Augmenting the
National Emergency Action Plan
For
Polio Eradication in 2012

DRAFT

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A) Executive summary

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

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

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

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

The new elements that the augmented plan brings are:

- Re-defining polio as a national emergency that must be urgently addressed, and ensuring that all arms of Government are engaged in eradicating polio
- Achieving oversight at district, province, and national level through National Task Force presided by the Prime Minister with wide representation of stakeholders including community leadership. Shifting emphasis to implementation of activities at UC level
- Concentrating efforts on highest risk areas and populations and ensuring that all children in these areas are reached with polio vaccine every immunization round, by the implementation of innovative strategies and partnerships where necessary.
- Implementing a broad ranging communications programme to engage communities and build demand for immunization at household level.
- Closely monitoring the quality of programme performance to identify problems, and to design specific actions to address them
- ***Reviewing implementation:*** The implementation of the augmented NEAP 2012 will be reviewed by the Prime Minister’s Task Force for Polio Eradication every three months, Provincial Task Forces chaired by the Chief Minister every month (Governor Khyber Pakhtunkhwa for FATA). A dedicated full time senior officer in the Prime Minister and Chief Minister (CM) Secretariats will be in place by December 2011 for coordination for the smooth implementation of the Plan and a report to the Prime Minister and Chief Minister fortnightly. As per advice of the

Prime Minister, performance of Deputy Commissioner / District Coordination Officer / Political Agents and Executive District Officer Health based on the performance indicators in the augmented NEAP is to be reflected in their Annual Confidential Reports.

B) *Context*

i. Developments in 2011 and rationale for Augmenting the NEAP

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

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

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

In the past two years, performance in key high risk areas in Balochistan and Sindh has been persistently poor. Failure of management and accountability results in programme failures including a) deployment of inadequate numbers of vaccination teams, b) inappropriate selection and poor training of vaccinators, c) misuse of transportation support provided for teams and supervisors, and d) no punishment for sub-optimal performance. Interventions at the district and sub-district levels and coordinated efforts through political and administrative leadership, if any, have been weak and, thus, so far failed to improve the situation.

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

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

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

ii. Epidemiology and risks of continued transmission

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

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

C) The Augmented National Emergency Action Plan 2012

i. GOAL

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

ii. MILESTONES

By January 2012

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

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

By March 2012

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

By July 2012

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

By October 2012

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

By December 2012

- Cessation of all wild poliovirus transmission in Pakistan

iii. OBJECTIVES

a) Achieve consistent government oversight, ownership, and accountability of polio programme performance at each administrative level in Pakistan

b) Ensure highest quality polio vaccination in the high risk districts/ agencies and populations that suffer from persistent transmission of poliovirus or recurrent re-introductions of poliovirus through improved quality and innovative approaches

c) Ensure consistent access to children in security compromised areas especially in FATA and Khyber Pakhtunkwa

iv. STRATEGIES TO AUGMENT IMPLEMENTATION OF THE STRATEGIC PLAN

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

1. Augmenting national management and oversight of the NEAP

a) The Prime Minister's National Task Force is responsible for fast-tracking implementation of the augmented National Emergency Action Plan. **A senior Focal Point** for polio eradication has been appointed by the Prime Minister to oversee implementation of the Plan, and will liaise with the office of the Prime Minister, President, the Ministry of the Inter-provincial Coordination (IPC) and other relevant Ministries at the federal level. The Focal Person will provide an oversight to implementation of the Augmented NEAP and coordinate with the provinces on behalf of the Prime Minister. A **senior full time government officer** will be designated by December 2011 and be responsible for coordinating between the PM Secretariat and secretariats of the Governors and Chief Ministers, Provincial Steering Committees, and PEI partners. The Focal Point and the above mentioned senior officer will be members of the National Task Force, and will report directly to the Prime Minister on fortnightly basis.

b) The Monitoring and Coordination Cell in the PM Secretariat will support the National Focal Point and will be responsible for monitoring the NEAP indicators at all levels and for tracking effective implementation of the strategic decisions and guidance provided by the National Task Force and the National Technical Advisory Group. In the post-devolution period, the Inter-provincial Coordination Ministry is currently the coordinating the immunization program at federal level and maintains close collaboration with provincial health departments.
   - Progress against the NEAP indicators shall be communicated to the Media and the general public after each SIA by the Prime Minister’s designated national spokesperson. Progress against the NEAP indicators shall also be made available online through the Government’s website for Polio Eradication in shape of Provincial, District and UC-level **“progress report cards”** against the NEAP indicators for each SIA.

c) **The Polio Control room** will be streamlined at the **national** level within the Polio Monitoring and Coordination Cell to receive the collated reported (administrative) data during the pre-campaign preparation and the campaign implementation phases. Polio Control Rooms will be functionalized at the **provincial level** in the offices of the Secretaries Health / Provincial EPI Managers and at the district level in the DCOs’ office. The Polio Control Room should also coordinate collection of real-time information from the field for all operational activities.

d) The **Polio "*Hot-Line*"** operation shall be reviewed and rolled-out on a wider scale as a key mechanism for public accountability. The Government owned media will leverage own resources and ensure that Polio Control Cell phone number is highly publicized several times a day during NIDs through TV and radio channels (PSAs/tickers), and print outlets (PSA insertions). The number of callers reporting poor service delivery shall be an indicator of community demand for OPV and public monitoring of campaign quality. Data on the numbers of received calls (province ad district wise) and the response to those calls will be collated and submitted to the Polio Monitoring and Coordination Cell within a week following each campaign.

2. ***Intensifying oversight in Provinces for urgent augmented efforts to implement the emergency plan.***

   a) A **senior full time government officer will be designated in each province** and in FATA by December 2011 to coordinate implementation of the NEAP at provincial level. The officer will report directly to the Chief Minister (and Governor KP/FATA) and will coordinate with the office of the Minister for Health, the Chief Secretary, the Secretary Health, Secretaries of other departments, and the PEI partners at the provincial level for ensuring tracking of NEAP indicators and accountability at the district and union council levels, in particular. The incumbent will be a member of the Provincial Task Force / Steering Committee, and will report directly the Chief Minister fortnightly.

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

   a) In the persistent transmission and repeatedly infected districts (see Annex V), the Chief Secretary of the province will ensure appointment of **proficient DCOs/DCs/ PAs/TMOs and EDOs-**H having proven capabilities of management and a good track record by December 2011. These officials will be charged with ensuring implementation of the NEAP in their districts. The public representatives of these districts will be requested to fully back the DCO and EDO-H for implementation of the NEAP and for ensuring meaningful accountability at all levels. ***As per the national structure, the DC is the administrative head at the district level. As a program of the highest national priority, the NEAP recognizes the immense importance of the DC's role and relates the success and the failure of the NEAP at the district and union council levels to the DC's performance in this respect. Appropriate actions of reward and accountability for the DC's performance must be initiated and reflected in the Annual Confidential Report. The performance of the DC/DCO/PA and the EDO-H will be reviewed monthly by the Chief Secretary, in particular through indicators for preparation and implementation of SIAs (indicators for the UPEC and DPEC efficiency and the % UCs achieving the target of 95% finger marking coverage by independent monitoring and LQAS).***

b) In the NIPA training, a specific component on polio eradication will be added to orient the administrative cadre on running polio operations in the district.

c) The national programme will immediately (by December 2011) prepare and disseminate a revised set of indicators to assess the quality of the preparations for the SIAs at the district and the UC levels; These indicators will take into account the existing NEAP indicators, and others based on the experience of the previous 12 months; the indicators for the implementation phase essentially remain the same. ***These indicators will be the basis for the Provincial Task Force / Provincial Steering Committee and the DPEC for assessment of preparation and performance by UCs and districts.***

d) The Deputy Commissioner (DC) / District Coordination Officer (DCO) / Town Municipal Officer (TMO) / Political Agent (PA) as Chairman of the DPEC / TPEC / APEC, will designate a **Government-paid full time officer** to ensure accountability for implementation of the district Emergency Action Plan by December 2011. ***This official will be responsible for ensuring the collection of data on the indicators for preparation and implementation of SIAs referred to above, and presenting this information to the DPEC, and will report to the DCO as chair of the DPEC.***

e) The Provincial Governments (Chief Secretary, Secretary Health and Deputy Commissioenr/DCO/PA) will ensure availability of a **qualified medical officer in every UC (*UC Medical Officer*)** who will function as the UPEC Chairman (please refer to section below on UPEC and the annex- III) Where an appropriate medical officer is not available, a dedicated senior government health official and /or senior official from a government department based in the particular UC will work as UPEC Chairman and UC MO. In addition to tasks mentioned under UPEC, the UC MO will be responsible for all aspects of preparation and implementation of SIA in the UC, including training of AICs and teams, monitoring of daily proper dispatch of teams, field supervision, end-day review meeting, coordination with UPEC members and data flow as per timeline given by the EDO-H in pre-SIA, during and post campaign phases. The UC MO will work closely and coordinate with the UCPW and UCO recruited by partners where available, in ensuring vaccination of every child in the UC especially those from the highest risk UCs. ***The DCO will ensure that the UC Medical Officer is posted permanently (with no or minimum turnover) to follow up the issues properly. His performance will be evaluated by the EDO-H (in consultation with the DCO) after every campaign followed by necessary actions***. Partners will support training of UC MOs to enable them to perform their functions by December 2011. The activities planning and implementation of the UCPWs and UCOs through their district supervisors will be coordinated through Area Coordinator at the sub-provincial level.

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

   a) <u>District Polio Eradication Committee</u>

   The DPEC meeting will be convened by the **DCO**; and ***considered as valid if presence of DCO as Chairman and EDO-H as Secretary is ensured (presence of the DCO and EDO-H is mandatory)*** with binding attendance of:
   - EDO Education, Community Development
   - EDO Revenue departments District Police Officer
   - District Khateeb
   - District Coordinator for National Program for Primary Health Care & Family Planning (LHWs Program)
   - District Heads of Governmental NGOs working in health, education, and social development sectors E.g. PPHI, NCHD, HANDS, Rural Support Programs, etc.
   - Active medical professional organizations e.g Pakistan Medical Association and Pakistan Pediatrics Association etc.
   - Members of parliament (MNAs, MPAs, Senators)
   - Local representatives of the partner organizations - WHO, UNICEF and Rotary International
   - Any other relevant notables.

The partner organizations' UC and district based staff (UCPW/UCO, PEO/DHCSO) will share their observations / findings about the quality of preparations for the consideration of DPEC and appropriate response / action including deferment of the campaign, if required.

A full meeting of the DPEC will be held at least **10 days before the campaign** to review the status of preparations and the results of UPEC meetings (completeness and timeliness) and to consider specific requests from the UPECs and any interventions required to make corrections at the UC level. The meeting of the DPEC must have in its agenda:

- the follow up of actions / decisions from the last meeting and holding person(s) accountable in case of faltering; review of trend of the performance (process and outcome) indicators
- appropriateness for plans for pre-SIA, during-SIA and post-SIA phases with focus on comprehensiveness of micro-plans, training quality and effective house to house visits to all families with follow up of those having absent children
- specific tasks assigned to the DPEC members in relation to the next SIA.

Copy of approved minutes of the meeting must be available within 2 days of the meeting and should reflect follow up of previous meeting's decisions and action points for future with clear indication of responsible official and timeline; and actions based on trend of a set of indicators. A sub-committee meeting will be held 4 days prior to the campaign to assess implementation of key recommendations, and to decide on implementation or deferment of

implementation UC by UC on the basis of preparation indicators (see section 5 below).

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

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

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

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

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

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

5. Deferment of scheduled campaigns in case of inadequate preparations

Monitoring of the preparatory phase of SIAs will be significantly enhanced through the collection and transmission of information on key indicators prepared by the national programme (see above). The indicators will establish ***a satisfactory preparedness level*** for UCs and districts, and will be monitored for UC level by the responsible officer designated by the DCO, and verified by

partner agency staff. ***UC indicators will be assessed by the DPEC i) 10 days before the campaign, when a first alert will be issued for any UC with inadequate preparations, and ii) 4 days before the campaign, when a decision will be made for each UC to implement, or defer implementation if preparation is inadequate.***

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

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

6. Additional Innovative Strategies

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

If there is consistent evidence of poor performance through IM data, LQAS data, or field evaluation, or if a campaign is suspended twice in any area (see above section on UPEC), forming implementation **partnerships with other Government or non-government organizations** for enhancing implementation of the campaign will be explored. Areas (**Quetta, Pishin, Killa Abdullah; and high risk areas in Karachi**) which already failed to achieve desired results despite repeated efforts and interventions qualify for this approach immediately (i.e. from December 2011 and onwards).

b) *Special approaches for key areas e.g FATA*

i) Immunization plus; periodic establishment of medical camps by the Department of Health (DoH) offering immunization services in addition to basic curative services. The medical camps should be established in key locations covering populations from areas which cannot be accessed by vaccination teams due to insecurity. The community may be offered incentives in the form of basic necessities e.g. soap, combs, towels etc. (supported by partner organizations) to motivate and create demand.

ii) Strengthening routine immunization through enhanced outreach activities: with add on of OPV for children aged less than 5 years. Since; there is demand for routine immunization (supposedly due to injections) in areas of FATA; there is likelihood that the OPV add-on will be readily accepted during such operations.

iii) Community based initiatives like Basic Development Need (BDN) should be utilized for promoting the vaccination (both routine immunization and the SIAs) and achieving the desired coverage by involving the community.

c) *Direct disbursement mechanism* of payment to grass root level polio eradication campaign workers to reduce the risks of non-payment or late payment, and enhance selection of appropriate vaccination team members and supervisors.

7. Enhancing post campaign monitoring and evaluation

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

i) The independent monitoring process will be reviewed by end January 2012 and any key changes in process will be implemented by the March SIA round.

ii) The possibility of using expanded partnerships with NGOs, Universities, and other competent groups to monitor in key high risk areas will be explored, as will the potential for completely outsourcing monitoring activities in given areas with significant data problems.

iii) LQAS will be carried out after every SIA round, concentrating on known high risk areas, as a supplement to independent monitoring data. LQAS will be used to assess impact of quality changes in key high risk districts and UCs.

8. Capacity Building by Partner Organizations

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

i) Orientation sessions will be conducted for the DCOs to familiarize them with the Polio Eradication operations and their critical role in leading the district and keeping the accountability; latest by mid – December.

ii) UC Medical officers will be trained by the Area Coordinators, Polio Eradication Officers, District Health Communication Support Officers and the C4D officers, on a consistent basis through to the end of December 2012.

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

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

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

i. **To ensure the public understands and shares public accountabilities towards the eradication goal**, the following activities will be undertaken

- High-level Polio ambassador shall participate at high-level Polio campaign launches and advocacy events once every quarter.
- Prime Minister's and Chief Ministers' offices will identify federal and provincial PEI spokesperson that shall be accountable for systematic engagement with mass media and the public on behalf of the PEI programme.
- A large-scale mass media campaign will be launched to mobilize widespread support and commitment towards polio eradication in Pakistan. Government owned media channels and print outlets will leverage own resources to provide pro-bono airtime and space for public service announcements (at least ten insertions, total of five days) in addition to publicizing Polio Control Cell phone number for every NID.
- A series of high-level inter-sectoral orientation meetings will take place with key provincial stakeholders to communicate the revised NEAP strategy, and to clarify roles and accountabilities expected at all levels.
- The media shall be proactively engaged as a key partner to publically communicate progress and setbacks towards the eradication goal.
- For 2012 polio campaigns influential celebrities shall be engaged as Polio advocates at the National and Provincial level to forge wide public support for Polio eradication in Pakistan.
- Key editors, health journalists and prominent TV anchors at federal and provincial level will be engaged for enhancing public momentum through periodic media briefings, journalist trainings, media fellowships and facilitated field visits.

- Pakistan Polio Eradication Initiative website will be set up to make critical information about the programme and implementation of NEAP available to the public.

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

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

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

- Interactive and in-depth radio content such as serials, short documentaries, news programmes will be developed to incorporate key polio messages. These programmes will be aired on credible radio channels. Government owned radio channels will leverage own resources provide pro-bono air time for such programming.

- Key religious and social leaders will be mapped in each district of KPK, FATA , Balochistan and Karachi by January 2012. Partnerships will be established to mobilize social support for OPV through fatwa's, campaign inaugurations, media publicity, mobilization of vaccination teams from local constituencies, and any other appropriate strategies.

- Endorsements on OPV safety will be acquired from influential medical and religious bodies and publicized in local and national media. At least one national level endorsement/statement from the Pakistan Pediatrics Association will be publicized by February 2012.

- Community and traditional influencers will be engaged through jirga's and hujrah's to promote support for the polio programme, and the safety of OPV.

iv. **Reaching the highest risk communities**

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

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

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

Conclusion

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

Annexure attached