Short Interval Additional Dose Strategy will continue to be utilized to rapidly build the immunity of the un-immunized or under-immunized populations;

**Enhanced Post Campaign Monitoring and Evaluation**

1. Review of the Independent Monitoring
2. Utilizing the extended partners for the Independent Monitoring
3. LQAS to be carried out to validate the results of the Independent Monitoring

**Improved Communication Strategies at the National, Provincial levels**

