NATIONAL EMERGENCY ACTION PLAN 2014

For Polio Eradication

Government of Islamic Republic of Pakistan

National Emergency Action Plan 2014
For Polio Eradication

Government of Islamic Republic of Pakistan

Endorsement of National Emergency Action Plan 2014 for Polio Eradication

The Prime Minister of Pakistan / Chairman National Task Force for Polio Eradication endorsed the National Emergency Action Plan for Polio Eradication in a meeting held on 11th March 2014 at Prime Minister House, Islamabad.

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

Foreword

Pakistan's polio eradication programme faced a number of significant challenges in 2013. These challenges meant that the ambition to stop the transmission of wild poliovirus by the end of the year was unfortunately not possible. In fact, the programme was severely challenged in 2013, as the number of wild polio cases increased. There are multiple reasons for this increase including unprecedented violent attacks on health workers, ongoing military operations in the tribal belt and a ban on polio vaccination imposed by militants in North and South Waziristan. This created distinct barriers between vaccinators and children. Lapses in campaign quality and demand creation efforts are also partly to blame for the increase in the number of paralyzed children.

However, despite these setbacks the programme also made progress. The number of districts infected with polio decreased, indicating that spread is more localized and type-3 of the poliovirus has not been detected since April 2012. In 2014, we will endeavor to build on that progress.

The polio eradication initiative is funded by the Government of Pakistan and it has been declared a national emergency to interrupt polio transmission and achieve the goal of polio eradication.

The Goal of NEAP 2014 is to interrupt transmission of wild poliovirus in Pakistan and it can only be achieved if all the strategies outlined in this document are rigorously implemented. There is a special focus on addressing low season transmission. Meaningful oversight and accountability at the district and UC level is an area in which the programme needs to improve to achieve significant impact.

The country is at a critical juncture where intensified polio eradication activities will determine if eradication of poliovirus will be successful in 2014. The programme relies on strong provincial leadership, as well as the district and agency administrations. Effective supervision and monitoring by Tehsil and Union Council Polio Eradication Committees, and the strong motivation of frontline workers will be instrumental in achieving polio eradication.

We must all face the challenges ahead and work together for the sake of our children to make Pakistan polio free.

Ayesha Raza Farooq

Prime Minister's Focal Person for Polio Eradication

Contents

Executive Summary

The Government of Pakistan has declared polio eradication a national emergency to interrupt poliovirus transmission and achieve the goal of a polio free Pakistan. It is a priority program of the country and is being funded by the Government Pakistan.

The National Emergency Action Plan for Polio Eradication (NEAP) was developed and approved in 2011 by the National Task Force (NTF) on Polio Eradication headed by the Prime Minister of Pakistan and subsequently launched by the President of Pakistan. The NEAP is being reviewed on a yearly basis and endorsed by the National Task Force. This is a 4th document in place to continue efforts to eradicate polio.

Pakistan started 2013 with the hope of eradicating the poliovirus but the polio eradication initiative had a difficult year due to continued violence towards polio workers and threats of violence. This caused limited access for polio teams in some areas of FATA, Khyber Pakhtunkhwa and in Karachi, resulting in an increase in the number of polio cases from 58 in 2012 to 93 in 2013. Additionally, 48 cases of circulating vaccine derived poliovirus type 2 (cVDPV2) were reported during the year. Despite these challenges, there have been several positive developments. The NEAP process continues to function and provide the basis for polio eradication in Pakistan. Most of Pakistan is polio free, WPV type-3 has not been detected since April 2012 and outbreaks in non-endemic areas are being resolved effectively.

At the beginning of 2014, the country is at a critical juncture and intensified polio eradication activities in the low transmission season will determine if eradication is achieved this year. The programme relies on strong provincial leadership, as well as oversight and accountability ensured by the district and agency administrations.

The Prime Minister's Polio Monitoring and Coordination Cell in consultation with provinces and partners on the basis of experiences and lessons learnt in 2013 have revised the National Emergency Action Plan for 2014. The consultation meeting with provinces was held on 9th January 2014 and agreed on the revised NEAP. The document was also reviewed by the National Steering Committee on PEI/EPI.

The Goal of the NEAP 2014 is to interrupt transmission of wild poliovirus in Pakistan, focusing on the low transmission season of the year.

Elements of the NEAP 2014:

Key elements of the NEAP 2014 and salient strategies are described in this document, some of which are enhancement of strategies already included in the NEAP 2013, and some of which are new approaches.

a) Polio eradication efforts continue to be a national emergency with international repercussions that must be urgently addressed through the engagement of all line departments of government.

b) Oversight at the national level continues through the National Task Force headed by the Prime Minister. The Prime Minister's Focal Person for polio eradication provides leadership to the Prime Minister's Polio Monitoring and Coordination Cell to oversee implementation of NEAP 2014 and continues to lead programme coordination with the offices of the Prime

Minister, President, and other relevant Ministries at the federal and provincial level.

c) Oversight continues at the provincial level through Provincial Task Force, headed by the Chief Secretary. At the district level oversight and accountability through the District Polio Eradication Committees (DPECs) headed by the Deputy Commissioners (Civil Military Coordination Committee headed by Political Agent in FATA).

d) The highest emphasis continues to be on the implementation of activities at Tehsil and Union Council level.

e) Special emphasis will remain on polio reservoirs, including development of individual integrated reservoir action plans, which encompass all aspects of operations, communications and security. There will be jointly agreed accountability mechanisms for these plans at the DPEC and UPEC levels.

f) Concentrated efforts continue to be on highest risk areas and populations to ensure that all children are reached with polio vaccine every immunization round.

g) Close monitoring of programme performance will continue to identify problems, and design specific actions to address these problems.

h) Routine immunization is essential for polio eradication and maintaining polio free status after the last polio case. It will now be monitored alongside polio eradication activities. Polio eradication operations should contribute to strengthen routine immunization.

i) Implement a broad communications programme to engage communities and build demand for immunization at household level will continue.

j) Ensure the safety and security of polio eradication workers, it will be critical to keep their confidence and hence the performance.

k) Ensure effective polio control/operations rooms at central, provincial and district/agency levels are functional.

l) Focus on high risk UCs in implementing all new strategies that improve quality of operations, communications and data analysis.

m) Implement Short Interval Additional Dose Strategy (SIADs) where appropriate to rapidly boost population immunity levels.

n) Strengthen monitoring and evaluation mechanisms by increased emphasis on intra-campaign monitoring, market surveys, and Lot Quality Assurance Sampling (LQAS).

o) Strengthen the transit strategy to ensure all children on the move are identified and vaccinated.

p) Track missed children to locate then vaccinate them.

q) Implement the high risk population strategy to map, track and reach these children.

r) Enforce zero tolerance for data misreporting/hiding and financial misappropriations.

s) Implement the Direct Disbursement Mechanism (DDM).

t) Strengthen cross border coordination with Afghanistan and intra-province coordination within the country.

u) Establish vaccine and cold-chain management at national, provincial, district and sub-district levels to ensure efficient utilization.

v) Notify Tehsil Polio Eradication Committees (TPECs) headed by the Assistant Commissioner of the Tehsil to provide management and supervision to UCs and present performance indicators to the DPEC.

Reviewing implementation status of NEAP:

The implementation status of the NEAP 2014 will be reviewed at various levels as follows:

a) The Prime Minister's Task Force for polio eradication will meet on a quarterly basis.

b) The National Polio Control Room led by the Prime Minister's Polio Monitoring and Coordination Cell will oversee and monitor the programme at the national level, with technical assistance of WHO, UNICEF and other key polio partners.

c) The Provincial Task Force chaired by the Chief Secretaries (Additional Chief Secretary in FATA) will review programme performance (preparation, implementation and results) for every SIA and take corrective measures based on findings. The Provincial Task Forces will submit a monthly report to the respective Chief Ministers, and FATA Task Force to Governor Khyber Pakhtunkhwa.

d) The Provincial Control Room must be functional, led by a senior officer at provincial level and assisted by the Provincial Technical Focal Person for NEAP and technical polio partners.

e) The District Polio Eradication Committee (DPEC) headed by the Deputy Commissioner will oversee the programme and reports to the Commissioner and provincial task force.

f) The Tehsil Polio Eradication Committees (TPECs) headed by the Assistant Commissioner of the Tehsil will review the progress of UCs, provide management and supervision to UCs and present performance indicators to the DPEC.

g) Civil Military Coordination Committee (CMCC) headed by the Political Agent of Agency will oversee the programme and report to FATA Task Force headed by the Additional Chief Secretary. The Agency level Polio Control Room will be functional with the purpose to liaise with Tehsil and Areas for implementation of SIAs.

h) The District Polio Control/operations Room situated in the Deputy Commissioner's office will be responsible for overseeing the NEAP implementation and quality of the polio eradication activities at the District, Tehsil and UC levels.

I All the polio partners will work as 'ONE POLIO TEAM' under the flag of District Control Room under the leadership of the Deputy Commissioner.

Context and Challenges

i. Progress in 2013 and development of the NEAP 2014

Pakistan started the year with the hope of eradicating the poliovirus but the polio eradication initiative had a difficult year in 2013 due to continued violence towards polio workers. Threats of violence caused limited access for polio teams in some areas of FATA, Khyber Pakhtunkhwa and in Karachi. This resulted in an increase in the number of confirmed WPV cases from 58 in 2012 to 91 in 2013. Additionally, there were 48 cases of circulating vaccine derived poliovirus type 2 (cVDPV2). Around 300,000 children remain without polio vaccination in North and South Waziristan and Khyber agency and intense circulation continues unabated in these areas. It is now recognized that WPV detected in Syria, Egypt and other parts of the Middle East has been genetically linked to Pakistan raising concern that conditions on travel from Pakistan could be introduced under the International Health Regulations (IHR).

Nevertheless, there have been several positive developments. The NEAP process continues to function and provide the basis for polio eradication in Pakistan. Most of Pakistan is polio free, including areas that were major reservoirs in the past such as Quetta Block and southern Punjab. WPV type-3 has not been detected in the last 18 months and outbreaks in non-endemic areas are being resolved effectively.

In FATA, an explosive outbreak of WPV is occurring and is not yet in remission. A total of 65 WPV cases were detected in FATA in 2013 representing 70% of all cases in Pakistan. This is directly linked to the polio vaccination ban imposed in South and North Waziristan Agencies rendering more than 260,000 children at risk. So far, children in these agencies have missed numerous SIAs.

Despite the strong commitment of the provincial leadership, interventions at the district and sub-district levels and accountability have been weak and leading to inconsistent performance. There is an ongoing intense viral circulation in adjoining areas of southern Afghanistan that has frequent and ongoing population movement with the Quetta Block. Low routine immunization coverage, coupled with probable surveillance gaps have resulted in another cVDPV2 outbreak in Jaffarabad and Mastung Districts that has made polio eradication efforts more complicated because of the need to address both WPV and cVDPV2.

Gadap Town, Karachi exhibited some progress in gaining access to the most difficult areas although zone B still is largely inaccessible to polio vaccinators. The situation has remained volatile since July 2012 and further exacerbated by targeted killings in December 2012 creating a sense of insecurity among 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 programme to continue conducting SIAs in this security compromised environment. At the same time, there has been a recent deterioration in the SIA performance in other parts of Karachi, evident in new WPV cases in Baldia and Bin Qasim towns. After several months of positive environmental samples,

Hyderabad was able to improve the situation through enhanced management and oversight by the district government. Interior Sindh, which has been free of human cases most of the year, succumbed to an importation of WPV in Kashmore District, northern Sindh. Aggressive case response SIA activities should bring this situation rapidly under control

The situation in Punjab declined in 2013 as there were importations of WPV in Central Punjab and presence of WPV environmental samples in Multan, Rawalpindi and Lahore. The positive environmental samples are alarming as these are in highly populated centers that have frequent migration from polio reservoir areas and that both Multan and Lahore went more than a year without positive samples. What is learned from these recent outbreaks is that SIAplanning and performance deteriorated with a precipitating factor being the lack of adherence to NEAP procedures. Also routine immunization coverage especially in Central Punjab has fallen to a level that cannot protect against importations of WPV.

The polio eradication initiative continues to operate in the midst of a global vaccine shortage and all efforts should be made to ensure that not only are campaign activities achieving high coverage, but also that there are full accountability of vaccine stock monitoring. In that way both user and system wastage can be minimized. It should be noted that several countries are currently conducting SIAs that are consuming large amounts of vaccine due to poliovirus linked to Pakistan.

Current Epidemiology

A total of 93 WPV cases were reported from Pakistan in 2013, compared to 58 WPV cases in 2012. All WPV cases were caused by WPV type-1 (WPV1). Additionally, Pakistan experience four outbreaks of cVDPV2 resulting in 48 cases in 2013. Despite this increase in the number of cases there was a reduction in the genetic biodiversity in 2013. The total number of WPV-1 genetic clusters was reduced from 4 in 2012 to 3 in 2013. There was also a reduction in the number of infected districts, from 28 in 2012 to 21 in 2013.

FATA is experiencing an explosive outbreak of WPV cases with 65. Cases detected in 2013, which is 70% of the total cases in Pakistan. This is primarily due to the ban on vaccination in North and South Waziristan and inaccessibility from conflict in Khyber Agency. It is apparent by an outbreak of cVDPV2 that routine immunization is also compromised and children are not receiving trivalent oral polio vaccine which contains type-2 polio vaccine. On a positive note, it has been 18 months since the last type 3 WPV was detected in Bara Tehsil, Khyber Agency. Further no positive type 3 environmental samples have been detected from 2011 to date.

Karachi continues to be a problematic area with eight of the 10 cases in Sindh Province in 2013 from the city. In addition, there was persistent isolation of WPV in the sewage samples collected from the three high risk towns of Karachi, particularly Gadap Town, which also had a cVDPV2 outbreak this year. Hyderabad city in interior Sindh had long periods of positive WPV environmental samples, until recent efforts appeared to stop circulation. Importations of WPV cases have occurred in Dadu District Central Sindh and Kashmore District in

Northern Sindh.

No WPV cases were reported in Balochistan in 2013. Moreover, the environmental samples collected in Quetta from February through November 2013 were negative for WPV. However, there were outbreaks of cVDPV2 in Jaffarabad District and Mastung District in 2013. Although it is commendable that Balochistan has not had any WPV in 2013, it remains vulnerable to importations polio due to poor SIA and routine immunization performance and frequent migration from other polio reservoir areas. A positive WPV1 environmental sample was detected from Quetta on 28 December thus demonstrating Quetta's vulnerability to re-introduction of wild poliovirus.

Although Khyber Pakhtunkhwa province has reported 11 WPV cases in 2013 compared to 27 cases in 2013, it is perhaps the most epidemiologically significant polio reservoir in the country. This is because Peshawar amplifies WPV coming in through migration from FATA then spreads it back to FATA and other parts of Pakistan. The reasons for polio outbreaks in Khyber Pakhtunkhwa are gaps in migrant and mobile population strategies, continued transmission in central Khyber Pakhtunkhwa region and persistent pockets of missed children.

Major risks of continued transmission in FATA and Khyber Pakhtunkhwa are primarily due to insecurity resulting in compromised access to children, gaps in adequately implementation of transit and migrant strategies, persistent pockets of refusals and failure to track and reach missed children after every SIA. Mobile populations and poorly covered areas constitute the greatest risk of re-introduction of WPV and further spread of the ongoing local transmission.

The programme continued environmental surveillance in 11 cities and towns in 2013 and will establish more sites in FATA, Khyber Pakhtunkhwa and Islamabad. This helps to better understand virus transmission patterns and tailor appropriate strategies for interruption.

- There was a significant decrease in the proportion of positive environmental samples compared to 2012. In 2013, 65/321 (20%) samples had wild poliovirus isolated compared to 78/200 (39%) in 2012.
- 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.
- Consecutive samples from Sukkur (Sindh) were negative for WPV during 2013 but samples from Hyderabad persistently produced positive samples demonstrating local transmission.
- Both Baldia and Gulshan-I-Iqbal environmental sites have recently experienced positive environmental samples after several consecutive negative samples in 2013. This setback is probably can be linked to a recent decline in SIA performance and proximity to Gadap.
- 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.

- Environmental samples from Peshawar 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 continues to hold back the country in its goal to further localize the circulation of the virus.

ii. Lessons Learnt in 2013

Throughout 2013 insecurity and other access issues presented major hurdles to progress towards polio eradication in Pakistan. However, in what could have been a year of tremendous setback, the programme was able to restrict the poliovirus to mainly the reservoir areas and stop circulation of type-3 poliovirus.

The programme has learned to proceed by using protected campaigns, enhanced transit strategy and missed children strategy. Low profile communication campaigns and the presentation of polio as part of a larger child health package were among key strategic responses to a new environment.

The implementation of the NEAP 2013 was disrupted during the period of the caretaker government due to absence of monitoring mechanisms at the central level and inadequate involvement of district administrations.

Polio vaccination when combined with other interventions such as measles vaccination or other routine immunization can create community demand for OPV. Following the attacks on polio workers in December 2012 and in 2013, the overall aim of the communications programme has shifted towards positioning polio vaccination so that community, political and religious leaders view OPV as an essential trusted commodity.

More attention needs to be given to understand the migratory patterns of key tribes and families moving in and out of inaccessible areas in KP and FATA.

The majority of refusals are clustered in under-vaccinated areas, particularly in KP and Karachi, and contribute to virus circulation (children from refusal families have constituted 10% of cases in 2013).

The preparatory stage of SIAs is still weak in some UCs and reflects a lack of ownership, teamwork and accountability at the UC level.

The functionality of Polio Control Rooms is not uniformly good throughout the country. However, where the National Emergency Action Plan has been followed and the leadership at provincial and district level has demonstrated full ownership, the Programme was able to achieve the expected results.

iii. Challenges for 2014

Security:

Inaccessibility due to insecurity continues to be the main reason why children miss polio vaccinations in Pakistan. There must be concerted efforts by all parties to understand and document the reasons for these missed children to develop strategies to ensure that better coverage is achieved in 2014. The security context in which all parties are operating remains complex and fluid. All parties must continue to work together to identify areas of security concern to enable

vaccination teams to work in the safest possible environment.

A polio security analysis function was created during 2013 to look at the overall security situation pertaining to the polio programme and to identify areas of inaccessibility caused by actual or perceived insecurity. This will enable a clearer picture to be obtained of where apparent inability of polio teams to enter some areas of Pakistan. While the safety of teams remains the main consideration, comprehensive analysis of the situation on the ground will also enable campaigns to go ahead on time. As much as possible SIAs should be conducted according to the approved NEAP SIA schedule.

In the provinces this function will be supported by a National Analytical officer who will co-ordinate security issues at the provincial, district, Union Council and Tehsil level where they relate to the polio programme. The analytical officer also will support the Government's polio eradication initiative by leading research into inaccessibility.

Low Routine Immunization Performance

Sub-optimal performance of routine immunization means that Pakistan has to rely on campaigns to ensure an immunity gap does not develop in the birth cohort. Additionally, low routine coverage means that there may not be enough protection against type-2 poliovirus since a majority of campaigns use bOPV, and the programme needs high routine immunization coverage to prevent circulating vaccine derived polio viruses (cVDPV). The routine immunization system must be strengthened to enable the country to successfully introduce inactivated polio vaccine (IPV) by the end of 2015, as part of the polio endgame strategic plan to withdraw tOPV by the end of 2016. Routine immunization also prevents other diseases such as measles, diphtheria, and pertussis, several types of pneumonia, tetanus and hepatitis B

Building trust and demand for OPV

The attacks on polio workers in December 2012 altered the operating environment and prompted a rapid re-adjustment of communication strategies and approaches. High-visibility campaigns were replaced with low-profile communication activities. Activities placed demand for polio vaccination within the broader context of demand for routine immunization (and other essential child health interventions), avoided promoting campaign dates, and focused largely on direct engagement with communities and families, where possible. During 2013, security became an integral component of planning and implementation on the ground.

The new security situation presented a number of challenges, including:

- difficulties in maintaining high (>80%) awareness of the campaign, due to inability to promote campaign dates;
- the suspension of door-to-door activities in security-compromised high-risk districts/areas;
- ban by militant faction on administering OPV in the North Waziristan and South Waziristan agencies of FATA and the adjacent Khyber Agency.
- low morale among vaccinators and communication network staff due to a highly insecure work environment; and,
- negative media coverage and the linking of polio campaigns to outside conspiracy.

The National Communication Technical Committee, which advises the National Steering Committee, agreed five principles that should guide all communication work under the altered circumstances:

- Reorientation of communication activities towards awareness generation and demand creation for broader child immunization and health goals;
- Reframing polio messages within the broader context of preventive health services for children and their well-being
- Shifting of communication activities from advertising and high-visibility campaigns to content integration and long-format programming;
- Building social and professional platforms to drive the programme at community level; and
- De-linking the programme from the “outside western conspiracy” view by repositioning the campaign as a Pakistani-driven campaign with a strong local image.

Global Vaccine Availability

Due to limited availability of OPV globally, it has become increasingly challenging to conduct planned polio campaigns, particularly in polio endemic countries. Recurring and intensified polio outbreaks in non-endemic countries have exacerbated the issue. In 2013 the vaccine situation proved very volatile and this

is projected to continue into 2014. For this reason it is critical, especially for polio endemic countries to look at risk mitigation strategies. To counter the problem of vaccine availability the programme must ensure:

- Higher reliability of forecast data and minimize the changes in SIA strategies as this impacts on global supply planning and allocations;
- Better monitoring of in-country stock levels and utilization, and minimized wastage rates;
- In-country registration of all WHO pre-qualified OPV manufacturers to have a broader supply base.

The National Emergency Action Plan 2014

I GOAL

The goal of the National Emergency Action Plan for Polio Eradication is to stop wild poliovirus transmission throughout Pakistan, focusing on the low transmission season of the year

ii. OBJECTIVES

a) Translate high level government oversight and ownership into meaningful accountability at district, Tehsil and UC levels;

b) Ensure highest quality polio vaccination in the country focusing on high risk Districts/Agencies, UC/Areas and priority 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 all children, especially in those areas that are not being currently accessed;

d) Ensure safe and protected campaigns in security compromised areas

e) Support strengthening of routine immunization through use of the NEAP oversight and monitoring mechanism

iii. Guiding principles for 2014

The guiding principle of the NEAP 2014 is to implement the plan in true spirit considering:

- Integrated action plans with operational, communication and security components for reservoir areas, missed children and high-risk populations
- An effective SIA strategy, especially Short interval Additional Dose Strategies (SIADS)
- Make every effort and explore all avenues to remove barriers between children and vaccine, particularly for high-risk groups
- Zero tolerance for misreporting and financial misappropriation
- Increased emphasis of intra-campaign monitoring by government and partners
- Action to reduce the risk of poliovirus circulating in polio-free areas
- Support for efforts to increase routine immunization
- Direct Disbursement Mechanism (DDM) as the only method of payment to front line workers

Iv. Milestones

The implementation of the NEAP 2014 is expected to reach the following milestones:

- Integrated micro-plans are field validated and available in all the high risk UCs of the country
- Appropriately proactive and functional TPECs and UPECs are in place in all districts (Area Polio Eradication Committees in Agencies)
- Comprehensive operational, security and communication plans for high risk areas are being implemented
- An increased number of LQAS is conducted and 90% or more of lots assessed through LQAS are accepted for the 90% coverage threshold
- DDM is fully functional in all the provinces and regions
- Provincial and District Vaccine Management Committees are functioning; meet regularly and gather information on vaccine stocks and utilization
- An action plan is in place and implemented to access children in inaccessible areas
- Market survey results in all of Pakistan indicate more than 95% coverage
- Refusals in KP, FATA, Quetta Block and Karachi are <5% of missed children (intra-campaign and post campaign)
- At least one additional site in each UC will offer routine immunization antigens during SIAs
- All Provincial Task Forces, DPECs and UPECs will monitor progress of routine immunization during their meetings

By December 2014

- Stop circulation of all WPVs and cVDPVs in the country

V. Oversight and Manage of the Programme

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) Prime Minister's Focal Person for polio eradication oversees implementation of the NEAP and liaises with the Prime Minister's Secretariat, the office of the President, the Ministry of National Health Services, Regulations and Coordination and other relevant Ministries at the federal level as well as provincial authorities. The Focal Person will continue to provide oversight to implementation of the NEAP and coordinate with the provinces on behalf of the Prime Minister. The Prime Minister's Focal Person will be a member of the National Task Force, and will report directly to the Prime Minister on a monthly basis. The Prime Minister's Focal Person will be assisted by the National Technical Focal Person. The Prime Minister's Polio Monitoring and Coordination Cell will

support the Prime Minister's Focal Person and will be responsible for monitoring the NEAP indicators and tracking effective implementation of the strategic decisions and guidance provided by the National Task Force and the National Technical Advisory Group.

The Ministry of National Health Services, Regulations and Coordination is an executing agency of PC-1 for Emergency Action Plan of Polio Eradication and routine immunization programme at federal level. The Ministry also coordinates with provincial health departments to manage the SIAs vaccine supply.

Progress against the NEAP indicators shall be communicated to the Media and the general public after each SIA by the National Steering Committee designated spokesperson. Progress on NEAP implementation shall also be made available online through the Prime Minister Polio Cell's website for Polio Eradication. 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 communication and social mobilization strategy and decisions.

c) The National Steering Committee for PEI/EPI will meet fortnightly (chaired by Prime Minister's Focal Person for Polio Eradication) to review the Programme performance and implementation of NEAP 2014 for both polio and routine immunization. There are three sub-committees to report to the National Steering Committee these include Weekly Surveillance Committee, National Communications Technical Committee and Vaccine Management Committee.

d) The Prime Minister's Polio Monitoring and Coordination Cell will take necessary measures to ensure that all the political and religious parties are on board for the national cause of polio eradication.

e) The functional Polio Control Room has been established at the Prime Minister's Polio Monitoring and Coordination Cell to receive reported (administrative) data during pre-campaign preparation and the campaign implementation phases and provide timely feedback to the provinces. Polio Control Room functioning will be optimized at the provincial level in the offices of the Chief Ministers/ Secretaries and at the district level in the Deputy Commissioners office (Political Agent office in FATA).

f) The functioning of the National Vaccine Management Committee will be led by the Ministry of National Health Services, Regulation and Coordination and meet on monthly basis with documented minutes to assess available vaccine stocks within the country at various levels and to forecast vaccine requirements and report to National Steering Committee. The NSC may notify a special sub-committee (NPM EPI, PM Polio Cell, WHO & UNICEF) to manage vaccine supply for Polio SIAs including release of vaccine to provinces.

2. Oversight mechanism in provinces for NEAP implementation

a) The Provincial Task Force for Polio eradication must be led by the Chief Secretary and will fast-track implementation of the National Emergency Action Plan.

b) A senior full time dedicated government officer must be designated immediately in each province and in FATA to lead 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 chairperson of the Provincial Task Force.

c) Polio Control Rooms will be situated and operationalized at the provincial level in the offices of the Chief Ministers/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 prepare a report after every campaign and circulate to all districts and concerned provincial departments as well as Central Control Room. 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 for both polio and routine immunization at the district and union council levels, in particular.

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 Security Coordination Committee headed by Secretary Home Department will review the security situation of all districts before implementation of campaigns. This committee will take appropriate action to ensure safe implementation of the polio immunization campaigns

f) Provincial Vaccine Management Committees headed by EPI Managers should improve their functioning to maintain all stocks positions at the provincial stores and to gather information from the districts, provide feedback to them and present input to the Federal Vaccine Management Committee. These committees will review the available vaccine stocks in the province on a regular basis and monitor vaccine distribution versus utilization on a 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) As per the national structure, the Deputy Commissioner is the administrative head at the district level and will continue to lead the polio and routine immunization Programme as a programme of the highest

national priority. The performance of the DC/DCO/PA and EDO H must be reviewed on monthly basis by the Chief Secretary, in particular through indicators for preparation and implementation of SIAs. The DC of the low performing district may be considered inefficient and Chief Secretary first issues warning and then and take necessary action for improvement. Appropriate actions of reward and accountability for the DC's performance will be reflected in the Annual Confidential Report.

b) A designated full time Government officer (Additional Deputy Commissioner/ Assistant Commissioner) of the DC to lead the District Polio Control Room as per its functions and develop close liaisons with all chairpersons of UPECs, collect data on the indicators for preparation and implementation of SIAs, presenting this information to the DPEC for appropriate actions, finalizing readiness report of each campaign and will report to the chairperson of the DPEC and ensure accountability for implementation of the Emergency Action Plan 2014.

c) The concerned authorities in the Provincial Governments will ensure availability of a Medical Officer in every UC (UC MO) particularly in the high risk UCs; who may function as the UPEC Chairperson. The compliance of Union Councils dedicating a Medical Officer to guide the polio eradication initiative activities will be monitored by the DCO! Where an appropriate medical officer is not available, a dedicated senior government health official and /or senior official from a government department based in the particular UC will work as UPEC Chairperson. Where available the UC Nazim will participate as a co-chair of UPEC. The UPEC will be responsible for all aspects of preparation and implementation of SIAs in the UC. UCPW and UCCO recruited by partners where available will assist the UC MO 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 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. 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)

District Polio Eradication Committee (DPEC)

The District PEC headed by the DC/DCO and Agency PEC headed Political Agent meets 5-10 days before the campaign. The participation of Chairperson and Secretary of Committee is mandatory with binding attendance of all concerned. 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.

a. The meeting of the DPEC must have in its agenda:

1. 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

2. Appropriateness for plans for pre-SIA, during-SIA and post-SIA phases with focus on comprehensiveness of micro-plans including transit strategy with supervision plan, training quality and effective house to house visits to all families with follow up of those having absent children

3. Specific tasks assigned to the DPEC members in relation to the next SIA.

4. The secretary of the DPEC must maintain record of all approved meeting minutes for sharing when required

5. The secretary of the DPEC must maintain record of all approved meeting minutes for sharing when required

a. A sub-committee meeting headed by incharge of District Control Room must be held 5 days prior to the campaign to assess implementation of key recommendations, and to decide on implementation or deferment UC by UC on the basis of preparation indicators. The assessment of the functionality of the DPEC is based on a defined set of indicators.

b. A security plan prepared jointly prepared by the health department and local law enforcement for implementation of the campaign must be submitted to the DC and DPEC. It is the responsibility of the DC to authorize whether or not a campaign can proceed with the necessary security arrangements for vaccination teams. The DC and local law enforcement should seek advice of community influencers and religious leaders about security plans and measures. If necessary, the DC may approach to the Chairman of the Provincial Security Coordination Committee for additional support.

c. 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 administrative support to all social mobilization activities carried out at the district and union council levels. The partners' communication staff (where present) will assist the district control room in this regard.

d. The district administration seeks support from parliamentarians (MNAs/MPAs) belonging to their own constituencies and involve them where their services are required to motivate community for vaccination to their children. who may 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 provide advocacy to enable 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 inaugurations before each campaign.

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

It is now apparent that there is occasionally a management gap between the district and UC level therefore it is proposed to establish Tehsil polio eradication committees to provide more supervision to the UC level. The functionality of the TPEC must be ensured with designation of the Assistant Commissioner (AC) as chairman, Deputy District Health Officer (DDHO) as its secretary and police officer in charge of Tehsil as an integral part. The meeting of the TPEC will be conducted next day after the last day of UPEC meeting and at least 1-2 days before DPEC meeting. The DDHO will hold a meeting with the TPEC chairman in Tehsil/taluk of his / her assignment before the DPEC meeting and present information on their Tehsil/taluka during the DPEC meeting including UC wise information/data of the Tehsil of their assignment. The partners' staff will ensure training of the DDHO (Tehsil focal person). A review meeting should be held on the fifth day of the campaign to review the achievements and challenges during the campaign and to suggest recommendations for the next one. The particular challenges should be brought to the DCO by the TPEC chairman.

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 or Union Council Nazim 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 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 integrated micro-plans including composition and quality of vaccination teams, transit team strategy including supervision plan, and engagement of the community influencers for information and motivation of the community; and plans for quality training, supervision and real time process data transmission on daily basis.

Information/data management at the UC level will be the responsibility of the UC Medical Officer (UCMO, UPEC Chairman). The UCMO will ensure that all Area In-charges in the UC 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.

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. 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 district control room and approved by the DC: 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 has inadequate preparation, then the DPEC must defer implementation for the district as a whole and emergency measures must be taken to complete preparations within one week period. Adequate preparation includes that all polio workers receive their DDM cards during training before the campaign and if this is not done then the campaign must be deferred.

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 before launching. 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. Prioritization of Districts and Areas for conducting polio SIAs

The districts of the country have been prioritized according to their endemicity or vulnerability to importation of Polioviruses. There are four priorities:

- **Priority 1:** Reservoirs/core endemic areas: Central & Southern Khyber Pakhtunkhwa, FATA, High risk towns of Karachi, Quetta Block, Sherani and Zhob in Balochistan, and demographically linked areas with reservoirs. These areas will receive 9-10 SIA rounds during the low season 2014
- **Priority 2:** High risk districts other than the reservoirs; parts of Northern Sindh & neighboring districts of Balochistan; Southern Punjab and Lasbella District in Balochistan. These areas will receive 4 SIA rounds during the 2014 low season
- **Priority 3:** Areas infected in the last 6 months that lie outside the reservoir areas. These areas will receive a special case response of 3 SIA rounds when polioviruses are detected
- **Priority 4:** Rest of country. These areas will receive 3 SIA rounds during 2014 low season

Additionally areas with persistent transmission of wild poliovirus such as Peshawar Karachi and FATA with have a specially tailored plan of activities made in conjunction with their own polio task forces. This may mean that TPEC/SPEC, DPEC/APEC and UPEC have to meet more frequently.

Peshawar

Peshawar is the key reservoir in the country. The environmental samples from Peshawar have been persistently positive for the last two years. Peshawar missed multiple low season vaccination rounds since December 2012 and quality of the implemented vaccination rounds has not been optimal enough for eliminating virus. A Number of polio vaccination campaigns in Peshawar were conducted in a staggered mode taking more than 10 days to complete. The low transmission season at the advent of 2013 could not be utilized fully mainly due to insecurity.

In view of the above, there has to be a detailed plan focusing on the low transmission season (January-May 2014), if Pakistan is to stop wild poliovirus transmission. As recommended by the Technical Advisory Group (TAG) on Polio Eradication in Pakistan, an intensified campaign schedule is required to be implemented during the low transmission season (10-15 supplementary immunization activities). The intensified SIA strategy to ensure successful implementation requires a sound communications and security plan. An appropriate communications strategy is necessary to foster good community participation and strong security planning to enable polio teams to work effectively. The Emergency Rapid Response Team (ERRT) from Prime Minister's Polio Monitoring and Coordination Cell will continue supporting the local teams.

Current vaccination campaigns are not stopping the poliovirus transmission in Peshawar. Therefore a special Peshawar task force has been established (led by the provincial government) to oversee the progress in Peshawar. The Peshawar Task Force will:

- Finalize the Peshawar work plan for the low transmission season (and rest of the year) in accordance with the NEAP 2014
- Ensure proper preparations including provision of adequate security cover to polio teams working in security compromised areas
- Ensure adequate implementation of polio vaccination campaigns focusing on achieving every child is reached, with special focus during the low season
- Ensure all the polio vaccination campaigns are conducted on a weekly basis for a three month period and then continue with the SIA schedule in the NEAP 2014
- WHO and UNICEF will increase its monitoring both during and post campaigns including extra spot surveys and LQAS
- Develop a plan with assistance from Federal level to use inactivated polio vaccine (IPV) in selected sites when appropriate

Karachi

Karachi is also one of the remaining polio reservoirs in the country, especially Union Council (UC) 4 of Gadap town. Environmental surveillance in Gadap Town indicates persistent wild poliovirus transmission. There is strong evidence that wild poliovirus transmission with epicenter in Gadap town UC-4 is expanding, reversing the gains made during the last 18 months.

A special Karachi task force will be established (led by the provincial Government) to oversee the Programme in Karachi. The task force will

- Finalize the Karachi work plan for the low transmission season (and rest of the year) in accordance with NEAP 2014
- Ensure proper preparations including provision of adequate security cover to polio teams working in security compromised areas
- Ensure especial focus on the high risk migrant/mobile populations during the SIAs and ensure adequate amount of transit vaccination points are operational
- Receive constant support from the provincial task force to ensure specific actions on quality and access problems
- Include senior members from the provincial interior and home ministries to ensure coordination of security for polio vaccination activities
- Develop a plan with assistance from Federal level to use inactivated polio vaccine (IPV) in selected sites when appropriate
- Ensure all the polio vaccination campaigns are conducted on a weekly basis for a three month period and then continue with the SIA schedule in the NEAP 2014

The Emergency Rapid Response Team (ERRT) from Prime Minister's Polio Monitoring and Coordination Cell will continue supporting the local teams in both Peshawar and Karachi.

Federally Administered Tribal Areas (FATA)

North Waziristan and Khyber agencies in FATA are experiencing an ongoing explosive polio outbreak and also driving the polio epidemiology in the country together with Peshawar and Karachi. North and South Waziristan agencies did not have any polio vaccination rounds conducted since June 2012, due to insecurity and opposition (ban) by local elements. Similarly, consistent access to all the children in Bara Tehsil of Khyber Agency has not been possible due to ongoing active military conflict.

The foremost requirement to stop poliovirus circulation in FATA is gaining consistent access to all children. This will be especially important in North and South Waziristan and Khyber Agency, during the current low transmission season. The FATA Task Force under the leadership of the Governor Khyber Pakhtunkhwa should take necessary steps to ensure consistent reach to all the children in FATA. A FATA work plan will be finalized in accordance with the NEAP 2014.

It is crucial to ensure proper preparations including provision of adequate security cover to polio teams working in security compromised areas. The Civil Military Coordination Committee must be functional in every agency and oversee progress of campaign activities. These include:

- Ensure proper preparations including provision of adequate security cover to polio teams working in security compromised areas

- Effective engagement with local law enforcement agencies, Frontier Constabulary, and military through the Polio Civil Military Coordination Committees at the regional, agency and sub-agency level to oversee campaign operations, communications and ensure protection of vaccinators. Conduct fortnightly review meetings with all the political agents
- Effective engagement of all the community factions through initiatives like "Grand Jirga" on polio eradication
- Develop a plan with assistance from Federal level to use inactivated polio vaccine (IPV) in selected sites when appropriate

7. Communication Strategies

The key communication objective for 2014 is to build trust and demand amongst the key communities to accept polio vaccination.

Specific activities may include individual meetings, campaign inaugurations, workshops, media engagement and large-scale campaigns that will support the desired changes in policy, practice or behavior.

Advocacy efforts will aim at political leaders, parliamentarians, religious scholars, local leaders and others, to create a conducive environment for the achievement of polio eradication. In particular, efforts will be sought from the government and political leadership at all levels to facilitate access to all children of FATA. Dialogue with prominent religious scholars shall be further strengthened to dispel misconceptions around polio eradication programme and gain community trust.

Communication shall employ all channels to deliver relevant information to families. It will build upon evidence obtained from various research and will be tailored to the needs of particular groups, identified as high risk or living in high risk districts. Communication risks will be proactively identified and addressed through positive messaging to dispel remaining misconceptions.. In addition, an integrated messaging strategy will be pursued to present polio as part of a larger health package and an important component in overall routine immunization.

8. Functional Vaccine Management Committees at All Levels

Vaccine Management is aimed to help improve the quality of vaccine and cold chain management from the time the vaccine arrives in the country down to the service delivery point. It entails: vaccine arrival procedures, vaccine storage temperatures, cold storage capacity, buildings, maintenance of cold chain equipment, transportation of vaccines, stock management, recording and reporting system, effective vaccine delivery, vaccine management practices as per standard operating procedures and supportive management systems.

The above mentioned procedures, according to the Effective Vaccine Management Initiative, are registered by a series of focused questions, which can be numerically scored based on the observed practices and records against the recommended standards. The questions are divided into seven management implementation categories including: Building, Storage capacity, Equipment, Management issues, Repair and Maintenance, Training and vehicles.

Compiling Standard Operating Procedures for Vaccine Management before, during and after the immunization activities should be ensured through functional

Vaccine Management Committees at all levels (comprising members from EPI and partners).

There is a need to improve and strengthen the existing data system for vaccine management with the currently available tools by introducing a comprehensive integrated computer based online system for immunization activities (Vaccines Logistic Management System – vLMIS). There is also a need to develop and implement National Cold Chain Standards with Cold Chain Inventory system led by vaccine management committees.

9. Functioning Security System

A polio security analysis function has been formed during 2013 to look at the overall security situation pertaining to the polio programme and to identify areas of inaccessibility where it is due to real or perceived insecurity.

In the provinces there is a Provincial Security Coordination Committee headed by the Home Secretary / Inspector General (IG) Police to oversee the security situation of the province and issue instructions to the districts to provide protection to polio workers. An Analytical Officer (UNICEF-WHO Security Analyst) will assist the provincial security committee to co-ordinate security issues at the Provincial, District, Union Council and Tehsil level where they relate to the polio programme, including identification of inaccessibility. At the Union Council level the in-charge of the police station will fully support polio teams during their work where needed for protected campaigns.

The key point of the security system for the polio campaigns is that a security plan is incorporated into the micro-plans at every level. The security plan is necessary at all levels in security compromised areas this may mean law enforcement personnel are essential, however, in low security risk areas law enforcement may not be required. This will be determined by the DPEC and supported by the district police officer. It means involving local law enforcement in the micro-planning process so that if security personnel are required they are fully integrated with the polio front line workers movements. Polio workers should not start a campaign activity if the proscribed security arrangements are not in place when they are to begin work. It is the decision of the DC/DCO/PA if polio or other immunization campaign should go ahead or not due to the security situation.

10. Emergency Rapid Response-Team

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

The Prime Minister's Polio Monitoring and Coordination Cell will continue to spearhead an Emergency Response Team (ERT), comprising of experts (epidemiologists and operational), to expedite the processes of responding to the polio cases/outbreaks and environmental wild poliovirus isolates in a timely manner and with highest possible efficiency. This team will be on call seven days a week, and will serve in coordination with the provincial teams, as the polio eradication programme's central point for responding to polio

outbreaks/environmental wild poliovirus isolates. The core team should be comprised of professionals with expertise on managing outbreak/importation associated case response activity targeting multiple districts in a limited time. The composition of the ERT can be modified according to the area(s) to be targeted with a backup pool of experts which can be mobilized, when required. The core team should move within 48 to 72 hours to the targeted areas (outbreak areas and areas at risk), and provide situational analysis and an appropriate response plan in coordination with the concerned provincial, divisional and district level teams.

In 2013, the ERT in Pakistan so far has supported Hyderabad and Karachi in Sindh; Rawalpindi and central Punjab outbreak (Toba TeK Singh, Sahiwal and surroundings); and Peshawar in Khyber Pakhtunkhwa. The ERT is required to continue its function to support the provinces as per recommendations of the National Steering Committee in controlling outbreak situation in 2014 and will report to Prime Minister polio cell on actions taken.

Key strategies for 2014 with special focus on reservoirs

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

The SIA data analysis indicates that a substantial number of children remain unvaccinated efter every SIA, and even after the 4th day of catch-up. Although the proportion of the total target population that remain unvaccinated the numbers are high enough to sustain virus circulation. It is important to ensure that all children missed during the SIAs are effectively tracked and vaccinated. The campaign should 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.

A list of still missed (unvaccinated) children due to any reason (non-availability, refusal or any other) should be available at relevant government health facilities following the campaign. The EPI staff of the health facility should continue to track 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. In the UPEC meeting for the subsequent SIA should review the tracking and vaccination of still missed children in the previous campaign.

The UCMO must conduct detailed analysis on the reasons of still missed children, with the assistance of partners' staff at UC level (where available). The analysis should 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 taken to track and vaccinate them. Clusters of refusals should be addressed through SOPs for addressing refusal clusters. These SOPs will ensure detailed tracking of refusals by EPI staff with the support of partners' staff where available, complete with collection of contact information and regular high-level follow-up during campaign days and after the campaign. 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)

The main objective of the SIADs is to rapidly build 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 and 2013 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

2014 should have a special focus on reservoir areas, high risk areas, outbreak areas and for Pashtun communities residing outside KP/FATA.

3. Special Strategies targeting underserved, migrant and transit populations

The majority of polio cases reported in 2013 occurred within specific underserved communities (four key tribes) residing in inaccessible or security-compromised areas.

Children belonging to some groups of the population are particularly susceptible to poliovirus due to factors relating to lifestyle, mobility, access to vaccination and other basic social services, security situation or their migration status.

Frequent, significant population movements of mobile population between endemic and non-endemic areas are the main source of virus spread in the country. Mobile and migrant populations are under-vaccinated compared to settled population groups.

Selected permanent transit sites have been equipped with refrigerators that will provide routine immunization antigens in addition to OPV. In fact all traffic flow transit sites leading in and out of polio reservoir areas, especially in FATA, KP and Karachi are being identified and will have intensified operations. In these areas, special task forces have been established to provide more enhanced management and oversight supported by the emergency rapid response team. Within these high risk areas particular attention will be paid to highest risk children in the following ways.

4. Social mobilizers to support missed children strategy

The polio control room data of 'still missed' children after four days of the campaign will be used for verification and follow-up on every missed child within the catchment area of social mobilizers. Missed children verification, conversion and coverage will start from the first day of the campaign and continue to the 10th day of the campaign.

Social mobilizers in union councils will report on missed children coverage to the Union Council medical officers (UCMO) and/or UC-level government focal persons on the 10th day of the campaign.

Social mobilizers in Union Councils will cross-verify the coverage data report shared at the UC level with district polio control room data. For discrepancies and/or not inclusion, the district polio control room focal person will be duly notified for corrective action.

Social mobilizers will share social profiles of missed children/HR groups and inaccessibility data with the UCMO for inclusion in the UC-level micro plans after 15 days of the campaign, and share at UPEC/DPEC meetings.

Social mobilizers will implement pre-campaign communication activities for unvaccinated children based on missed children logbook data. In addition, Social mobilizers will monitor and/or facilitate polio teams training sessions with

special focus on inter-personal communication.

During immunization rounds, social mobilizers will monitor the polio teams with daily focus on coverage of non-available and refusal children. Social mobilizers will conduct tally sheet analysis on the fourth day of the campaign.

The missed children logbook database will be available with the district polio control room in areas that have social mobilizers, and will be shared with provincial polio control rooms within 10 days of the campaign.

5. Surveillance strategy

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.

There are four main strategies that will be used to improve the effectiveness of current AFP surveillance

1. Enhanced supervision and monitoring of the existing reporting sites with supervision visits that include active case review
2. Expand the existing AFP surveillance network by better identification of new private health facilities and key non-formal sites such as traditional healers or other non-certified practitioners
3. Expand the number of environmental sampling sites to better verify the existing circulation of polioviruses and eventually to document the absence of poliovirus circulation
4. Conduct active surveillance during polio and other SIAs. This means polio workers will ask in the community about suspect AFP cases while working in SIAs then report these suspect cases to appropriate district surveillance officers

6. Integrated control rooms

During 2013, 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.

In 2014 the Provincial Control Room must be set up and led by a senior official designated by the Chief Secretaries within their control. 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 Central Polio 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 (WHO, UNICEF etc).

PCR data will be used regularly to improve vaccine management during 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. In addition, the polio control rooms will receive and report data about coverage, drop-out rates, and actual activities compared to plans and other challenges for routine immunization.

7. Strengthening Monitoring and Evaluation mechanisms

Capacity Development and monitoring will be enhanced to improve analysis of all forms of data (operations, communication, vaccine & logistics), especially at the UC level. Polio Info database has been in place with an intention to made social data available at UC level in a simpler form to ensure data-driven micro plans prior to each campaign.

The programme is currently relying on district level government and partners' staff for intra-campaign monitoring. WHO and UNICEF staff at district and UC level will support in intra-campaign monitoring.

The observations of intra-campaign monitoring will be shared with the district leadership during the evening review meeting that follows campaign days, and corrective actions are taken. The UCMO will develop clear monitoring plans for pre-campaign, intra-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. For all monitoring, the UC level supervisors, including UCMOs and partners' UC level staff (UCOs and UCPWs), will be in the field to monitor all activities. During the post campaign phase, the tracking of missed children will be closely monitored.

In the post campaign phase market /hospital surveys and in selected areas independent monitoring and Lot Quality Assurance Sampling (LQAS) will be performed to assess the campaign quality by partners' staff. LQAS data have been shown to be most accurate. The programme significantly expanded the number of LQAS in 2013 compared to 2012 and expect to further expand its use in 2014, utilizing all district based WHO Polio Eradication Officers and Area Coordinators (UNICEF supported DHCSOs). The provincial and national level WHO staff also support LQAS to assess the UC level performance. A campaign awareness component will also be added to LQAS in 2014. Independent monitoring has been limited due to security concerns but if feasible this monitoring mechanism will be reinstated in 2014.

8. Strengthening partnerships for FATA

The success of polio eradication in Pakistan partly depends on cooperation and coordination among multiple stakeholders at different levels. Tackling refusals

from OPV, misconceptions and other challenges requires joint efforts of all polio partners, including civil society and private sector. Through strategic advocacy activities, stakeholders and high risk communities may be engaged in dialogue about immunization to promote greater understanding.

In 2014, partnerships will evolve around fostering closer cooperation with parliamentarians, particularly with the national and provincial Standing Committees on Health; religious leaders and scholars; media and private sector.

9. Direct Disbursement Mechanism (DDM)

The DDM has now been expanded to the whole country by November 2013 under the auspices of the Prime Minister's Polio Monitoring and Coordination Cell. It is now the only mechanism for paying incentives to all front line polio workers. 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 has helped to ensure that all the teams mentioned in the UC micro-plans actually participate in the campaign and also in improving the teams quality, especially preventing children < 18 years old (due to condition of CNIC). It has been 95% effective implementation in this regard. The DDM is optimized using the services of the banks and cellular phone companies (and possibly some other institutions, if needed) to guarantee that the frontline workers receive their incentives with ease.

It is the responsibility of the district administration to ensure provision of all the documents and correct information essential for DDM and send these to the province in a timely manner to provincial level for processing. Delays at any level will result in an overall delay in payment for polio workers. Improvements are now being established to further streamline the processing to speed up the payment mechanism for all polio workers.

10. Integrated micro-planning at Union Council Level

Integrated micro-planning at the UC level is the cornerstone of successful SIA implementation. The micro-plans ensure all components of activity are covered including mapping of the areas with location of high risk and migrant populations, starting and ending point of each team day activity, key landmarks such as schools, mosques, churches, transit points and any other important sites. The micro-plan must include the details of each polio team member and their assigned supervisor, plus the necessary logistics. Micro-plans need to be regularly reviewed and field validated then altered based on past campaign monitoring and field validation. All identified missed areas from past rounds must be included in the next micro-plan. Micro-planning must be a collaborative effort between all departments in the UC calling on revenue department, education, local law enforcement, religious leaders, civil society organizations and others in addition to the health department. Requests for additional polio teams either for house to house, street vaccination or transit team activity can be considered with justification and inclusion in the micro-plans. If additional resources are discovered are needed to reach every child every time then it will most likely be provided if the district and province confirm the new micro-plan is necessary . An

acceptable micro-plan must have all of these:

a) Human Resources

b) Vaccine and Logistics Map of refusal clusters and high risk and migrant populations

c) Security Plan

d) Supervision Plan

e) Social Profile of the area

f) Social mobilization plan

g) List of religious leaders and key community influencers in the area

h) Identification of all nursery schools and madrassas in the area. This also means contacting and informing these institutions before the campaign

i) Mapping of Transit Points and Transit Team deployment and supervision plan

j) Mapping of fixed vaccination and team vaccine collection points. These must include routine immunization fixed and outreach sites in the area

k) Polio team members training plan

There should be joint verification of inclusion of high risk groups into micro plans prior to each campaign. Integration of operational, communication, training and security components into micro plans for all high risk and security compromised UCs shall be a joint responsibility of the Polio Eradication officer, WHO district level staff and DHCSOs under guidance of the UCMO.

11. Strengthening Intra-provincial and cross-border coordination

Poliovirus continues to move from the polio endemic areas of the country to non-endemic areas, to stop this on-going transmission of poliovirus circulation. For this purpose intra provincial cross-border meetings between the bordering districts throughout Pakistan have been conducted.

Districts sharing borders with other provinces should have regular meetings. Objective of these meetings is to strengthen the existing transit points and establish new transit points at the border crossings, review the Union council level micro-plans of the bordering union councils and incorporate transit points into their micro-plans. Develop a joint supervisory mechanism for transit teams and transit points. There should also be discussion of security issues, AFP surveillance and tracking of missed children.

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 polioviruses indicate sharing of wild polioviruses on both sides of the border; hence the two countries constitute one epidemiological block and have to work together to stop polio transmission.

Strengthening these cross border vaccination posts by provision of regular vaccines, logistics and an appropriate place for the posts with adequate security. Supervisory mechanism for these posts needs to be established and regular

supervision by the district and provincial teams need to be made to make these posts viable.

12. 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. Similar committees have been constituted and should now be functional (meeting and reporting regularly) 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.

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

1. National Vaccine Management Committee meeting regularly as per TORs to oversee the all the pertinent vaccine management issues in the country including implementation of vLMIS in the country;
2. Provincial Vaccine Management Committees (PVMCs) developed and reporting regularly to National Vaccine Management Committee (NVMC), on Provincial and District Stores' OPV stock balance (segregated by type of OPV) on prescribed format within one week after each SIA for polio (including SIADs, Mop Ups and case responses) from January 2014, until vLMIS is up and running which will provide this information online;
3. Vaccine management SOPs fully implemented at all levels in the country;
4. A systematic standard method for estimation of target children for all the SIAs in place at all levels throughout the country from January 2014;
5. Vaccine management data continued to be reported/included in SDMS/vLMIS;
6. Develop and implement national cold chain standards with cold chain inventory system by end of 2014;
7. Vaccine management module included in training curriculum of polio workers.

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

13. Optimizing the Polio Eradication Initiative for strengthening Routine Immunization

Routine immunization is one of the 4 basic strategies for polio eradication. It is very important to have good quality routine immunization to sustain the achievements of polio eradication. Additionally, a well-functioning routine immunization programme is necessary to support the introduction of IPV use that

will be necessary as the country and the world moves towards certification of polio eradication. 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).

The Polio Eradication Initiative plans to support strengthening routine immunization services in the following ways:

- Support for developing Integrated UC micro-plans for routine immunization and polio activities
- Capacity building for frontline workers and polio staff
- Integrated communication for routine immunization
- Increased delivery of routine immunization services during SIAs
- Supporting strengthening surveillance for vaccine preventable diseases
- Monitoring routine immunization through polio oversight and accountability mechanisms

The PEI strengthening of routine immunization will be achieved through these activities

1. Reviewing the progress on routine immunization during Polio Task Forces meeting at the National and Provincial Levels and during DEPEC and UPEC meetings. This will include results of field monitoring data, vaccine supply, trends in zero dose children, number of functioning routine immunization sites and vaccine preventable disease outbreaks
2. Lessons learned and applied to Polio SIA micro planning will be used to develop an integrated routine immunization micro-plan that will include all fixed and outreach sessions, vaccine and logistics required, budget, social mobilization and considers Polio SIA implementation days
3. Using advocacy and social mobilization activities of polio eradication to promote for routine immunization
4. Expanding the use of polio vaccination team meeting points as a temporary EPI fixed site during SIAs to be kept open as temporary routine immunization outreach sites during the 3 days of the campaign. This will required a few skilled staff to be incorporated into the UC Polio SIA micro-plan
5. Changing tally sheets to reflect the number of children < 1 year (EPI target age) and children > 1 year with all children < 1 year being referred to EPI centers to check on their routine immunization status
6. Tracking and vaccinating zero dose routine EPI children recorded by mobile vaccination teams during SIAs
7. Active search for outbreaks of vaccine preventable diseases during polio or other SIAS
8. Polio Eradication Officers, UCPWs, UCOs and UCMOs conduct monitoring of routine immunization sessions in selected areas

9. 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

14. Training and Capacity Building

Capacity building is a priority for the polio eradication initiative and a National Training Task Force has been put in place to enable a systematic and coordinated approach to training and capacity building. This structure could be extended to the provincial level, with the creation of Provincial Training Committees.

The focus of the work of the National Training Task Force is the development and delivery of monitoring tools to track unreached children; building and implementing robust curriculums in interpersonal communication (IPC); Tally Sheet Analysis, Micro-plan Validation, Routine Immunization and Vaccine Management; Communications for Development (C4D) and Social Mobilization; Surveillance, Security and Psychosocial Support for Polio Vaccinators and Social Mobilizers; and, enhanced approaches to the training of trainers.

Another focus for capacity building is to strengthen implementation of routine immunization throughout the Pakistan, particularly in terms of grass-roots level management, and a harmonious adaptation to the Vaccine Logistics Management Information System (VLMIS) as currently being introduced in the country. Of particular interest for capacity building is that of the Union Council Medical Officer level.

15. Vaccine Procurement

The forecasting and projection of supplementary immunization activities (OPV mapping) is prepared according to the recommendations of the Technical Advisory Group. OPV mapping for 2014 was endorsed by the National Steering Committee in December 2013, and all procurement will be done strictly in accordance with OPV mapping and the Steering Committee endorsement. A high level of activity is planned for 2014 with five NIDs and four SNIDs, along with SIADs and mop-ups, in order to ensure interruption of wild poliovirus circulation by end-2014.

To prevent shortage of vaccines at all levels from Federal to Province to District and further down need to ensure the following components:

- Accuracy of forecast/projections (requirements of OPV) vs. target population
- Stock positions are taken into account and deducted from new requirements
- Vaccines (OPV) is only utilized for the intended and approved purpose (specific SIA)
- Any unused vaccine balances are returned to higher levels and not utilized for other ad-hoc activities

In 2013 global availability of vaccine will remain a challenge and has serious impact on the feasibility to conduct SIAs as per programme technical requirement.

Conclusion

2013 was a difficult year for polio eradication efforts in Pakistan because of the killing of polio workers, unpredictable vaccine availability and remaining inaccessibility to vaccinate in some of the highest risk areas. Despite these challenges that resulted in an increase in the overall number of wild poliovirus cases there was some progress as it has been more than 18 months since the last type 3 wild poliovirus was detected, Balochistan has remained without wild poliovirus detected since February 2013 and reduction in the genetic biodiversity of polioviruses. The NEAP 2014 is built upon the lessons learnt in 2013, 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 2014 as the best opportunity to make progress towards polio eradication in Pakistan.

Annexes

Annex I

Acronyms and abbreviations

AFP	Acute Flaccid Paralysis
AJK	Azad Jammu & Kashmir
APEC	Agency Polio Eradication Committee
CM	Chief Minister
CNIC	Computerized National Identity Card
cVDPV	Circulating Vaccine Derived Polio Virus
DC	Deputy Commissioner
DCO	District Coordination Officer
DHCSO	District Health Communication Support Officer
DPEC	District Polio Eradication Committee
DDHO	Deputy District Heath Officer
DDM	Direct Disbursement Mechanism
EDO	Executive District Officer
EPI	Expanded Programme on Immunization FATA
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
SPEC	Sub-division Polio Eradication Committee
TPEC	Tehsil Polio Eradication Committee
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

Essential Committees for Polio Eradication and Polio Control / Operations Rooms

1. National Task Force for Polio Eradication

The National Task Force (NTF) will oversee and monitor the progress made against National Emergency Plan of Action for polio eradication throughout the country with especial focus on high risk districts. The main role of the NTF is to ensure that appropriate support is available to all provinces for successful implementation of District/Agency/Town Specific Plans for polio eradication.

Functions of National Task Force

The National Task Force will meet every six months to review the following aspects of Polio eradication initiative

1. The progress made in provinces against National Emergency Action Plan for eradication of Polio and direct the federal and provincial governments to take remedial measures
2. Inter-provincial and inter sectoral coordination and give direction on issues if any of them hampering the efforts.
3. Adequate resources are secured for the implementation of National Emergency Plan of Action for polio eradication.

National Task Force Composition:

- Prime Minister Islamic Republic of Pakistan (Chairman)
- Governor Khyber Pakhtunkhwa / FATA
- Chief Ministers of all provinces
- Minister for National Health Services Regulation and Coordination
- Prime Minister's Focal Person for Polio Eradication
- Secretary to the Prime Minister
- Secretary National Health Services Regulation and Coordination
- Chief Secretaries of all provinces and areas
- Representative of the Chief of Army Staff
- Parliamentarians
- National Technical Focal Person, Prime Minister's Polio Monitoring Cell / Focal Person
- National Programme Manager EPI

- Representatives of WHO, UNICEF, Rotary and Bill Gates Foundation, WB and USAID
- Any other nominee

2. National Steering Committee (NSC) for Polio Eradication Initiative (PEI) and Expanded Program onmmm Immunization (EPI)

Chairperson: Prime Minister's Focal Person for PEI

Secretary: National Technical Focal Person, Prime Minister's Polio Monitoring Cell

Membership:

1. National EPI/PEI Coordinator
2. Health Education Advisor Ministry of National Health Services,
3. Director Surveillance EPI
4. WHO Country Representative, Polio Team Leader, SIA Coordinator, Surveillance, Coordinator, Emergency Rapid Response Coordinator
5. UNICEF Country Representative, Polio Team Leader, Communications Coordinator, Vaccine Procurement Specialist, High Risk Population Coordinator
6. Rotary International Representative
7. JICA Representative
8. Director USAID Health Population & Nutrition and Health Specialist USAID
9. Micronutrient Initiative Representative
10. CIDA Representative
11. DFID Representative
12. Other representatives to be invited when necessary

Terms of reference:

- The committee will meet fortnightly and when required
- NSC will be responsible to guide the program based on decisions of the National Task Force and advice of Technical Advisory Group (TAG) and Independent Monitoring Board (IMB) for Global Polio Eradication Initiative
- NSC will report on the current epidemiological status of Polioviruses
- will be responsible for all the activities under Polio Eradication Initiative
- development and implement oversight of all Polio activities
- calculate the need, location and frequency of Supplementary

Immunization Activities (SIAs) in the country based on surveillance data review

- review logistics requirement and procurement for the forthcoming campaigns
- will finally endorse the communication plan that have been submitted by the National Communications Technical Committee
- NSC will be responsible for campaign evaluation results and feedback to the provinces
- EPI Manger will report on EPI performance, especially the OPV3 status of non-Polio AFP cases and give feedback to the provinces
- EPI Manager will also give regular updates on the vaccine supply situation for both Polio campaigns and EPI
- EPI Manager will provide updates on other vaccine preventable disease outbreaks

There are the following official sub-committees of the NSC:

1. Weekly Surveillance Meeting,
2. National Technical Communications Committee
3. National Vaccine Management Committee for Polio SIAs

3. Provincial Task Force / Steering Committee (PSC)

Each province should have a Provincial Task Force (PTF) / Provincial Steering Committee (PSC) to oversee and monitor the progress made against Emergency Plan of Action for polio eradication in the province.

Functions of PSC/PTF

The PSC/PTF should meet before/after every campaign to review and monitor the following aspects of Polio eradication initiative

1. Progress made in the province against NEAP and provides guidance on challenges being faced by each district.
2. Involvement of district and sub-district level arm of government to assume the responsibility of ensuring implementation of District Specific plan.
3. Involvement of the line departments and assigning specific roles and tasks to each department for the successful campaign implementation.
4. The plan and progress for advocacy and social mobilization activities at provincial and sub-provincial levels and ensure availability of adequate resources and their optimal use.

Committee Composition:

- Chief Secretary – (Chairman)
- Secretary, Health Department – (Secretary)

- Technical Focal Person for NEAP for Polio Eradication in Chief Minister Office (Secretariat)
- Secretary, Department of Education, Information, Local Government, Auqaf and Home.
- Director General Health Services
- All Commissioners and Deputy Commissioners of the province (Political Agents (PA) of FATA)
- Provincial EPI Manager
- Provincial Head of LHWs Program, PRSP/PPHI
- Provincial Heads of development partners (WHO, UNICEF, Rotary etc)
- Any other nominee of Chief Secretary

4. District Polio Eradication Committee (DPEC)

Each District/Agency/Town will have a Polio Eradication Committee (DPEC/APEC) to oversee Polio eradication and routine immunization 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 2014.

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.

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.

g) Monitor progress and challenges for routine immunization in the district

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

5. Tehsil Polio Eradication Committee (TPEC)/Sub-division Polio Eradication (SPEC) functions and composition

Each Tehsil will have a Polio Eradication Committee (TPEC) to plan and coordinate Polio vaccination campaign and routine immunization activities at Tehsil level. The main role of the TPEC 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.

Pre-campaign

- Review the overall pre-campaign preparations of the UCs residing in the Tehsil
- Ensure that all UC micro-plans have been reviewed/field validated in accordance with NEAP standards
- Ensure that micro-plans have proper team and AICs selection, justifiable work load and area assignments
- Make plans for logistic distribution, especially vaccine distribution points
- Ensure each UC has a proper security plan that is reviewed by the Tehsil Police in Charge
- Submit the summary of TPEC findings and recommendations to the DCO office.

During campaign:

- 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.
- Take actions based on findings found during the evening meeting
- 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:

- Hold a review meeting on the fifth day after start of the campaign to evaluate the achievements and problems found during the campaign
- 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
- Review of the micro-plan in the light of the findings/observations of the last campaign.
- AC will report the findings to the DCO especially areas of concern as soon as possible after the campaign
- Monitor the progress and challenges of routine immunization in the different Union Councils

Committee Composition:

- The Assistant Commissioner of Tehsil
- The Deputy District Health Officer (DDHO)
- The police officer in charge of the Tehsil
- The Nazims of each UC in Tehsil
- The union council medical officers (UCMOs)
- evenue Officer (Patwari)
- artner Organizations' UC Polio Worker (UCPW) and UC Communication Officer (UCO), where present.
- Prominent religious person/s if available

6. Union Council Polio Eradication Committee (UPEC)

Each Union Council will have a Polio Eradication Committee (UPEC) to plan and coordinate Polio vaccination campaign and routine immunization 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:

- 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
- Monitor the progress and challenges of routine immunization in the Union Council

Committee Composition:

- UC Medical Officer (Senior Heath 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 and Lead Religious person/s

Polio Control / Operations Rooms

7. National (Federal) Polio Control / Operations Room

- *The National level control/operations room is to be based in the Prime Minister's Polio Monitoring and Coordination Cell (PM's Polio Cell).*
- *The National control room is to be led by the National Technical Focal Person, PM's Cell or his representative*
- *The PM's Cell under the auspices of the Prime Minister's Focal Person for Polio Eradication has to ensure that the National Control Room is fully equipped with all the necessary apparatus and documents (e.g. computers, printers, fax, internet/e-mail, phone, necessary maps etc.)*

Functions

- *Gather information/data from all the province during the pre-campaign preparation phase; collate it in the SIAs Data Management System (SDMS), perform necessary analyses and: a) provide feedback to the provincial level; b) share it with all the important stake holders.*
- *Present summary of A-NEAP preparation indicators to the National Steering Committee of Polio Eradication*
- *Gather data/ information daily from all the provinces during the campaign Implementation, collate/compile it in the SDMS and provide necessary feedback to the provinces*
- *Relay the results of the post campaign assessment received from the provinces to all the important national and international stake holders.*

Compositions

- *National Technical officer, Prime Minister's Polio Monitoring and Coordination Cell*
- *Representative of the National EPI Manager*
- *Representative of WHO country office*
- *Representative of UNICEF country office*
- *Data Manager designated by the PM's Polio Cell*
- *Representative of any other important organization as deemed necessary by the Prime Minister's Polio Monitoring and Coordination Cell*

8. Provincial Polio Control / Operations Room

- The provincial level control/operations room is to be based in the office of the Provincial EPI Manager.
- The provincial control room is to be led by the Technical Focal Person (TFP) from the office of Chief Minister (or any other designated officer by the office of Chief Minister or Chief Secretary if the TFP is not available / designated in the province).

- The Provincial EPI Manager under the auspices of the Chief Secretary and Secretary Health 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.)

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.
- Present summary of A-NEAP preparation indicators to the offices of the Chief Secretary and Secretary Health 10 days and 4 days before the campaign with proposed actions (corrective actions, campaign deferment etc.)
- Gather data/ information daily from all the districts during the campaign Implementation, collate/compile it in the SDMS and relay it to the Federal control room on daily basis. At the same time the provincial control room may provide daily feedback to the districts based on review of the control room data.
- Relay the results of the post campaign assessment (performed by the partner organizations) received from the districts to the offices of the Chief Secretary and Secretary Health.

Compositions

- Technical Focal Person from the Office of Chief Minister
- Representative of office of Secretary Health
- Provincial EPI Manager or his representative
- Representative of WHO Provincial Hub
- Representative of UNICEF Provincial Hub
- Data Manager designated by the EPI Manager
- Representative of the Rotary International
- Representative of any other local important organization as deemed necessary by the office of Chief Minister and Secretary Health

9. District Polio Control / Operations Room

- *The district level control/operations room is to be based in the office of the Chief Executive of the district (Deputy Commissioner (DC)/District Coordination Officer (DCO)/Political Agent)*
- *The district level control room is to be led by an officer (at least Grade-18 in the Government's hierarchy) 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 apparatus and documents (e.g. computers, printers,*

fax, internet/e-mail, phone, UC wise map of the district walled, necessary indicators showing the performance displayed etc.)

Functions

- *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*
- *Present summary of A-NEAP preparation indicators to the DPEC during its meetings before the campaign in the stipulated dates*
- *Gather data/ information daily from all the UC during the campaign Implementation, collate/compile it in the SDMS and relay it to the provincial control room on daily basis*
- *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*

Compositions

- *Designated officer by the DC/DCO/PA*
- *District EPI Coordinator*
- *District Surveillance Coordinator*
- *National STOP Team Member (where designated)*
- *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 (where available)*
- *Representative of any other local important organization as deemed necessary by the DC/DCO/PA Office*

10. Supplementary Immunizations Days' (SIAs) Data Management

The SIAs data was managed through MS excel since the inception. Timely reporting of the data and its use at various levels has become exceedingly important with the passage time. After the launch of the *National Emergency Action Plan (NEAP)*, timely transmission of data from UC to district and higher levels has become extremely important in view that the NEAP strongly focuses on the actionable information reaching the authorities in time in order to enable them to take well timed appropriate actions.

With the support of WHO, the program developed a SIAs Data Management System (SDMS) which is being used since June 2012. SDMS is a MS Access

based relational database developed for SIAs data entry and analysis. Some important data analyses and reports are predefined in this system it has built-in capability to easily analyze the data required by the managers.

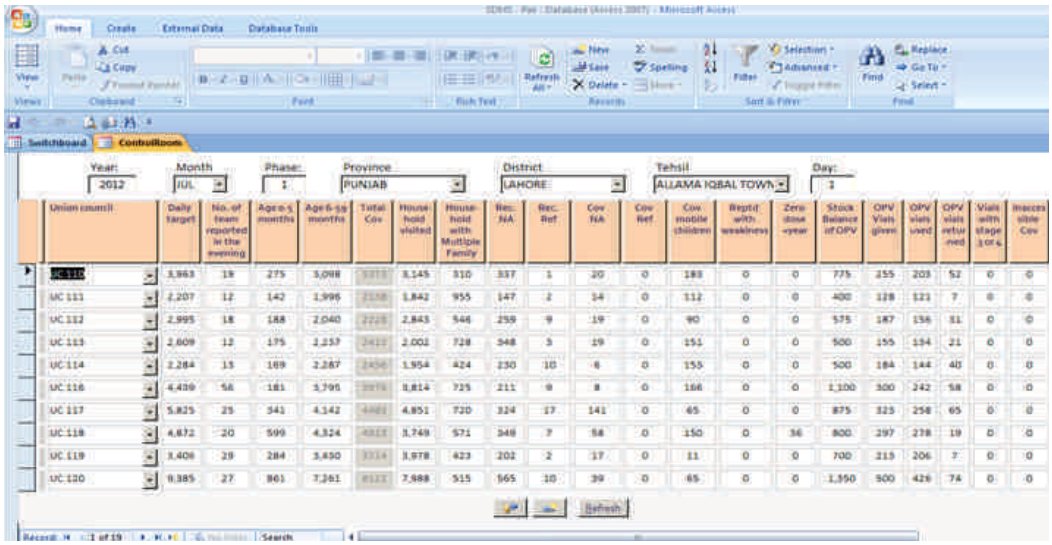
The Components covered in SDMS include:

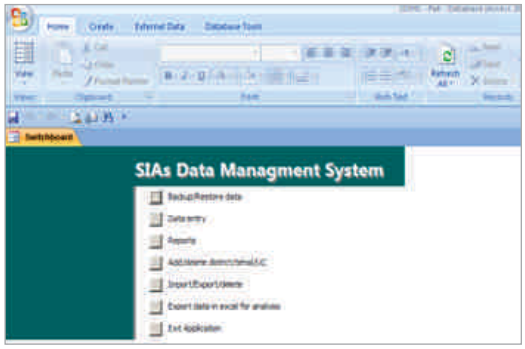
- Reported Planning Information / data
- Planning quality data (NEAP Indicators)
- Administrative coverage data
- Process Monitoring Data
- Post Campaign Independent Monitoring (IM)
- Post Campaign Market Survey
- Post Campaign Lot Quality Assurance Sampling (LQAS)

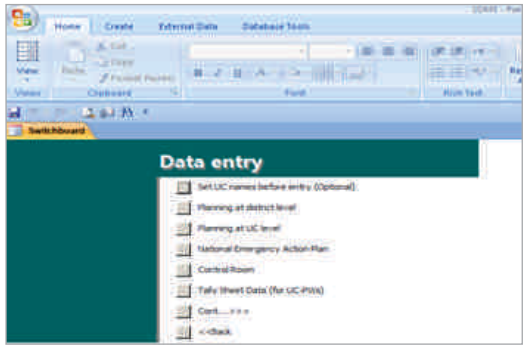
The SDMS has proven useful for standardizing the data, reducing errors, swift data analysis and producing maps / graphs, facilitating data access at all levels and improving the data quality. Data personnel from all the provinces and majority of the districts have been trained and the SIAs data is now being transmitted through SDMS. The database is flexible for any alteration and can be modified according to the program requirements. Below are some screen-shots of the SDMS:

SDMS Switchboard

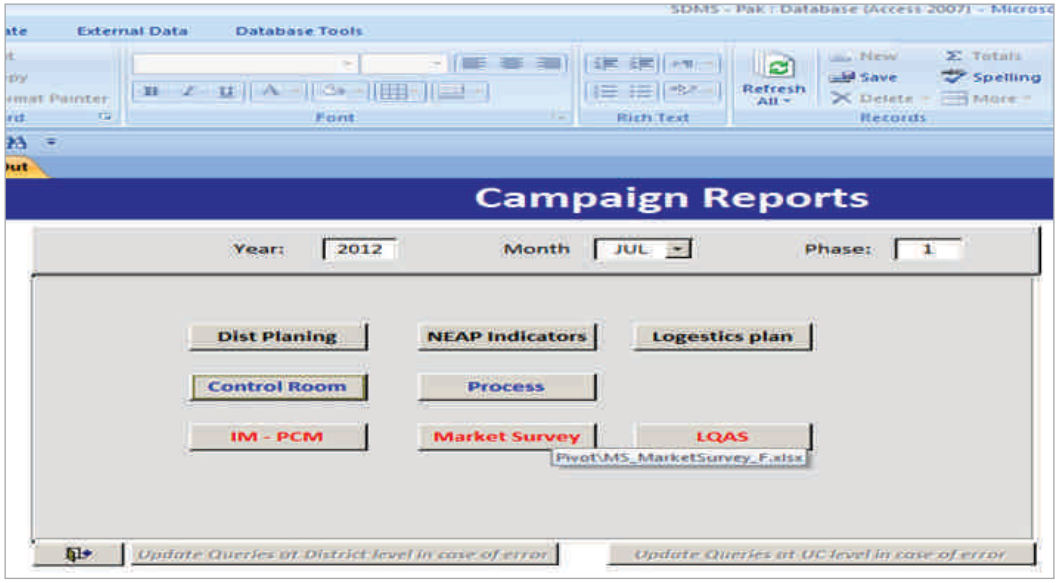
Control Room Data







Different types of reports



Campaign Indicators for High Risk UC of District/Agency

HR UC	Preparatory / NEAP Indicators													Process Indicators							Outcome Indicators									Not yet vaccinated			PP Covg.
	1	2	3	4	5	6	7	7.1	7.2	7.3	7.4	7.5	7.6	8	9	10	11	12	13	14	15	16	17	18	19	20	20.1	20.2	20.3	21	22	23	24
UC1																								99									
UC2	Y	Y	Y	Y	3	3	16	14	14	14	16	16	16			95																500	
UC3																								51		1				2000			88
UC4	Y	N	N	Y	4	3	20	20	20	20	16	16	16			88			55								1						
UC5	Y	Y	Y	Y	4	4	18	16	16	16	18	17	18				77													500		20	
UC6	N	Y	N	Y	5	5	22	20	21	20	20	20	20									88						1					94
UC7																								94								30	
UC8	N	Y	Y	Y	3	3	16	10	10	10	11	11	11			94													1				99
UC9																																	
UC10																																	

1- Is UC MO full time?
2- UPEC meeting held on time?
3-UPEC chaired by UCMO?
4- UPEC Co-chaired by UC Sec?
5- Total no. of AICs
6- No. of Area Microp. field updated?
7- Total no. of teams
7.1- No. of Teams with 1Govt.
7.2- No. of Teams with 1Local
7.3- No. of Teams with 1female
7.4- No. of Teams trained based on standardized module
7.5- All team members > 18 years
7.6- UC is ready for campaign / deffered?

8-%Teams with 1 female
9-% Teams Trained
10-%Teams Recording missed children
11-% Teams go to missed children
12-%Teams visited by supervisor
13-%Superv. Fill checklist
14-%Superv. Adeq. Transport

15-% Children finger marked (IM)
16-% Children finger marked (MS)
17-% Children 'No Team' (IM)
18-% Children 'No Team' (MS)
19-% Ucs <95% Children FM (IM)
20-LQAS Not Rejected 95%
20.1-LQAS Rejected 95%
20.2-LQAS Rejected 90%
20.3-LQAS Rejected 80%

21- No. of recorded still NA / missed children
22- No. of recorded still refusal children
23- No. of inaccessible children
24- % Coverage in Priority Polulation

UC Defferment Criterias		
6: =100%	7.1: >80%	7.2: >80%
7.3: >80%	7.4: =100%	7.5: =100%

Optimal
Sub-optimal
Below optimal

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

District	Total target population for the campaign	Children reported vaccinated		Reported unvaccinated children																Vaccine analysis			
				Children recorded as unvaccinated						Children vaccinated from recorded unvaccinated						Children still unvaccinated among recorded unvaccinated							
				Not Available		Refusal		Total		Not		Refusal		Total		Not		Refusal		Total			
		No. of children reported vaccinated	% Children vaccinated Based on Total Target	n	% among targeted	n	% among targeted	n	% among targeted	n	% among recorded	n	% among recorded	n	% among recorded	n	% among targeted	n	% among targeted	n	% among targeted	Doses given	Doses Used	Doses Returned	Vaccine wastage
Sherani	58,492	59,490	102	5,642	10.0	283	0.48	5,925	10.0	1,015	18	2	1	1,017	17	4,627	7.9	281	0.48	4,908	8.4	3,373	3,280	93	9
Zhob	68,003	64,592	95	6,019	9.0	2,059	3.03	8,078	12.0	5,821	97	1,373	67	7,194	89	198	0.3	686	1.01	884	1.3	3,962	3,485	477	7
Chitral	31,977	31,595	99	2,623	8.0	26	0.08	2,649	8.0	2,383	91	22	85	2,405	91	240	0.8	4	0.01	244	0.8	1,835	1,693	142	7
Total	**158,472**	**155,677**	**98**	**14,284**	**9.0**	**2,368**	**1.49**	**16,652**	**11.0**	**9,219**	**65**	**1,397**	**59**	**10,616**	**64**	**5,065**	**3.2**	**971**	**0.61**	**6,036**	**3.8**	**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	Children reported vaccinated		Reported unvaccinated children																Vaccine analysis			
				Children recorded as unvaccinated						Children vaccinated from recorded unvaccinated						Children still unvaccinated among recorded unvaccinated							
				Not Available		Refusal		Total		Not		Refusal		Total		Not Available		Refusal		Total			
		No. of children reported vaccinated	% Children vaccinated Based on Total Target	n	% among targeted	n	% among targeted	n	% among targeted	n	% among recorded	n	% among recorded	n	% among recorded	n	% among targeted	n	% among targeted	n	% among targeted	Doses given	Doses Used	Doses Returned	Vaccine wastage
UC1	3,899	3,877	99	408	10.5	5	0.1	413	10.6	385	94	5	100	390	94	23	0.6	0	0.00	23	0.6	4,560	4,200	360	8
UC2	3,021	3,071	102	333	11.0	10	0.3	343	11.4	296	89	8	80	304	89	37	1.2	2	0.07	39	1.3	3,600	3,380	220	9
UC3	8,149	8,136	100	742	9.1	15	0.2	757	9.3	671	90	12	80	683	90	71	0.9	3	0.04	74	0.9	10,340	8,980	1,360	9
Total	**15,069**	**15,084**	**100**	**1,483**	**9.8**	**30**	**0.2**	**1,513**	**10.0**	**1,352**	**91**	**25**	**83**	**1,377**	**91**	**131**	**0.9**	**5**	**0.03**	**136**	**0.9**	**18,500**	**16,560**	**1,940**	**9**

** SDMS to be used for campaign data entry and collation*

AnnexIII

Schedule of SIAs in 2014

FORECAST
for Requirement of OPV for 2014

	Target population	34,632,608	2014 January - December		
Proposed Dates	**Type of SIA**	**Target Population**	**Population to be Incldued**	**OPV Requirement**	**Type of vaccine**
est. 06-08 January	SIAD	8,658,152	25%	9,956,875	bOPV
est. 20-22 January	**NID**	34,632,608	100%	39,827,500	bOPV
est. 10-12 February	SIAD	8,658,152	25%	9,956,875	bOPV
est. 24-26 February	**NID**	34,632,608	100%	39,827,500	bOPV
est. 10-12 March	SIAD	8,658,152	25%	9,956,875	bOPV
est. 24-26 March	**NID**	34,632,608	100%	39,827,500	tOPV
est. 14-16 April	**SNID**	17,316,304	50%	19,913,750	mOPV1/bOPV
est. 05-07 May	**SNID**	17,316,304	50%	19,913,750	mOPV1/bOPV
est. 19-21 May	SIAD	8,658,152	25%	9,956,875	tOPV
est. 18-20 August	SIAD	8,658,152	25%	9,956,875	mOPV1
est. 08-10 September	SIAD	8,658,152	25%	9,956,875	mOPV1
est. 29 Sept - 01 October	SIAD	8,658,152	25%	9,956,875	mOPV1
est. 20-22 October	**SNID**	17,316,304	50%	19,913,750	bOPV
est. 10-12 November	**NID**	34,632,608	100%	39,827,500	bOPV
est. 24-26 November	**SNID**	17,316,304	50%	19,913,750	bOPV
est. 08-10 December	**NID**	34,632,608	100%	39,827,500	tOPV
est 22-24 December	SIAD	8,658,152	25%	9,956,875	mOPV1
Case/outbreak responses		*8,658,152*	*25%*	*9,956,875*	*mOPV1*
Specific for mop-ups		13,160,391	*38%*	15,134,450	*bOPV*
Specific for contingency mop-ups		-	*0%*	-	
Total Requirement of OPV for 2014				**383,538,822**	

SIAs	Total Requirement of vaccine for 2014
For NIDs	199,137,498
For SNIDs	79,654,999
For SIADs	79,654,999
Case/Outbreak response	25,091,325
Total	*383,538,822*

Narrative :

1) Campaign activities for 2014. The WHO/UNICEF Pakistan projections approved through NSC on 13.08.2013 have been revised due to the evolving epidemiological situation and TAG recommendations. Currently Pakistan has 74 wpv1 and 44 cVDPV cases as well as 48 positive environmental samples. In view of this, a significant number of immunization activities will be required to interupt transmission of the virus. The continuation of the aggressive case response strategy will be necessary for isolates outside of the polio virus reservoir areas.

Due to no access to Waziristan and Khyber Agencies, which have the highest circulation of polio virus, it is necessary to continue to repeatedly vaccinate the highest populated areas to contain the virus to the inaccessible area. The programme also needs to be ready for utilizing any window of opportunity to vaccinate in the inaccessible areas.

To summarize the key points:

* continuation of intensified SIA strategy in polio reservoirs;
* continuation of aggressive case response strategy;
* preparedness for immediate vaccination, when the window of opportunity appears in inaccessible areas.

2) Period June to August 2014 - It was decided not to have any bigger activities during these three months due to the hot season and Ramadan in July. However, it is therefore critical to receive the vaccines earmarked for case/outbreak responses, as these ds are intended to be used during this period.

3) Case/outbreak responses - mOPV1 will be the vaccine of choice for WPV1, followed by bOPV. The tOPV will be used for response to cVDPV2 cases. For each case response, three (3) successive rounds of vaccination activity will be required.

4) Special contingency for mop-ups - the mOPV1 is for covering mop-ups in the priority 1 polio reservoir areas and other selected districts.

GoP endorsed projections through NSC revised as per 10.12.2013 Vers. 10.12.2013

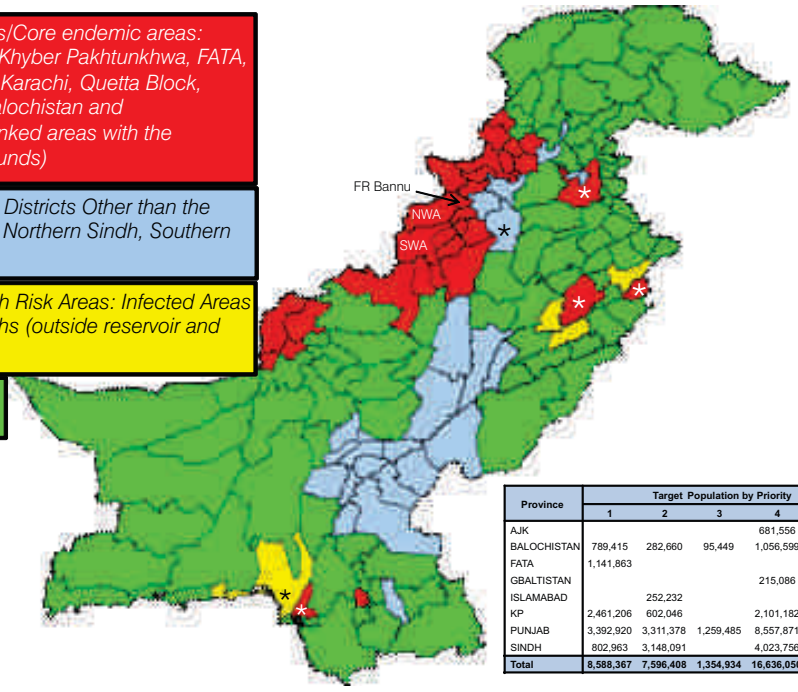
Prioritization of Districts for SIAs'

Priority 1: Reservoirs/Core endemic areas: Central & southern Khyber Pakhtunkhwa, FATA, High Risk Towns of Karachi, Quetta Block, Sherani, Zhob in Balochistan and Demographically Linked areas with the Reservoirs (9-10 rounds)

Priority 2: High Risk Districts Other than the Reservoirs: Parts of Northern Sindh, Southern Punjab (4 rounds)

Priority 3: Other High Risk Areas: Infected Areas during last six months (outside reservoir and High Risk Belt)

Rest of the Country (3 rounds)



Province	Target Population by Priority				
	1	2	3	4	Total
AJK				681,556	681,556
BALOCHISTAN	789,415	282,660	95,449	1,056,599	2,224,123
FATA	1,141,863				1,141,863
GBALTISTAN				215,086	215,086
ISLAMABAD		252,232			252,232
KP	2,461,206	602,046		2,101,182	5,164,434
PUNJAB	3,392,920	3,311,378	1,259,485	8,557,871	16,521,654
SINDH	802,963	3,148,091		4,023,756	7,974,810
Total	8,588,367	7,596,408	1,354,934	16,636,050	34,175,758

^ Newly flagged priority-1

* Partial (high Risk Populations / areas); Rawalpindi, Lahore, Faisalabad, Mianwali (Punjab), Lasbella (Balochistan), Karachi Baldia, Gadap, Gulshan (Sindh)

Note: Afghan refugees and population from North and South Waziristan will be treated as priority-1

Prioritization of districts based on epidemiological situation

Priority 1

Province	Target
BALOCHISTAN	**789,415**
KABDULAH	132,639
PISHIN	111,040
QUETTA	475,166
SHARANI	16,878
ZHOB	53,692
FATA	**1,141,863**
BAJOUR	229,103
FR BANNU	44,009
FR DIKHAN	14,639
FR KOHAT	20,257
FR LAKKI	8,182
FR PESHAWAR	12,719
FR TANK	10,568
KHYBER	228,980
KURRAM	138,689
MOHMAND	87,445
ORAKZAI	66,268
WAZIR-N	162,177
WAZIR-S	118,827
KP	**2,461,206**
BANNU	155,076
CHARSADA	293,837
DIKHAN	269,775
HANGU	115,850
LAKKIMRWT	146,509
MARDAN	360,990
NOWSHERA	272,815
PESHAWAR	769,388
TANK	76,966
PUNJAB	**3,392,920**
FAISALABAD	1,188,067
LAHORE	1,493,499
RAWALPINDI	711,354
SINDH	**802,963**
HYDERABAD	297,844
KHIBALDIA	119,862
KHIGADAP	220,401
KHIGIQBAL	164,855
Grand Total	**8,588,367**

Priority 2

Province	Target
BALOCHISTAN	**282,660**
JAFARABAD	166,113
NSIRABAD	116,547
ISLAMABAD	**252,232**
CDA	131,737
ICT	120,495
KP	**602,046**
KARAK	112,904
KOHAT	190,762
SWABI	258,432
TORGHAR	39,948
PUNJAB	**3,311,378**
DGKHAN	502,867
MIANWALI	213,107
MULTAN	721,871
MUZFARGARH	720,800
RAJANPUR	355,176
RYKHAN	797,557
SINDH	**3,148,091**
GHOTKI	333,094
JACOBABAD	236,759
KAMBAR	284,410
KASHMORE	223,317
KHAIRPUR	439,463
KHGULBERG	72,104
KHILIAQAT	83,535
KHISITE	133,114
LARKANA	295,939
MIRPURKHAS	272,599
NFEROZ	268,954
SHIKARPUR	242,392
SUKKUR	262,412
Grand Total	**7,596,408**

Priority 3

Province	Target
BALOCHISTAN	**95,449**
LASBELA	95,449
PUNJAB	**1,259,485**
SAHIWAL	393,141
SHEIKUPURA	540,222
TTSINGH	326,122
Grand Total	**1,354,934**

Priority 4

Province	Target
AJK	**681,556**
BAGH	61,525
BHIMBER	70,615
HATTIAN	39,697
HAVELI	24,448
KOTLI	131,557
MIRPUR	73,551
MUZAFFARABAD	108,607
NEELUM	30,643
POONCH	92,111
SUDNUTI	48,802
BALOCHISTAN	**1,056,599**
AWARAN	29,712
BARKHAN	25,593
BOLAN	69,742
CHAGHAI	52,393
DBUGTI	40,753
GWADUR	41,389
HARNAI	19,700
JHALMAGSI	25,867
KALAT	71,817
KECH	147,489
KHARAN	24,008
KHUZDAR	115,475
KOHLU	22,090
KSAIFULAH	55,564
LORALAI	62,244
MASTUNG	53,617
MUSAKHEL	28,123
NOSHKI	33,986
PANJGOUR	52,804
SIBI	41,586
WASHUK	19,205
ZIARAT	23,442
GBALTISTAN	**215,086**
ASTORE	16,409
DIAMIR	45,323
GHANCHE	16,808
GHIZER	27,091
GILGIT	38,837
HUNZANAGAR	16,278
SKARDU	54,340

Province	Target
KP	**2,101,182**
ABOTABAD	198,281
BATAGRAM	79,399
BUNIR	176,890
CHITRAL	69,940
DIRLOWER	253,070
DIRUPPER	151,458
HARIPUR	156,872
KOHISTAN	78,456
MALAKAND	115,056
MANSEHRA	282,153
SHANGLA	128,777
SWAT	410,830
PUNJAB	**8,557,871**
ATTOCK	253,819
BAHAWALPUR	545,198
BAHWLNAGAR	436,062
BHAKKAR	233,639
CHAKWAL	183,169
CHINIOT	222,113
GUJRANWALA	773,338
GUJRAT	396,235
HAFIZABAD	185,606
JHANG	408,652
JHELUM	168,175
KASUR	519,081
KHANEWAL	440,081
KHUSHAB	171,390
LAYYAH	263,332
LODHRAN	278,064
MBDIN	226,960
NANKANASAHIB	219,405
NAROWAL	267,430
OKARA	511,336
PAKPATTEN	280,189
SARGODHA	538,197
SIALKOT	571,297
VEHARI	465,104

Province	Target
SINDH	**4,023,756**
BADIN	322,313
DADU	320,363
JAMSHORO	192,021
KHIBINQASIM	110,864
KHIJAMSHEED	137,878
KHIKAMARI	111,454
KHIKORANGI	145,435
KHILANDHI	193,004
KHILAYARI	91,749
KHIMALIR	76,740
KHINNAZIM	72,605
KHINORTH	117,242
KHIORANGI	165,733
KHISADDAR	135,224
KHISHAHFAISAL	74,088
MATIARI	141,265
SANGHAR	362,964
SBENAZIRABAD	303,691
T.ALLAHYAR	145,225
THARPARKAR	213,516
THATTA	277,401
TMKHAN	115,944
UMERKOT	197,037
Grand Total	**16,636,050**

High Risk Districts (33) Newly flagged priority-1

Annex IV

Indicators for UPEC & DPEC Preparations, Advocacy, Vaccine Procurement and Routine EPI

a. 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) 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

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:
	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
	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 Programme 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 In charges 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 Programme 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"

Advocacy	1. # of action plans developed and implemented by parliamentary standing committees on health
	2. # of religious leaders actively supporting Polio eradication Programmeme
	3. % of positive media coverage on Polio eradication Programmeme
	4. # of civil initiatives supporting PolioProgrammeme initiated and implemented by CSOs/CBOs
	5. # of projects contributing to Polio eradication supported by private sector
Social Mobilization	1. # of high-risk districts where social mobilizers are deployed
	2. % of refusal resolved by COMNet
	3. % of not available children covered by social mobilizers
	4. # households in inaccessible areas reached by COMNet
	5. # of zero dose children reported to UCMO
	6. # of influencers/elders accompanying/providing support to campaigns
Capacity building	1. Training Task Forces established in all provinces
	2. % of vaccinators, social mobilizers trained in IPC based on a standardized IPC module
	3. # of missed children tracked by vaccinators, social mobilizers through the application of new monitoring tools
	4. # of certified trainers accomplishing TOT based on Master Trainer's curriculum
Vaccine procurement (Supply)	1. % of vaccine consignments arrived at port of entry minimum three (3) weeks prior to campaign start (NID/SNID)
	2. % of required vaccine for a specific NID/SNID received at district level minimum three (3) days prior to campaign start.
	3. Coverage of 90% (verified through finger marking) achieved in accessible areas of all high risk districts.
Routine Immunization Indicators for DPEC	1. What proportion of UCs in the district developed an integrated micro plan for outreach vaccination session (%)
	2. Number and proportion of outreach vaccination sessions planned according to the micro plan was monitored in the district by PEI and health department staff
	3. Total number and proportion of monitored outreach vaccination sessions were actually found held according to micro-plan
	4. Number and proportion 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

	5. Number and proportion 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
	6. Vaccine stock and utilization information in the district for the immediate past month
	7. Trend of number of zero dose children identified through last 4 Polio SIAs held in the district
	8. Timeliness and completeness of integrated weekly VPD surveillance system (both indicators should be at least 80%)
Routine Immunization Indicators for Provincial Task Force	1. Total number of BHU and above level health facilities in the province and number of them providing regular vaccination service
	2. Number of UCs without any EPI centre in the province
	3. Total number of vaccinators in the province and number of UC without any vaccinator
	4. Total number of Union Council without any comprehensive quarterly micro plan for outreach vaccination service
	5. Number of districts achieved cumulative Penta 3 coverage above 80% till last month
	6. Number of districts achieved Penta 1 to Penta 3 cumulative dropout rate below 10% till last month
	7. Number of districts had monthly outreach vaccination session dropout rate above 5% during the past months since the last Task Force meeting held
	8. Number of districts achieved 80% or more timeliness for weekly VPD surveillance reporting till last epidemiological week
	9. Number of districts achieved 80% or more completeness for weekly VPD surveillance reporting till last epidemiological week • Trend of number of zero dose children identified through last 4 Polio SIAs held in the province • Vaccine stock and utilization information in the province for the immediate past quarter
Post campaign assessment indicators	1. % of the LQAS lots Pass (Target: 90%)
	2. % UCs (Tehsils?) that achieved 95% vaccination estimates through post campaign marketing surveys (target: 90%)
	3. % children missed due to refusal as per Independent Monitoring (<5% of missed children)

Annex-IV
Polio Eradication Initiative Pakistan Emergency Operational, Communication and Security Guidelines for 2014 Polio Immunization Activities in Pakistan

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 Programme among the most affected communities

1. 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.

2. 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 Cordination 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

-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

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:

Polio plus outreach fixed sites and accelerate other development projects for these underserved areas.

where large immunity gaps have emerged and these children become especially susceptible to Poliovirus infection when they migrate into another area where there is circulation of Polioviruses. These include those areas where no confirmed cases have been detected but the presence of Polioviruses is known to be in the environment. Additionally, population movement is not restricted within the country only. There is constant movement across the border with Afghanistan, which itself is still Polio endemic, thus a potential source of Poliovirus spread. Special population groups such as Pawidiris, Kochis and nomads are highly mobile and do play a role in transporting Polio viruses.

Special strategies to address population movement within the country and across border are part of the National Emergency Action Plan (NEAP) to vaccinate children in transit during SIAs. Movement between accessible and inaccessible parts of Pakistan (example North and South Waziristan and FATA and Khyber Pakhtunkhwa) and at key crossroads within the country, it is necessary for these vaccination points to work throughout the month whether there is a SIA or not. It has been demonstrated that migrant and mobile populations are responsible for sustaining Poliovirus circulation and spreading the Poliovirus from one area to another. Data has shown that these populations are less well vaccinated compared to stable populations as they do not have as many vaccination opportunities. As a result of this, they act both to dilute the population immunity and act as a vehicle for carrying virus to and from the reservoir areas.

Another important factor to consider with migration is temporary movement that occurs during the standard SIA period of 4-5 days, which results in significant numbers of not available children that may be missed. One way of reducing the number of not available children is to ensure that they have every opportunity to be vaccinated when they are away from their home. Even if the mobile team visits the house where they are going to, these children may be missed during the actual transit period between locations unless they are vaccinated while travelling.

Permanent Transit Teams

Permanent transit vaccination teams are necessary where there is a constant flow of persons coming from areas where vaccination is limited or where there is frequent travel causing these children to being missed during other vaccination opportunities and where people are coming to and from Poliovirus reservoir areas including other countries. Examples of where these permanent transit vaccination sites can be are:

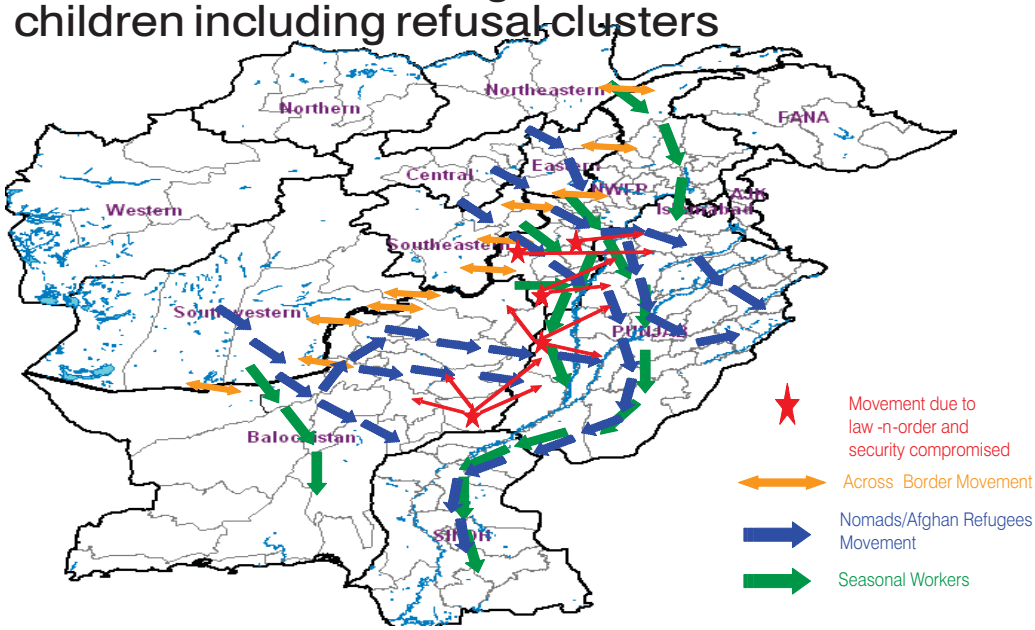
- Border Crossings (These are borders between countries, between provinces or districts especially where areas are inaccessible to vaccination)
- Toll Plazas (This is necessary particularly leading between urban areas and borders)
- Motorway Rest stops (This represents an opportunity to catch children in transit where there may be more time to vaccinate them)
- Hospitals (Tertiary care hospitals(both government and private) because of their specialties and facilities draw patients from other cities, districts, provinces and even countries in the border areas)
- Religious Shrines (These shrines draw people from other areas in large numbers, including many children and sometimes the children and adults are sick coming from Poliovirus reservoir areas and may be under-vaccinated,
- Market Places and large bazaars (These are static points and are daily visited by a huge number of people.)

Challenges to reach children from high-risk groups include:

1. Insufficient amount of functioning Permanent Transit Points
2. Micro-plans are not regularly updated to reflect significant movements of populations
3. Lack of communication activities at transit points as most of the vaccination teams are not accompanied by social mobilizers and lack of supervision and monitoring
4. No formal evaluation of transit points, no specific criteria for determining whether transit points are efficient

Annex-VI

SOP's for addressing cluster of still missed children including 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 refusals should be made before the next campaign.

Annex VII

Surveillance for Polioviruses

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.

Annex VIII

Priority areas of contribution of PEI for routine immunization

1. INTEGRATED UNION COUNCIL MICRO-PLAN

The routine immunization micro-plan is to be developed at UC level by the UC immunization team headed by UCMO. The team will be made up by local vaccinators, LHVs, LHSs, the nutrition supervisor, the CDC supervisor, and sanitary petrol and other local immunization staff. UCPWs and UCOs will facilitate and support this exercise through the provision of

information on polio SIA micro-planning. District level Polio staff may also provide technical support wherever necessary.

Steps in developing the UC micro-plan will include:

- drawing a UC map showing all health facilities and EPI centers, and major geographical landmarks;
- identifying the catchment area of existing EPI fixed centers;
- dividing the UC into 15 – 18 blocks and assigning an outreach team to each block;
- Assigning a specific date for conduction of the outreach session;
- Developing vaccine and logistics distribution, transportation and supervision plan.

Outreach activities can be adjusted to the SIA schedule. 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.

UC should develop the micro-plan for at least three months at a time and a copy of the micro-plan should be kept at Tehsil/Taluka and district level. The session plan should integrate polio SIAs, as well as other vaccination campaigns e.g. measles.

2. Integrated Communication

For a successful and sustainable immunization programme it is critical that an advocacy, communication and social mobilization strategy is developed. This strategy should strengthen routine immunization systems to achieve higher coverage rates for all antigens and reduce missed opportunities, unreached children, and drop-out rates. A successful strategy facilitates community awareness of immunization as a public health priority and ensures commitment and participation in immunization services, and disease detection and reporting. Key communication activities include:

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 social mobilizers

iv. Mobilization sessions by staff in their catchment areas.

Conducting Temporary Routine Immunization Outreach During SIAS

Current practice is to conduct routine immunization at the fixed site in the main health facility of a Union Council. In order to improve coverage, reduce barriers to immunization in the community and to capitalize on the assets used for SIAs, it is proposed that each polio SIA team center for where vaccines are distributed to teams has a skilled person provided to give routine immunization antigens with OPV to infants in the area. This will require some routine immunization vaccines, A-D syringes, safety box, vaccine carrier with four conditioned ice packs and of course one skilled person to give the injections to the infants at the polio SIA team center. Increasing the number of routine immunization sites increases the opportunities for infants to be vaccinated therefore should increase the area's routine immunization coverage.

Also at the same time, polio vaccination mobile teams can inform mothers that their children < 2 years should go to a routine immunization site to check on their child's immunization status and complete missing immunizations. If there are also temporary routine immunization sites during SIA it will make it more convenient for mothers to bring their children for routine immunization.

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 and logistics for EPI

-Ensuring Safe Injections

-Making an integrated micro-plan for routine immunization and polio SIAs

-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. 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, and Pertussis.

IV. 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?

List the number of vials of: BCG,OPV, Pentavalent or DTP-HepB-HiB, PCV10, Measles, and Tetanus Toxoid

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

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.

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 for the District Polio Control room in DPEC meeting

1. What proportion of UCs in the district developed an integ rated micro plan for outreach vaccination session	%
2. Number and proportion of outreach vaccination sessions planned according to the micro plan was monitored in the district by PEI and health department staff	# (%)
3. Total number and proportion of monitored outreach vaccination sessions were actually found held according to micro-plan	# (%)
4. Number and proportion 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	# (%)
5. Number and proportion 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	# (%)

6.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	1st dose	2nd dose	3rd dose	4th dose	5th dose	
Routine immunization									
BCG									
OPV									
Penta									
PCV10									
Measles									
TT									
SIA									
OPV									
Others									

7. 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
1st SIA	
2nd SIA	
3rd SIA	
4th SIA	

8. Timeliness and completeness of integrated weekly VPD surveillance system (both indicators should be at least 80%)

(a) 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 ÷ a X Last EPI wks. number) X 100
(b) How many total weekly VPD surveillance report received in the district from health facilities till last week since beginning of the year	Completeness: (c ÷ a X Last EPI wks. number) X 100

Routine immunization indicators to be monitored by the Provincial Task Force

1.Basic indicators (display data by district)

Total number of BHU and above level health facilities in the province and out of them number of health facilities provide regular vaccination service	
Number of UCs 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 micro plan for outreach vaccination service	
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
1st SIA	
2nd SIA	
3rd SIA	
4th SIA	

3.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	1st dose	2nd dose	3rd dose	4th dose	5th dose	
Routine immunization									
BCG									
OPV									
Penta									
PCV10									
Measles									
TT									
SIA									
OPV									
Others									

Annex IX

DDM Process and Rights of Polio Workers

The DDM will be the only mechanism of paying incentives to the frontline workers. It will ensure safe timely and transparent payment. It also aims at minimizing risk of recruitment of under-age or ghost vaccinators as eligibility for enrollments to the programs is against a valid Computerized National Identity Card (CNIC). DDM is risk free for the AIC and other supervisors who in the past were handling large sum of money in cash.

DDM cards are included in the list of the campaign logistics. The Polio team member during the training needs to fill the card and during the campaign all the monitors will check if each polio team member is carrying the card and CNIC along with the tally sheet. The UCMO-AIC must ensure provision of all the documents and information (correct and precise) essential for DDM.

DDM Steps Start to Finish

Step 1 - Federal distributes DDM cards to EDO and line district according to the approved micro-plan and budget before each campaign. District will distribute to the UCMOs

Step 2 - UCMO/AIC to distribute DDM cards to vaccinators during the training and ensure that they are completed correctly.

Step 3 - Vaccinators/AIC/UCMO keep own card during the campaign and ensure that supervisor signs at the end of each day of the campaign

S**tep 4 -** Vaccinators to submit fully completed cards to the AIC on the last day of the campaign

Step 5 - AIC to ensure that all vaccinator cards for their area have been submitted, and in-turn submit to UCMO together with own duly completed card

Step 6 - UCMO to approve all vaccinator and AIC cards for their area and in turn submit to PEO together with their own duly completed card

Step 7 - DPHMT to verify all the cards for the entire district and ensure that data is correctly entered in the DDM data base. To ensure that soft files and original cards are sent to the WHO Provincial Finance team.

Step 8 - Provincial Finance team to verify cards and validate data and forward data to Federal Office for payment.

Step 9 - DDM Federal Team to verify data and process payment with respective bank

Step 10 Bank to send SMS to beneficiaries for OMNI payments and issue XPIN for MCB payments

Step 11 - Federal Team to send payment confirmation and XPIN to Provincial Office

Step 12 - Provincial Office to send confirmation and XPIN to DPHMT

Step 13 - DPHMT to inform UCMO, AIC and Vaccinator to collect their payments from the Bank/collection centers.

Responsibilities

UCMO

1. Distribute cards during training according to approved micro-plan.
2. Collect duly completed AIC and Vaccinator cards for their area at the end of each campaign.
3. Verify information on cards and approve all cards.
4. Submit all cards to PEO 2 days after the last day of the campaign.
5. To collect own payment within 30 days of receiving SMS or XPIN.

AIC

1. Distribute cards during training according to approved micro-plan
2. Ensure that vaccinator complete cards with correct information – verify CNIC, mobile numbers
3. Ensure that all vaccinators are over 18 and have valid CNICs
4. Sign vaccinator cards at the end of each day
5. Collect all vaccinator team member cards and submit to UCMO on the last day of the campaign
6. To collect own payment within 30 days of receiving SMS or XPIN

Vaccinator

1. Complete a DDM card during the training with the correct information and provide a copy of CNIC (the CNIC should be valid and your own, relative or husbands/ guardian CNIC will not be accepted).
2. Carry DDM card and CNIC when out vaccinating.
3. Ensure that the AIC signs the card at the end of each working day during the campaign.
4. Submit fully completed and signed card to AIC on last day of the campaign
5. Collect own payment within 30 days of receiving SMS, OMNI card or XPIN

Mode of payment

MCB

1. Demand draft (Cross cheque)

Requirements

a) Bank Account

2. Inter-bank transfer

Requirements

1. Bank account with any bank in Pakistan
2. Branch address
3. Branch Code

3. Over the counter payments in any MCB banking hall

Requirements

1. XPIN – unique code provided by MCB
2. Valid CNIC

UBL/OMNI

1. Mobile phone payments from any ONMI agent

   Requirements

   a) Active personal mobile number

   b) SMS notification of payment sent OMNI

   c) Valid CNIC

2. Card payments from any ONMI agent

   Requirements

   a) OMNI card issued by UBL/OMNI

   b) Valid CNIC

Note: Beneficiaries should only provide personal mobile numbers

- Beneficiaries should avoid frequent changes of mobile numbers
- The OMNI card is issued once and should be kept safe. Replacement takes time.
- OMNI card PIN should be kept safe.

CNIC validations:

If a CNIC has expired the polio worker is responsible for applying for a renewal from the relevant authorities before working during a campaign. The receipt issued by the authorities when submitting renewal applications should be attached to the card. An individual without a valid CNIC or a renewal receipt cannot work.

Components of the DDM card:

On the training day all front line workers (UMCO, AIC, Vaccinator) shall complete the following mandatory information as stated in the card.

- Full name as written as on the CNIC
- Gender box to be marked
- Individuals signature
- Function of the worker and team number for team member vaccinators
- Complete residential address
- Copy of valid CNIC
- Complete bank account details (if available) - account number, bank name, branch name, address, bank/branch code.
- Personal mobile number (if available)
- Province, District/Tehsil/Agency/Town and Union Council to be completed