POLIO GLOBAL ERADICATION INITIATIVE

PHASE II

STRATEGIC PLAN FOR POLIO OUTBREAK RESPONSE

May–December 2014

THE SYRIAN ARAB REPUBLIC, IRAQ AND SURROUNDING COUNTRIES
SYRIAN ARAB REPUBLIC, IRAQ, JORDAN, LEBANON, TURKEY, WEST BANK AND GAZA STRIP, EGYPT AND IRAN

World Health Organization

unicef

Design by Paprika (Annecy, France)

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In October 2013, wild poliovirus was detected in the Syrian Arab Republic. A robust coordinated multipartner plan was implemented to interrupt virus transmission to protect the children in the region from paralytic polio.

CONTENTS

I. EXECUTIVE SUMMARY

The "Phase II WHO/UNICEF Strategic Plan for Polio Outbreak Response" in the Middle East outlines the specific actions that will be implemented across the Syrian Arab Republic, Iraq, Jordan, Lebanon, Turkey, Egypt, the Islamic Republic of Iran, and the West Bank and Gaza Strip[1] from May to December 2014 to fully interrupt wild poliovirus transmission and prevent further international spread.

Since the Syrian Arab Republic announced a polio outbreak on 28 October 2013, 36 cases have been confirmed in the country, with the most recent reported case had the onset of paralysis on 21 January 2014. Furthermore, Iraq confirmed the first Syria-related poliovirus case in an unvaccinated child who had the onset of paralysis on 10 February 2014.

Following the confirmation of a polio outbreak in October 2013, a comprehensive multicountry strategic plan for a polio response in the Middle East was put in place. The multicountry response in Phase I has been rapid, coordinated and focused on reaching the maximum number of children across the seven countries with oral polio vaccine (OPV).

As of 30 April 2014, 30 supplementary immunization activities (SIAs) have been conducted across the seven target countries using over 100 million doses of vaccines and targeting approximately 25 million children in multiple rounds of vaccination. In addition, detection and reporting of acute flaccid paralysis (AFP) cases have been intensified, national communications plans have been developed and updated, and efforts are under way to strengthen routine immunization.

However, significant risks still remain that the outbreak will spread further within the Syrian Arab Republic and/or Iraq, and expand to neighbouring countries and potentially beyond. This threatens a collective global good and demonstrates that until endemic areas are cleared of the poliovirus, the risk of reinfection in countries with low immunization rates will be ever-present.

Building on the successes of Phase I implementation, based on a new risk assessment for the region and recognizing the operational gaps and weaknesses identified in the *Middle East Polio Outbreak Response Review*, the overall goals of the Phase II strategic plan in two zones of intervention will be to:

- **interrupt poliovirus transmission** in remaining focal areas of transmission by August 2014 through high-quality SIAs;
- **improve the quality** of AFP cases surveillance to ensure that any new cases of poliomyelitis are rapidly confirmed and responded to; and
- **sustain polio-free status** through increased routine immunization coverage and periodic SIAs.

Phase II of the response will focus on:

- **quality** – improving the quality and intensity of key activities including SIAs, AFP surveillance and routine immunization services, with emphasis on monitoring during and after campaigns; and
- **reach** – systematic mapping of hard-to-reach populations wherever they may be, and specific targeting of these populations in subsequent SIAs and with routine immunization and surveillance services.

The costs of implementing Phase II of the strategy are estimated at US$ 59 million.

1 Throughout this document, the West Bank and Gaza Strip refer to the area defined by the UN General Assembly (GA Resolution 67/9) as the State of Palestine.

II. BACKGROUND

On 28 October 2013, the Minister of Health of the Syrian Arab Republic announced that after 15 years' absence, polio had returned to the Middle East. Since that time, 36 cases have been confirmed in the Syrian Arab Republic, with the most recent reported case had onset of paralysis on 21 January 2014. Furthermore, Iraq confirmed the first wild poliovirus type 1 (WPV1) case since 2000 in a 6-month-old, unvaccinated child who had the onset of paralysis on 10 February 2014.

Following the confirmation of a polio outbreak in October 2013, a comprehensive multicountry strategic plan for a polio response in the Middle East was put in place, which focused on conducting mass polio vaccination campaigns targeting approximately 25 million children aged under 5 years. The goal of the strategic plan was to interrupt wild poliovirus transmission in the Syrian Arab Republic and surrounding countries by the end of March 2014 through:

- implementing large-scale and repeated supplementary immunization activities (SIAs) to stop the outbreak and protect all populations at risk;
- enhanced reporting and investigation of acute flaccid paralysis cases (AFP) to ensure rapid detection and response to any wild poliovirus transmission; and
- improved routine immunization coverage to provide protection in the longer term and to sustain polio-free status.

As of 30 April 2014, 30 SIAs had been conducted across the region, targeting approximately 25 million children with multiple doses, in:

- the Syrian Arab Republic (six nationwide SIAs);
- Iraq (three nationwide SIAs, three subnational SIAs and one SIA conducted in October 2013 planned prior to the outbreak);
- Jordan (three nationwide SIAs);
- Lebanon (four nationwide SIAs);
- Egypt (three nationwide SIAs and one subnational SIA);
- Turkey (four subnational SIAs); and
- the West Bank and Gaza Strip (two SIAs).

Details of these campaigns, including coverage estimates based on administrative and post-campaign evaluation data, can be found in Annex 2.

The multicountry intervention and response in Phase I have been rapid, coordinated and focused on reaching the maximum number of children across the seven countries. However, significant risks still remain. The operational gaps and weaknesses identified in the recent *Middle East Polio Outbreak Response Review* need to be addressed systematically in the planning and implementation of the Phase II response plans at country and regional levels, to ensure all children in remaining focal areas of transmission are vaccinated with multiple doses of oral polio vaccine (OPV).

III. GOALS AND OBJECTIVES

Building on the successes of Phase I implementation, based on a new risk assessment for the region, and recognizing the gaps and weaknesses identified in the *Middle East Polio Outbreak Response Review*, the overall goals of the Phase II strategic plan will be to:

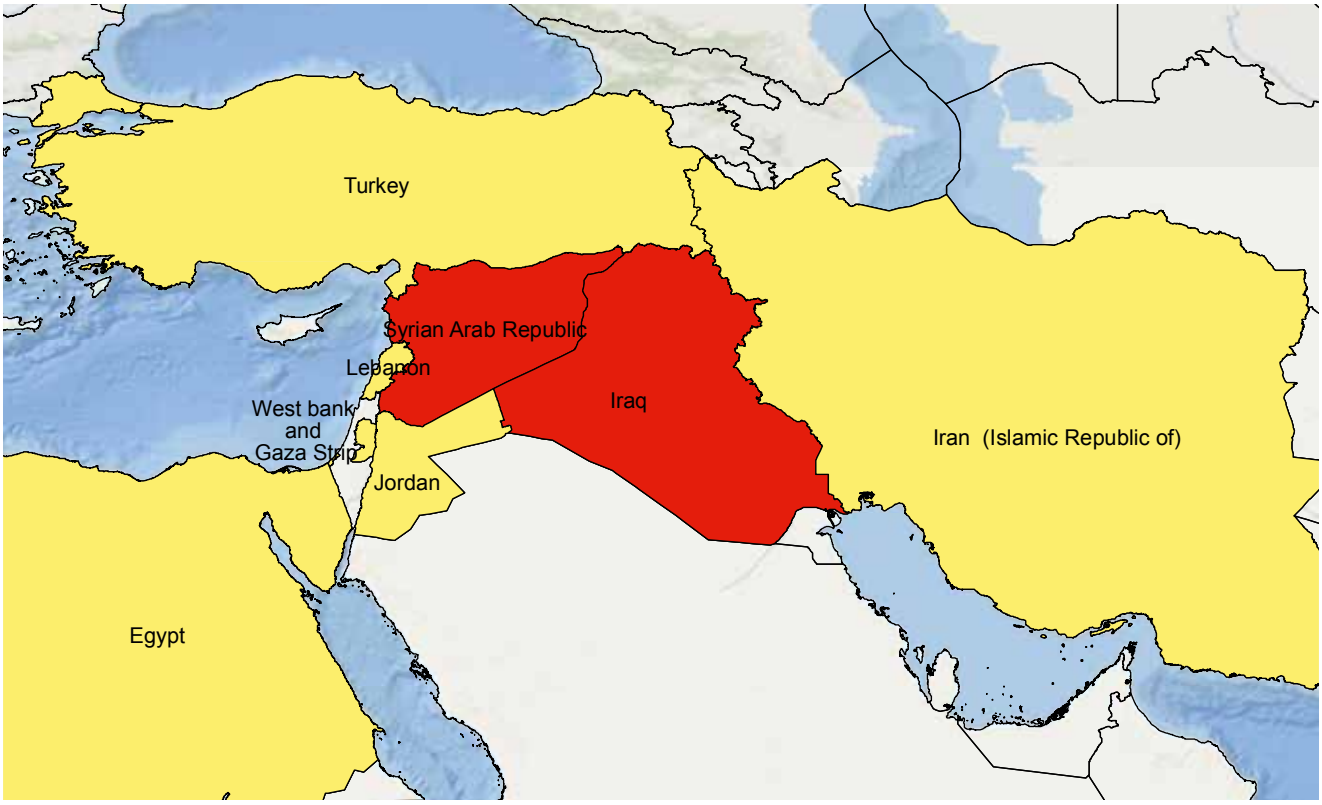
- **interrupt poliovirus transmission** in remaining focal areas of transmission by:
  - identifying unreached children and ensure they are all vaccinated;
  - increasing the reach, intensity and quality of repeated large-scale and targeted SIAs;
- **improve the sensitivity and quality of surveillance** of AFP cases to ensure any new cases of poliomyelitis are rapidly confirmed and responded to; and
- **sustain the polio-free status** through increased routine immunization coverage and periodic SIAs.

Based on a risk assessment, two priority zones of intervention have been defined:

Zone 1: Primary Outbreak Intervention Zone: Syrian Arab Republic and Iraq

Zone 2: Risk Reduction Zone: Turkey, Lebanon, Jordan, the West Bank and Gaza Strip, Egypt and the Islamic Republic of Iran

Figure 1. Polio outbreak response zones, Phase II



OBJECTIVES

The objective in Zone 1 is to interrupt wild poliovirus (WPV) transmission in the Syrian Arab Republic and Iraq by August 2014, by implementing the proven Global Polio Eradication Initiative (GPEI) outbreak response strategy.

- Target 1: at least two rounds of National Immunization Days (NIDs) by November 2014, reaching 95% of the targeted population (validated by post-campaign monitoring);
- Target 2: Subnational Immunization Days (SNIDs) in focal areas of transmission, areas with low coverage or high risk of transmission, reaching 95% of the targeted population;
- Target 3: any new governorate with confirmed WPV1 infection implements a large-scale mop-up response within 14 days; and
- Target 4: reach an annualized non-polio AFP (NPAFP) rate of ≥2/100 000 and ≥80% of AFP cases with adequate stool specimens, both nationally and in all governorates, by September 2014.

The objective in Zone 2 is to prevent further polio spread to neighbouring countries at immediate risk of virus transmission (Turkey, Lebanon, Jordan, the West Bank and Gaza Strip, Egypt and the Islamic Republic of Iran).

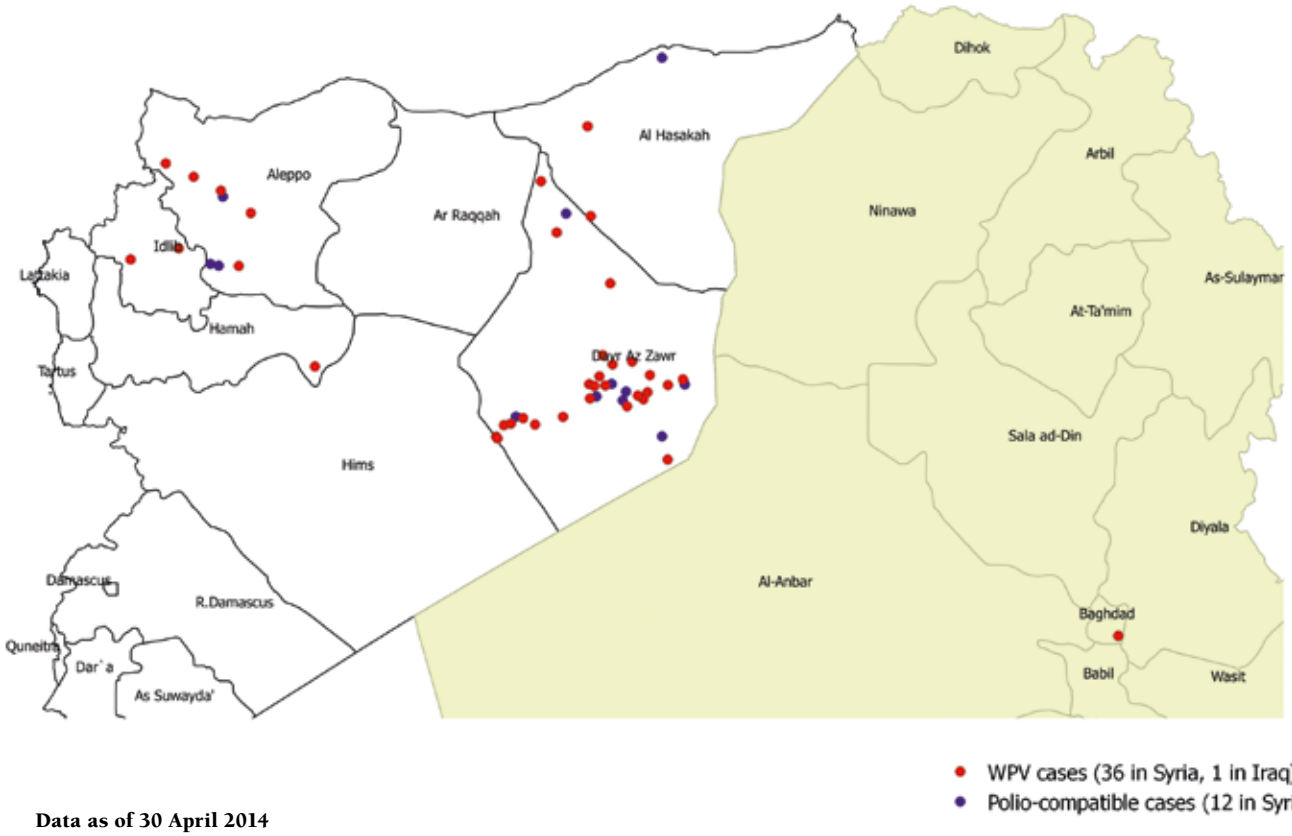
- Target 1: reach an annualized NPAFP rate of ≥2/100 000 and ≥80% of AFP cases with adequate stool specimens by September 2014;
- Target 2: coverage of 95% of target population in at least one NID, validated by post-campaign monitoring;
- Target 3: at least two targeted SNIDs in areas with low coverage or high risk of transmission, reaching 95% of targeted population;
- Target 4: polio vaccination of 95% of Syrian refugees aged under 5 years on arrival in the country or camps near borders;
- Target 5: any new country with confirmed WPV1 infection implements a large-scale mop-up response within 14 days, and prepares a national outbreak response plan within 21 days; and
- Target 6: routine polio vaccination of 95% of children (POL-3) by December 2014 (including refugees), with a coverage of at least 85% in all governorates.

IV. SITUATION OVERVIEW AND EPIDEMIOLOGY

Since the return of polio to the Middle East in October 2013, 36 cases due to WPV1 have been confirmed in the Syrian Arab Republic. Genetic sequencing indicated that the virus had been in the region for nearly a year (linked to a virus detected in environmental samples in Egypt in December 2012, with closely related strains also detected in environmental samples in Israel and the West Bank and Gaza Strip since February 2013). Of the 36 polio cases confirmed in the Syrian Arab Republic, 70% are from Deir Al Zour (25); other cases are from Aleppo (5), Idleb (3), Hasakeh (2) and Hama (1). Of the confirmed polio cases, 52% never received OPV (19/36). (In 2013, the proportion of "zero-dose", non-polio AFP cases among children aged 6 to 59 months was 9% nationally and 8% in the first quarter of 2014, an increase from 5% in 2011.)

In the confirmed WPV1 case in Baghdad-Resafa governorate, Iraq (see Figure 2), genetic sequencing indicates the virus is most closely related to the virus detected in December 2013 in Hasakeh in the Syrian Arab Republic.

Figure 2. Map of wild poliovirus and compatible cases in the Syrian Arab Republic and Iraq

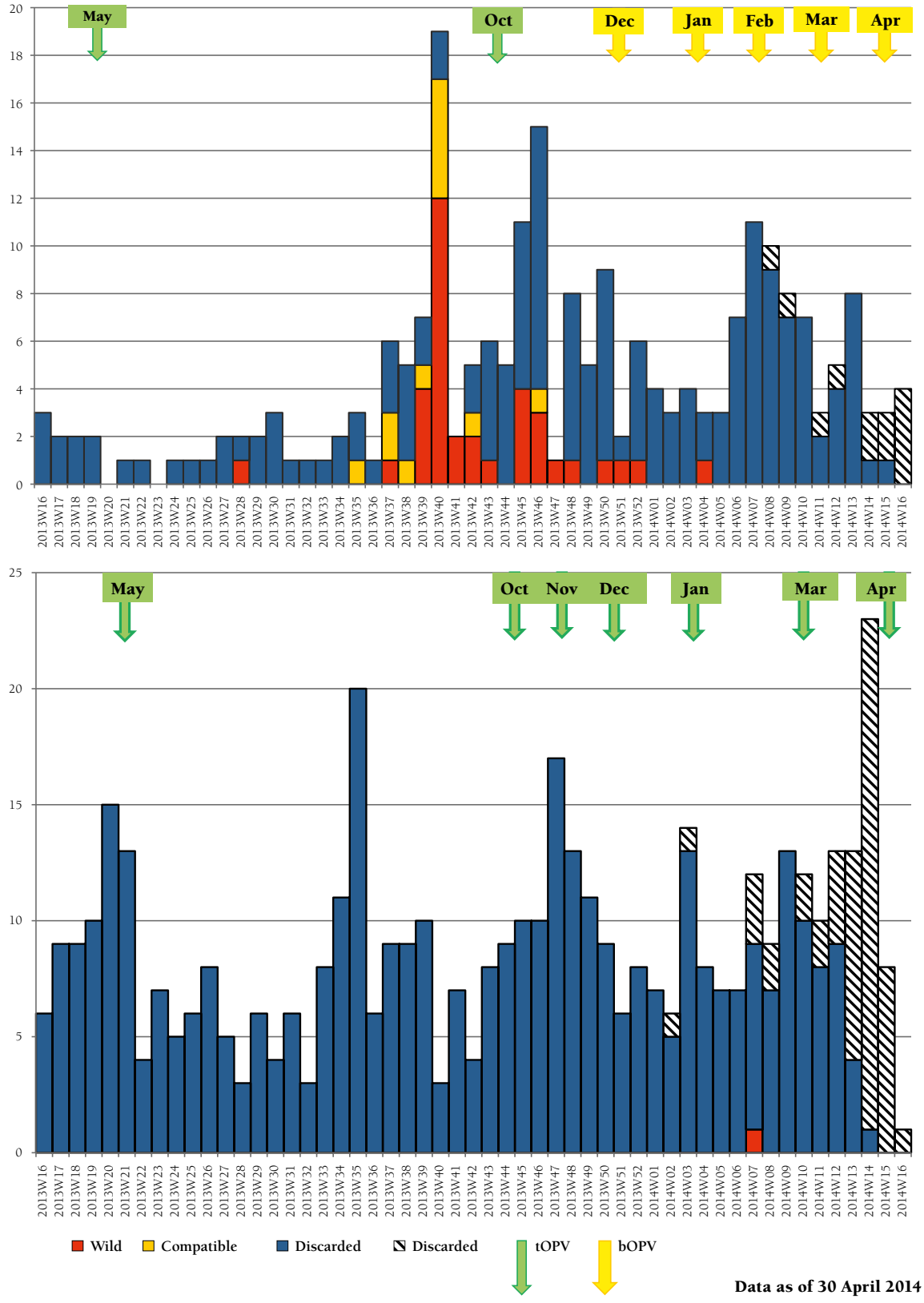


Data as of 30 April 2014

In the first quarter of 2014, the number of confirmed polio and compatible cases significantly declined. Within the context of a marked improvement in the AFP surveillance, only two WPV cases were confirmed in the first quarter of 2014, as compared to 35 confirmed WPV cases in 2013. From the available data, it seems that the outbreak might have peaked in the Syrian Arab Republic in week 40 of 2013 (see Figure 3). The number of confirmed WPV cases steadily decreased from week 40 in the Syrian Arab Republic, with no new case confirmed for six consecutive weeks after the January case. This decline is largely attributed to the success of

the aggressive outbreak response activities. As of the end of April, six NIDs were implemented in the Syrian Arab Republic, in addition to four SNIDs conducted in contested areas. Furthermore, there was a progressive increase in the number of children vaccinated in each round. However, despite progress in the Syrian Arab Republic, polio encroached into neighbouring Iraq, with one polio case confirmed.

Figure 3. AFP and confirmed polio cases the Syrian Arab Republic and Iraq, April 2013–April 2014



V. RESPONSE TO DATE

Overall, the Syrian Arab Republic and surrounding countries in the Middle East have engaged in a massive response to the emergence of wild poliovirus in the region. In a complex political and security environment, governments, with the assistance and partnership of UN agencies and nongovernmental organizations (NGOs), have accessed and vaccinated millions of children in multiple rounds of SIAs. In addition, detection and reporting of AFP cases have been intensified, national communications plans have been implemented, and efforts are under way to strengthen routine immunization.

An interim review of the response thus far was carried out in March 2014 and an assessment of achievement of objectives to date is presented in Table 1.

Table 1. Targets by intervention zone and status as of March 2014

Zone	Target	Status	Comments
All countries	To interrupt wild polio virus transmission by end of March 2014	**At risk**	The seven countries included in Phase I have implemented 24 SIAs. No polio was detected in Jordan, Lebanon, Egypt, and Turkey, and decline in virus in environmental samples in West Bank and Gaza Strip The last polio case in Syria had paralysis onset on 21 January 2014; however, polio was detected in Iraq.
Zone 1: Syrian Arab Republic	NPAFP rate greater than 2/100 000	**On track**	All governorates except Aleppo and Tartous achieved NPAFP rate ≥ 2/100 000 (Sep 2013–Feb 2014)
	Six rounds of NIDs by April 2014	**On track**	Five rounds completed with two rounds planned for April and May 2014
	December SIAs reach 90% of accessible population	**Partially**	In Dec 2013, 2.2 million children under 5 years vaccinated Post-campaign monitoring covers 79%
	January reaches 90% of entire target population	**Partially**	2.5 million children under 5 years vaccinated Post-campaign monitoring covers 88%
Zone 2: areas in surrounding countries bordering transmission zones	Annualized AFP rate greater than 2/100 000	**Not achieved**	NPAFP rate improved but still below 2/100 000 in provinces in Turkey, Iraq and Jordan
	In at least three SNIDs or NIDs, 95% coverage	**Partially**	All campaigns achieved high administrative coverage Low post-campaign monitoring coverage among hard-to-reach population and refugees in Jordan and Lebanon
	Vaccination of 95% of refugee children on registration/arrival in camps	**Achieved**	All children are referred to health service on arrival for routine vaccination
Zone 3: other areas in surrounding countries	Annualized AFP rate greater than 2/100 000	**Not achieved**	Annualized NPAFP rate was below the target in Turkey, Lebanon, West Bank and Gaza Strip, and Lebanon
	In at least two NIDs, 95% coverage	**Not achieved**	High administrative SIA coverage, but no PCM data available for Turkey, West Bank and Gaza Strip, Egypt or Iraq
	Routine polio vaccination of 95% by Dec 2014	**At risk**	Low and/or falling coverage in Lebanon and Iraq

Data as of 30 April 2014

Supplementary immunization activities have been conducted across the region since October 2013, targeting approximately 25 million children with multiple doses of oral polio vaccine. The Ministry of Health (MoH) of the Syrian Arab Republic conducted the first SIA on 24 October 2013, within five days of the regional polio outbreak alert. As of 30 April, the seven target countries have carried out 30 SIAs. Further information on SIA campaign implementation can be found in Annex 2.

Particular challenges to implementing SIAs included:

- insecurity, particularly in the Syrian Arab Republic and Iraq, which affected access to some high-risk areas and resultant low coverage rates in these areas;
- low risk perception among families and medical personnel who did not fully understand the urgency and need of repeated rounds;
- fatigue within national health systems due to the human resources and time demands from the SIAs; and
- lack of independent monitoring in some countries and inconsistent use of finger marking made it difficult to objectively assess post-campaign coverage.

The following **AFP surveillance** targets were achieved up to March 2014:

- four out of the seven countries met the target NPAFP rate of ≥2/100 000;
- five out of the seven countries met the target of ≥80% of AFP cases notified within seven days of the onset of paralysis;
- all seven countries met the target of ≥80% of AFP cases investigated within 48 hours of being reported; and
- six out of the seven countries met the target of ≥80% proportion of AFP cases with adequate stool specimens.

Further information on AFP surveillance can be found in Annex 2. Particular challenges to AFP surveillance in the region included:

- access to areas, particularly northern governorates of the Syrian Arab Republic, to carry out active AFP case surveillance and sample collections;
- suboptimal active surveillance and AFP case reporting and investigation;
- lack of standard AFP case definitions and awareness among clinicians; and
- lack of standardized stool sample collection and transport protocols.

Jordan, Turkey and the West Bank and Gaza Strip have more than 95% estimated **routine immunization coverage** of three doses of polio (POL-3). Egypt has less than 95% POL-3 coverage and the Syrian Arab Republic, Lebanon and Iraq have less than 80% POL-3 coverage. Further information on routine immunization can be found in Annex 2.

Particular challenges to routine immunization in the region included:

- the collapse of routine immunization infrastructure (including facilities and cold chain) in the Syrian Arab Republic;
- a lack of mapping of areas and population groups with suboptimal routine immunization coverage;
- a lack of catch-up protocols for under-immunized children, particularly among refugee populations; and
- a lack of reporting and data sharing from the private sector and partners, particularly those serving refugee populations.

A **regional communications for development strategy** was implemented to ensure more than 90% of caregivers with children aged under 5 years had appropriate knowledge of polio vaccination. This included knowledge of campaign dates, the importance of repeated doses and routine immunization, vaccine safety, risk of non-compliance, and ensuring children are immunized during SIAs.

The regional external communications strategy emphasized the risk of polio returning to the region and the importance of a coordinated, regional response, advocating for health system strengthening and maintaining a political commitment.

High household awareness of polio campaigns has been achieved across the region, but low awareness rates are still prevalent in high-risk areas of unvaccinated children. Post campaign monitoring in the Syrian Arab Republic, Lebanon and Jordan indicated that 70% of missed children are in areas with low risk perception, unawareness of the campaign, and misconceptions about OPV.

Particular challenges to communications and social mobilization in the region include:

- poor focus on community-level interventions during campaigns and lack of engagement of local communication actors, particularly in hard-to-reach areas and underserved populations; and
- a lack of diversified media outlets that can reach a wider audience.

The region required more than 105 million doses of **oral polio vaccine** in the first six months of the outbreak response. Only the Syrian Arab Republic and the West Bank and Gaza Strip reported some delays in vaccine transport and provision to insecure areas.

Particular challenges to vaccine supply in the region included:

- a lack of timely sharing of country plans and requests with the vaccine supply division;
- suboptimal vaccine stock management procedures, including accurate reporting of balances and wastage rates at the country level;
- bOPV is not licensed for use in the region, except in Turkey, so each shipment needs a waiver and exemption; and
- use of non-standardized target populations which provides challenges to timely and accurate vaccine supply and delivery.

VI. CURRENT RISK ASSESSMENT

The risk is still high that the outbreak will spread further within the Syrian Arab Republic and/or Iraq, and expand to neighbouring countries and potentially beyond. This threatens a collective global good and demonstrates that until endemic areas are cleared of the poliovirus, the risk of reinfection in countries with low immunization rates will be ever-present.

The following positive factors exist:

- the huge number of children reached in successive SIAs blunts the risk of an explosive outbreak of poliomyelitis;
- surveillance is improving in detection rates, case investigations and laboratory confirmation;
- overall routine polio vaccination coverage remains high in the region; and
- there is a good understanding at the community level of the need for and benefits of vaccination, and demand for vaccination services is still high overall.

Yet, a significant number of negative factors remain:

- The detection of a case of WPV1 in Iraq, linked to the northern Syrian Arab Republic, demonstrates the capacity of the virus to spread across borders. It now represents a new challenge to full interruption of virus transmission in the region.
- Population displacement both within the Syrian Arab Republic and beyond the country continues. Many children are still inaccessible within the Syrian Arab Republic due to conflict, and many refugees outside the country are either unregistered or living in informal tented settlements in host countries. Since the beginning of the conflict in the Syrian Arab Republic, over 9.5 million persons, almost half of the country's population, have been displaced, including over 2.5 million into neighbouring countries, primarily Jordan, Lebanon, Iraq and Turkey (see Annex 2, Figure 5).
- Pockets of intense insecurity in Iraq persist, which hamper vaccine service delivery and can delay AFP investigation.
- The influx of refugees puts pressure on government services, and in some areas has led to resentment from local communities.
- Surveillance, while improving, is still suboptimal in some countries, especially at the subnational level (see Annex 2, Figure 4).
- Routine coverage is still too low in countries like Iraq, the Syrian Arab Republic and Lebanon. A disrupted routine immunization programme over the past three years has left large numbers of children susceptible to polio in both the Syrian Arab Republic and Iraq (see Annex 2, Figure 6).
- The region is entering the "high" transmission season.

Conclusion: Following the detection of wild poliovirus type 1 cases in the Syrian Arab Republic and Iraq, and despite a robust response in Phase I by the seven targeted countries, a continued multicountry intervention is needed to rapidly detect and interrupt wild poliovirus transmission and protect children in the region from paralytic poliomyelitis.

VII. PHASE II: RESPONSE PRIORITIES AND KEY ACTIONS

Phase II of the response will focus on:

- **quality** – improving the quality and intensity of key activities including SIAs, AFP surveillance and routine immunization services, with emphasis on monitoring during and after campaigns; and
- **reach** – systematic mapping of hard-to-reach populations wherever they may be, and specific targeting of these populations in subsequent SIAs, routine immunization and surveillance services.

With the confirmation of a WPV1 case in Iraq, Phase II countries include all from Phase I (the Syrian Arab Republic, Iraq, Turkey, Lebanon, Jordan, Egypt, and the West Bank and Gaza Strip) with the addition of the Islamic Republic of Iran for planning and SIA implementation purposes.

Supplementary immunization activities

Based on the current epidemiologic situation and in view of the recent confirmation of a polio case in Iraq, the following are the major activities planned:

- intensified SIAs in the Primary Outbreak Intervention Zone (the Syrian Arab Republic and Iraq) with a focus on reaching areas and populations previously not reached due to inaccessibility or insecurity;
- targeted campaigns to reach high-risk areas/populations in the Risk Reduction Zone (Lebanon, Jordan, Turkey, Egypt, the West Bank and Gaza Strip, and the Islamic Republic of Iran);
- synchronized, large-scale, multicountry campaigns by the fourth quarter of 2014; and
- systematic improvement of SIAs quality to ensure all children in remaining focal areas of transmission are reached by:
  - mapping high-risk groups for special attention in SIAs and routine immunization services;
  - implementing intra-campaign monitoring; and
  - implementing post-campaign monitoring.

Table 2. Proposed schedule of SIAs for Phase II of the polio response

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Zone 1								
The Syrian Arab Republic	NID (2.8, bOPV)	NID (2.8, tOPV)		SNIDs (2.0, bOPV)		NID (2.8, bOPV)	NID (2.8, bOPV)	
Iraq	NID (5.6, tOPV)	SNIDs (3.0, bOPV)		SNIDs (3.0, tOPV)	NID (5.6, tOPV)	NID (5.6, tOPV)		
Zone 2								
Lebanon			tOPV 0.15	tOPV 0.15	bOPV 0.15	NID (0.6, bOPV)	NID (0.6, bOPV)	
Jordan		SNIDs (0.20, tOPV)		SNIDs (0.20, tOPV)		NID (1.0, tOPV)	NID (1.0, tOPV)	
Turkey	SNID	Identify high-risk population and immunize them				SNID	SNID	
Egypt	Identify high-risk population and immunize them					NID (14.5, tOPV)		SNID (4.5, tOPV)
The West Bank and Gaza Strip	Identify high-risk population and immunize them					NID (0.7, OPV)	NID (0.7, OPV)	
The Islamic Republic of Iran	SNID (0.25, bOPV)	SNID (0.25, bOPV)						

Data as of 30 April 2014

AFP surveillance

While AFP surveillance benchmark indicators are steadily improving, significant gaps and weaknesses still remain. Therefore, in Phase II of the response, all countries will develop a surveillance strengthening plan by June 2014 that will include:

- updated under-15 population figures including refugees and migrants;
- establishing/strengthening active surveillance to ensure a wide network, regular quality visits, supervision and performance monitoring;
- awareness meetings for orientation of health personnel together with training of surveillance focal points and sensitization of medical professionals (e.g. medical and paediatricians' associations) and regular sharing of information on the current epidemiologic situation and performance;
- review of current AFP case investigation practices including stool transportation, identification of bottlenecks and development/updating of transport protocols to address delays;
- regular analysis of data at all levels to identify subnational gaps and feedback for action; and
- implementation of detailed investigations (to include social and behavioural determinates) of zero-dose AFP cases (and confirmed WPV, if applicable) to inform immunization and communication activities.

Routine immunization services

Of the eight countries in the regional polio response, five (Jordan, Turkey, the West Bank and Gaza Strip, the Islamic Republic of Iran and Egypt) have POL-3 coverage of over 90% according to WHO/UNICEF estimates, whereas three countries (the Syrian Arab Republic, Iraq and Lebanon) have POL-3 coverage rates of between 50% and 79%.

Overall, the goals and targets for the Middle East polio response regarding routine immunization (RI) is routine polio vaccination of 95% (POL-3) by December 2014, with a coverage of at least 85% in all governorates.

To accomplish these targets, all countries will need to:

- identify and map areas/groups with suboptimal routine immunization using different sources of information;
- develop catch-up protocols for under-immunized children at different ages;
- maximize opportunities for delivering routine immunization
  - at border crossing points;
  - ensuring inclusion of RI in package of mobile teams;
  - providing support to health facilities serving refugee populations (vaccine and staff);
- improve reporting and data sharing from the private sector and different partners involved in providing vaccination; and
- explore innovative strategies for including immunization with other antigens, for example child health interventions (e.g. child health days) and integration with other service providers (e.g. WASH, food services, education, etc.) by June 2014.

In addition, a specific plan for strengthening immunization services in the Syrian Arab Republic, Iraq and Lebanon will be developed by August 2014, building on the experiences from the polio outbreak response.

Social mobilization and communications

An updated regional communications strategy will be developed by May 2014 which will drive the social mobilization and communication activities across the eight target countries.

The communications objective is to increase awareness and risk perception, and create positive vaccine attitude and behaviour.

Plans will focus on:

- mass media using regional and country media/print material/social media and school packages; and
- community mobilization and strengthening of interpersonal communication (IPC) skills of health workers, especially in hard-to-reach areas/populations.

A wide variety of campaign monitoring and evaluation methods will be used to document the impact of the different interventions and ensure evidence-based planning.

The regional/country media strategy will be tailored to:

- continue advocacy and raising risk perception of polio and other vaccine preventable diseases to governments and communities amid competing priorities;
- develop high-impact content and involve targeted media channels to capture attention;

- promote regional protection against communicable diseases, including polio;
- proactively communicate immunization successes and remaining barriers;
- reduce stigmatization of Syrian refugees among host communities;
- use polio to show regional cohesion and support;
- strengthen communications, coordination and key messages with partners (OCHA, UNRWA, IOM, UNHCR); and
- invest in activities for regional immunization weeks.

At the national level, social mobilization and communication activities will continue to:

- highlight the continued risk of a virus outbreak without full protection against polio using OPV;
- diversify local strategies/channels to respond to different vaccine delivery approaches and communicate specific campaign dates;
- localize communications plans according to specific population groups and local media analysis;
- maintain public trust in the vaccine and the vaccinators;
- collect critical data on reasons for missed children during and after each SIA;
- develop quality materials that are tailored to the social context; develop high-quality attractive messages to address parents' concerns and create risk perception, demand and acceptance of repeated campaigns;
- strengthen IPC skills of health workers to address the public's safety concerns and low risk perception;
- include messages on RI during and between SIAs;
- mitigate the tension from stigmatization of the Syrian population in the region; and
- be prepared with media packages that include answers to frequently asked questions (including difficult questions) and updated fact sheets, and use diverse spokespeople.

Vaccines logistics and cold chain

Countries supported by UNICEF and WHO will:

- improve vaccine stock management, including accurate reporting of balances and wastage rates to the regional office on a regular basis;
- provide timely sharing of plans and requests with the supply division;
- expedite the process of bOPV licensing;
- use specific CCL indicators for identifying gaps and strengthening in-country cold chain and logistics (this would also have a direct impact on the overall CCL capacity to deliver other vaccines in campaigns or through the routine immunization programme); and
- ensure micro-plans are updated regularly to adequately reflect gaps in cold chain equipment/ vaccine storage, especially at the peripheral level.

VIII. HARD-TO-REACH AND INACCESSIBLE POPULATIONS

Phase II of the outbreak response must have a special focus on children not reached in previous campaigns. The reasons for non-vaccination are different in each country, and solutions in each country will depend on local circumstances and opportunities.

In particular, special efforts will be made to reach children in insecure areas as well as in hard-to-reach populations, including refugees and nomadic populations. Different approaches and strategies may be needed in:

- populations in contested areas
- populations in besieged cities/towns/areas
- populations in areas with active conflict or security operations
- populations that are mobile
- populations that may be discriminated against.

All the countries have hard-to-reach populations, including refugees and nomadic populations. Therefore, in Phase II, WHO and UNICEF along with partners in GPEI will:

- provide technical support to vaccination in areas not reachable by the Syrian Ministry of Health, through innovative arrangements for vaccine supply and delivery along with assistance in micro-planning, cold chain management and training;
- seek access to besieged areas through high-level advocacy and local negotiations including "humanitarian pauses"; and
- pre-position vaccine and cold chain equipment near areas of active conflict/security operations to rapidly take advantage of peaceful periods.

All countries will:

- identify, map and track high-risk populations/inaccessible areas after each SIA round at the lowest possible levels;
- conduct a security/access analysis to identify reasons for inaccessibility and determine risk mitigation actions;
- develop plans to access high-risk areas/hard-to-reach populations which involve NGOs, the Red Crescent and local communities in the high-risk areas;
- for refugees, encourage registration and develop mechanisms for tracking registered refugees, and implement strategies to reach unregistered refugees in host communities (e.g. liaison through UNHCR, IOM, community links and package delivery);
- identify health-care-seeking behaviour of high-risk populations;
- ensure acceptance in health facilities and provide support to those serving hard-to-reach populations;
- provide guidelines on routine immunization (catch-up) to the under-immunized; and
- expand the surveillance network to health facilities used by hard-to-reach populations and initiate community surveillance among them.

IX. NATIONAL, INTERNATIONAL AND INTERAGENCY COORDINATION

National

Activities aimed at ending polio transmission, preventing its importation and reducing the risk of transmission where the disease is imported must be coordinated at the national level by a multiagency and multidisciplinary team led by the Ministry of Health.

- WHO, UNICEF, partners in GPEI and other UN agencies will continue to support national polio response control teams/rooms.
- Weekly meetings of polio control rooms/teams will be held at the national level.
- Each country will produce and share a weekly situation report.
- Countries will provide regular updates to WHO and UNICEF on planning for NIDs, AFP surveillance and activities aimed at strengthening routine immunization services.

International

- The response at the regional level will continue to be coordinated by a joint WHO/UNICEF outbreak response team based in Amman, Jordan.
- The regional response team, with the support of other partners in GPEI (the Centers for Disease Control and Prevention and the Bill & Melinda Gates Foundation) will continue to support national polio risk management efforts.
- An inter-ministerial meeting is planned for May 2014 in conjunction with the WHO World Health Assembly, to review progress in the response and address any outstanding issues.
- A weekly *Epidemiological Situation Report* covering all eight countries will be produced and disseminated as well as a weekly briefing for technical partners based in Amman.
- A monthly bulletin for partners will continue to be produced, summarizing the epidemiological situation, country activities, financial situation and ongoing needs, and a monthly donors/partners briefing meeting will be held for partners based in Amman.

Interagency

- A format for sharing information between agencies (WHO, UNICEF, UNHCR and IOM) will be developed and will ensure regular, timely sharing of data.
- Agencies will explore ways to increase involvement of NGOs and use their operational capacity, especially in hard-to-reach populations.
- Regular, weekly WHO/UNICEF meetings at the regional and country level will be held for information sharing.
- The WHO-UNICEF Regional Office and Country Offices will hold conference calls as needed.

X. BUDGETS, HUMAN RESOURCES AND FINANCIAL PLANNING

In Phase I of the response (November 2013–May 2014), the seven countries involved responded with large financial commitments to implement SIAs and enhance AFP surveillance. Where needed, financial contributions from donors were channelled through the UN agencies to close funding gaps.

Moving into Phase II, funding mechanisms are transitioning from emergent systems to standardized systems. As part of this transition, greater detail surrounding funding requests to donors is required, and a more standardized donor reporting format is expected. To facilitate these changes in financial requirements, WHO and UNICEF are providing technical assistance in funding planning and reporting to the eight countries involved in the Phase II response.

The implementation of Phase II of the Middle East polio outbreak response is estimated to cost approximately US$ 59 million.

Table 3. Budget summary for the Phase II Middle East polio outbreak response

Item	Budget
Vaccine procurement	14 525 000*
Operational costs (SIAs)	28 270 000
Assistance to AFP surveillance	2 886 500
Strengthening of routine immunization services	3 745 000
Communications campaigns	9 190 000
Effective coordination	1 028 500
Total	59 645 000

*Includes extra vaccine for border vaccination in the Islamic Republic of Iran

Data as of 30 April 2014

XI. MONITORING AND EVALUATION

Reviews of polio outbreak responses are mandated and required by World Health Assembly Resolution 59.1. The reviews should occur at three-month intervals and focus on determining the speed and effectiveness of the outbreak response, as well as identify gaps in implementation and make recommendations to improve the intervention.

The next outbreak response reviews will be carried out on September 2014. If required, a third review and planning meeting will be held in December 2014.

Countries are requested to develop and implement quarterly financial audits, and to conduct monitoring and evaluation activities for SIAs, RI and AFP surveillance in August 2014.

ANNEX 1: SUMMARY OF COUNTRY WORKPLANS

SYRIAN ARAB REPUBLIC

Planned activities		*2014*								*Budget*
		May	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	
Supplementary immunization activities	Type: NID, SNID	**NID**	**NID**		**SNID**		**NID**	**NID**		US$ 3.5 million of which OPV costs US$ 2.35 million
	Target population (in millions)	**2.8**	**2.8**		**2**		**2.8**	**2.8**		
	Vaccine type (if known: tOPV, bOPV)	**bOPV**	**tOPV**		**bOPV**		**bOPV**	**bOPV**		
Assistance to AFP surveillance		**Implementation/intensification of active surveillance** • Conduct field visits and refresher training in governorates/districts where AFP surveillance is suboptimal • Develop and distribute AFP surveillance manuals and posters • Develop and distribute weekly surveillance update • Review national protocol and procedures for AFP case investigation including specimen collection								US$ 100 000
Strengthened routine polio immunization/immunization services		• Identify and map governorates and districts with poor RI performance including nomadic groups, and train staff in priority districts • Develop strategy for increased routine coverage: Reach Every District (RED) • Support facilities serving hard-to-reach populations (vaccine, cold chain, staff) • Deploy "mobile teams" for emergency public information (EPI) implementation • Conduct complex coverage survey at the national level								US$ 385 000
Communications campaign		• Design/develop television spots and media, airing on local and regional media • Design and develop printed material (posters and flyers, Q&A, signs) • Design and develop PR strategy (television talk shows appearance/celebrities) • Design and develop school packages								US$ 200 000
Effective coordination of country support (national, interagency, international)		• National: polio control room, weekly polio response bulletin, biweekly meeting of polio response partners • International: technical contribution to Weekly Middle East Situation Report, participation in regional coordination meetings and reviews								US$ 110 000

IRAQ

Planned activities		*2014*								*Budget*
		May	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	
Supplementary immunization activities	Type: NID, SNID	**NID**	**SNID**		**SNID**	**NID**	**NID**			US$ 19.4 million of which OPV costs US$ 4.4 million
	Target population (in millions)	**5.6**	**3**		**3**	**5.6**	**5.6**			
	Vaccine type (if known: tOPV, bOPV)	**tOPV**	**bOPV**		**bOPV**	**tOPV**	**tOPV**			
Assistance to AFP surveillance		**Strengthening AFP surveillance in the high-risk zones** • Muthanna in addition to the nine priority provinces • Minister of Health meets with DGs of health before each SIA round to ensure their leadership and full involvement in polio eradication activities • Refresher training on surveillance for doctors, surveillance focal points and paramedical staff • Sharing of information on NPAFP among partners and at provincial level • Mapping of data by districts for surveillance • Weekly AFP surveillance bulletin • One national AFP surveillance review meeting • Independent surveillance review • Strengthening of community-based surveillance • Strengthening of communication activities for AFP surveillance (education and communications materials and training) • Iraq laboratory accreditation by field visit • Active surveillance • Support of AFP surveillance activities (notification and investigation, etc.) • Twenty advocacy meetings, one for each governorate • Twenty supervisory visits, one for each governorate • Two workshops each for two days, one for Baghdad and near governorates, and the other for far governorates to be held with the assistant of the National Polio Lab (NPL)								US$ 1 million

	2014	*Budget*
Strengthened routine polio immunization/immunization services	**Strengthening RI in high-risk governorates** • Review coverage in disputed districts • Conduct cross-border planning (border synchronized micro-planning) • Review and update RI data management tool and train staff to accommodate new schedule • Update EPI response plan focused on logistics • Reactivate RED approach strategy • Advocate for primary health-care staffing to be reviewed • Include evidence-based communications plans in the micro-plan • Focus communications training on vaccinators and health staff • Strengthen community engagement • Assess regional and district cold chains • Expand and strengthen cold chain management • Advocate among decision-makers for using bivalent vaccine	US$ 1 million
Communications campaign	**Improving general awareness and demand** • Mobilize community towards high-risk groups involving local leadership • Strengthen partnerships with private medical sector • Partner with private sector companies • Increase visibility and urgency of campaign through social and mass media • Institutionalize communications for development-trained staff in all ministries of the Government of Iraq • Conduct knowledge, attitudes and practices (KAP) study • Audience analysis segmentation • Train vaccinators in IPC • Strengthen location-based technology with low immunity profile • Use YouTube and Google public messaging • Engage in media – talk shows on television • Use school package for health advocacy through children • Involve religious leaders in advocacy • Print materials and air television spots on local channels	US$ 5 million
Effective coordination of country support (national, interagency, international)	• Form national polio steering committee comprising MoH, UNICEF, WHO and other stakeholders • Hold weekly review meetings with MoH, UNICEF and WHO • UN Humanitarian Country Team discusses polio response	US$ 300 000

JORDAN

Planned activities		2014								Budget
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Supplementary immunization activities	Type: NID, SNID		**SNID**		**SNID**		**NID**	**NID**		US$ 3.2 million of which OPV costs US$ 460 000
	Target population (in millions)		**0.2**		**0.2**		**1**	**1**		
	Vaccine type (if known: tOPV, bOPV)		**tOPV**		**tOPV**		**tOPV**	**tOPV**		
Assistance to AFP surveillance		**Strengthening AFP/measles/rubella surveillance** • Sensitization to health directors • Sensitization to clinicians (paediatricians, neurologists, general practitioners, orthopaedics) • Training of EPI officers at governorate level, clinicians, staff nurses, sanitarians • Training of focal persons in hospitals (infection control officer/staff nurse) • Training and placing of five surveillance officers • Training of social mobilizers • Development, printing and distribution of AFP guidelines • Development, printing and display of stool collection protocol in all paediatric departments • Development of one-page AFP surveillance bulletin monthly								US$ 750 000
Strengthened routine polio immunization/immunization services		• Conduct in-depth analysis of RI coverage at sub-governorate level and take corrective actions • Strengthen and sustain the regular RI coverage in Syrian refugees camp settings • Ensure easy accessibility of all out-of-camps refugees to nearest vaccination centre • Map hard-to-reach areas/populations to ensure coverage with mobile teams • Ensure coverage of out-of-camps non-Jordanian children with RI • Offer refresher training for health-care workers on routine EPI • Update, print and distribute immunization guidelines • Develop, print and distribute posters on vaccine management • Conduct national EPI coverage survey								US$ 250 000
Communications campaign		• Use civil society, NGOs and community-based organizations • Strengthen the capacity of health-care workers regarding communications • Mobilize the private sector • Ensure functional and continued partnership with media								US$ 500 000
Effective coordination of country support (national, interagency, international)		• Strengthen the existing coordination mechanism (especially with the private sector)								US$ 80 000

LEBANON

Planned activities		*2014*								*Budget*
		May	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	
Supplementary immunization activities	Type: NID, SNID	**High-risk area/population approach + surveillance + capacity to scale up**					**NID**	**NID**		US$ 3 million of which OPV costs US$ 270 000
	Target population (in millions)	**0.2*3 anticipated mop-ups**					**0.6**	**0.6**		
	Vaccine type (if known: tOPV, bOPV)	**OPV (tOPV until existing stock runs out, then switch to bOPV)**					**bOPV**			
Assistance to AFP surveillance		To address the already identified gaps and issues related to AFP surveillance, as well the rigorous applications of the set-up recommendations, namely: • full AFP surveillance review including bi-monthly workshop; • update protocols for specimen collection and transportation; • provision of additional cold boxes for specimen transport; • sentinel stool surveys (random sampling from hospitals); • monthly feedback bulletin (subnational level); • awareness-raising among clinicians; • extension of active surveillance to hospitals receiving Syrian refugees; • refresher trainings of all Ministry of Public Health (MoPH) and hospital focal points; • trainings for community surveillance informants (Shawish, Mokhtar, etc.); • development of professional tools for AFP surveillance; • development of information, education and communications materials for AFP awareness, detection and reporting; • development of APF e-learning and digitized content; • selection, training and deployment of APF surveillance officers; • rehabilitation of surveillance premises; • set-up of an AFP hotline; and • training of all Mobile Medical Units teams on AFP surveillance.								US$ 400 000

	2014	Budget
Strengthened routine polio immunization/immunization services	Strengthened routine polio immunization (IPV + bOPV) with enhancement of other immunization services through addressing all identified gaps and issues. • Improve planning by developing special plans to cover high-risk areas/populations (improving health-seeking behaviour) • Improve supervision by introducing third-party monitoring using real time reporting through mobile technology • Provide stock-management training to Qada physicians • Encourage reporting from the private sector • Facilitate distribution of OPV in the private sector • Expand and strengthen mobile strategies for high-risk populations including border doses • Work with UNHCR and MoPH to ensure provision and uptake of free immunization services by refugees in public health centres and hospitals • Provide technical staff to MoPH (centrally and peripherally) • Revise the EPI multiyear plan in the context of the polio outbreak • Strengthen the cold chain as it pertains to the polio outbreak	US$ 600 000
Communications campaign	There are five priority focus areas. • Mass awareness: create a high national-to-local profile around campaigns and for core campaign messages on urgency, OPV safety and multiple dose • Political support: bolster socio-political commitment to achieve quality campaigns from national to Qada level • Underserved strategy: boost risk awareness and systematic uptake among Syrians and vulnerable Lebanese in targeted population centres, particularly the urban poor • Private sector: unlock private sector resistance to close the middle class immunity gap • Health communications and monitoring: strengthen field capacity for on-message IPC and evidence-based planning	US$ 2.3 million
Effective coordination of country support (national, interagency, international)	Through the following: • government leads the response with partner support from WHO, UNICEF and UNHCR, with a campaign launch (HE MoH) and media briefings; • task force (MoPH, WHO, UNICEF, NCC-EPI) meetings every month during the outbreak period and every three months during non-outbreak periods, to take place for effective strategy implementation and roles distribution; • coordination with Qada physicians and MoPH partners to clarify the required set of rules and strategy that need to be implemented locally; • regular and timely data sharing among partners (weekly summary of activities); and • a desktop simulation exercise.	US$ 100 000

TURKEY

Planned activities		*2014*								*Budget*
		May	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	
Supplementary immunization activities	Type: NID, SNID	**SNID**					**SNID**	**SNID**		US$ 1.5 million*
	Target population (in millions)	**0.62**					**TBC**	**TBC**		
	Vaccine type (if known: tOPV, bOPV)	**tOPV**					**tOPV**	**tOPV**		
Assistance to AFP surveillance		• Field visits and refresher training in provinces/districts where AFP surveillance is suboptimal • Training support on AFP surveillance – revitalization of active surveillance • Update and distribution of AFP surveillance manuals and poster on AFP surveillance • Development and distribution of weekly surveillance update • Development and introduction of AFP surveillance module to support national case-based database, analysis and reporting to WHO, and sharing with partners • Facilitation in transportation of stool samples to the National Institute of Public Health and the Environment (RIVM), Bilthoven, The Netherlands • Provision of necessary support and assistance (collection kits, carriers, etc.) to the national lab in Ankara • Turkey laboratory accreditation by field visit • Independent field surveillance review								US$ 250 000
Strengthened routine polio immunization/immunization services		• In-depth analysis of routine immunization coverage at the subnational level and corrective actions • National coverage survey and in-depth analysis of the size of susceptible (high-risk) population (local and refugees) • Strengthening and sustaining of the regular RI coverage in Syrian refugees camp settings • Easy accessibility of urban refugees to nearest vaccination centre, and ensuring coverage of out-of-camps, non-Turkish children with RI • Refresher training for health-care workers on routine immunization • Updating, printing and distribution of immunization guidelines • Development, printing and distribution of posters on vaccine management								US$ 300 000

	2014	Budget
Communications	• Support the government to develop a communications plan, including a risk communications component • Engage with civil society and NGOs/INGOs to increase outreach, including to Syrian refugees • Strengthen the capacity of health-care workers regarding communications • Support the development and dissemination of communications materials • Use the well-developed network of UNICEF through the child-friendly spaces project; UNICEF will look for opportunities to use the existing child-friendly spaces network and schools to improve IPC in the camps	US$ 500 000
Effective coordination of country support (national, interagency, international)	• Overall strengthening of the coordination of an emergency polio outbreak response by the MoH, UNICEF and WHO with UN partners, NGOs, the donor community, and health authorities at the country and provincial levels • Regular technical meetings and discussions between WHO, UNICEF and the Public Health Institution of the Turkish MoH at the country/provincial level • Coordination of polio-related issues on the border	US$ 415 000

* Cost of OPV; the Government of Turkey bears operational costs for SIAs and this information is not currently available.

Target population for October and November 2014 rounds will be confirmed following the WHO polio risk assessment mission on 14-15 May 2014 and the European Regional Certification Commission for Poliomyelitis Eradication meeting on 3-5 June 2014.

EGYPT

Planned activities		*2014*								*Budget*
		May	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	
Supplementary immunization activities	Type: NID, SNID					**SNIDs**	**NIDs**		**SNIDs**	US$ 10.1 million* of which OPV costs US$ 4.5 million*[1]
	Target population (in millions)					**4.5**	**14.5**		**4.5**	
	Vaccine type (if known: tOPV, bOPV)					**tOPV**	**tOPV**		**tOPV**	
Assistance to AFP surveillance		• Maintain high level of surveillance indicators at all levels • Cooperate with UNICEF and UNHCR in locating Syrian refugees in Egypt and conduct an active AFP surveillance								US$ 300 000
Strengthened routine polio immunization/immunization services		• Maintain OPV3 coverage above 95% at all levels • Create a map of Syrian children and complete vaccination of their routine immunization • Make special plans for hard-to-reach areas and difficult groups								US$ 100 000
Communications campaign		• UNICEF and MoHP is cooperating in planning, implementing and monitoring a comprehensive media campaign and social mobilization activities. • Health awareness sessions will be conducted with caretakers, particularly mothers, during their visits to the PHUs of the MoHP to offer their children immunization during the SIAs. • Special outreach communication activities will be conducted with Syrian women, community and religious leaders, and NGOs in Egypt to promote the SIAs and routine immunization.								US$ 600 000*[2]
Effective coordination of country support (national, interagency, international)		• An active inter-country coordination committee (ICC) regularly meets to plan for the SIAs and avail the required support to MoHP. • Members of the ICC are MoHP, WHO, UNICEF, USAID, Rotary and the Japanese government. • MoHP is harmonizing its SIA activities with the global and regional plan of action and guidelines.								US$ 1 000

*[1] MoHP is in the process of registering bOPV and, when approved, will be used instead of tOPV.
*[2] Included in the NIDs budget and covered by UNICEF

WEST BANK AND GAZA STRIP

Planned activities		2014 May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Budget
Supplementary immunization activities	Type: NID, SNID	**Identify high-risk population and immunize them**					**NID***	**NID***		US$ 1 million
	Target population (in millions)						**.675*[2]**	**.675*[2]**		of which OPV cost‡
	Vaccine type					*[3]				US$ 300 000
Assistance to AFP surveillance		• Maintain good surveillance indicators – 2013 NPAFP rate 2.2, stool adequacy 95%; 2014 NPAFP 1.7, stool adequacy 100% • Maintain and enhance environmental surveillance/survey • Collect environmental sample regularly and continuously in 17 districts • Maintain and enhance an active surveillance system • Conduct training for health workers								US$ 50 000
Strengthened routine polio immunization/immunization services for 2014-2015		• Update cold chain materials and equipment • Establish six new cold rooms • Purchase 300 refrigerators • Conduct 13 training sessions for health workers on safety injection, cold chain and vaccine monitoring								US$ 600 000
Communications campaign		• Improve community KAP (routine immunization, campaign) • Strengthen health worker capacity in communications • Distribute advocacy materials (posters, banners, brochures, mugs and T-shirts) • Implement a spot message on local television and radio • Conduct advocacy meetings with partners (UNRWA and NGOs) and medical associations (paediatricians and neurologists)								US$ 50 000
Effective coordination of country support (national, interagency, international)		• Conduct quarterly, and as needed, EPI committee review meetings • Strengthen coordination between MoH, WHO, UNICEF, UNRWA and Paediatric Medical Association • Increase the number of meetings for the national immunization technical advisory groups, national polio certification committee and measles elimination committee • Document activities performed and share widely (all polio efforts including mop-ups, NIDs, targeted campaigns and mobile team efforts)								US$ 20 000

* NIDs depending on need and based on epidemiology within the region

*[2] NID target population ~ 675,000 children aged under 5 years; SNIDs target depends on the high-risk population targeted at that time

*[3] Discussions will take place with the EPI Committee, General Directorate and Minister of Health to determine if bOPV will be used in Phase II campaign activities.

‡ OPV financial figure above includes costs for additional vaccine to be used both in the SIAs and in the cross-border activities

ISLAMIC REPUBLIC OF IRAN

Planned activities		*2014* May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	*Budget*
Supplementary immunization activities	Type: NID, SNID	**SNIDs**	**SNIDS**							US$ 350 000 for Ops and US$ 670 000* for OPV for
	Target population (in millions)	**.25**	**.25**							
	Vaccine type (if known: tOPV, bOPV)	**bOPV**	**bOPV**							
Assistance to AFP surveillance		**Intensify private sector awareness** • Continuously sensitize physicians to polio importance, importation dangers, etc. • Create a partnership with the private sector (paediatric associations) – recognize physicians and the private health facilities on their AFP surveillance efforts								US$ 36 500*
Strengthened routine polio immunization/immunization services		**Maintain high coverage** Continue vaccinating at cross-border points and airports for children aged under 15 years, including Iranians visiting Iraq and Iraqis coming to the Islamic Republic of Iran. Map out unregistered populations among the communities using CHVs. • Assess the profile of unregistered populations (size, age group, vaccination status, literacy level and socio-economic/demographic status), updating the house-to-house checklists • Assess the capacity of the health system (staff, communications skills and knowledge of the issues/gaps), and revise the health facility catchment population • Establish community networks, and partner with community leaders to create trust in the unregistered populations • Plan for the activities • Monitor and evaluate the planned activities, including communication of the issues/gaps, and revise the health facility catchment population								US$ 510 000*[1]

	2014	Budget
Communications campaign	**Maintain high awareness** • Assess the capacity of the health system, communications skills and knowledge of the issues/gap • Tailor messages to the community profile • Monitor and evaluate communications	US$ 40 000
Effective coordination of country support (national, interagency, international)	**Strengthen coordination with Iraq government, especially with the Kurdistan region**	US$ 2 500

* a) National and Provincial Authority meeting = 1.5 million x 1 = 1.5 million (US$ 500), (31 paediatric association chairs and national team) = 31 x 1.5 million = 46.5 million tomans (US$ 15 000); b) eight provincial meetings (with provincial paediatricians) for 1 day = 8 x 1.5 million = 12 million tomans (US$ 4 000), c) 31 district-level awareness meetings = 31 x 1.5 million = 46.5 million tomans (US$ 15 000), d) support continuous sensitization = 6 million tomans (US$ 2 000)

*1 Strengthen communications for maintaining high coverage, procurement of vaccines for cross-border, airport and checkpoint vaccination = 1.5 billion tomans (US$ 500 000); conduct a desk review: coordination of the desk review, five provincial meetings @ 3 million tomans (US$ 1 000) per meeting; conduct training for health workers: 3 x 26 districts @ 1.5 million tomans (US$ 500); conduct meetings at the community level, 1 meeting x 26 districts x 1 million tomans (US$ 350) = 26 million tomans; supervisory visits, one per quarter x 26 x 4 teams x 10 days @ 1.5 million = 6 million tomans (US$ 2 000)

*2 Production of television spots: 3 x 300 000 per spot = 900 000 tomans (US$ 300); meeting with media: 2 meetings x 1.5 million = 3 million tomans (US$ 1 000); establish/maintain a database for communications indicators = 2 million tomans (US$ 700); community-level training on IPC = 3 meeting x 3 persons per district x 26 districts x 1.5 million tomans (US$ 500) = 7.4 million tomans (US$ 2 500)

ANNEX 2 TABLES AND FIGURES

Table 4. Children vaccinated in polio campaigns in the Middle East: November 2013–April 2014

Country/Area	Number of children vaccinated						Post-campaign monitoring (recall)					
	Nov-13	*Dec-13*	*Jan-14*	*Feb-14*	*Mar-14*	*Apr-14*	*Nov-13*	*Dec-13*	*Jan-14*	*Feb-14*	*Mar-14*	*14-Apr*
Syrian Arab Republic	2 432 751	2 246 762	2 532 476	2 745 554	2 919 682	2 913 640	ND	79%	88%	88%	93%	92%
Jordan	1 138 285	915 420			1 084 776		94%	76%*			88%	
Lebanon	580 770	589 054			492 706		90%	78%			ND	78%
Iraq	1 208 087	4 846 158	649 105	235 366	5 372 156	5 840 387	ND	ND	ND			92%
Egypt	14 226 411	14 387 578			68 770	14 779 741	ND	ND				
Turkey	1 148 918	1 316 326		266 141				ND				
West Bank and Gaza Strip		639 481	655 236					ND	ND			
Total	**20 735 222**	**24 940 779**	**3 836 817**	**3 247 061**	**9 938 090**	**23 533 768**						

ND Not done

* *Rapid assessment survey among Syrian refugees*

Data as of 30 April 2014

Table 5. AFP surveillance indicators by country/area, 2013 and 2014

	NPAFP rate*		% AFP case notified within seven days from onset of paralysis		% cases investigated within 48 hours from notification		% adequate stool specimens	
Country/area & Year	*2013*	*2014*	*2013*	*2014*	*2013*	*2014*	*2013*	*2014*
Syrian Arab Republic	1.7	3.2	78	75	94	95	68	92
Iraq	3.1	3.0	82	89	89	81	84	93
Jordan	1.4	1.1	77	83	100	100	91	100
Lebanon	2.2	1.6	30	43	94	100	46	71
Turkey	1.2	0.7	50	58	99	98	80	88
West Bank and Gaza Strip	2.2	2.1	87	88	84	100	95	100
Egypt	3.0	3.0	97	99	93	92	93	82

Target met

Target not met

Table 6. Polio immunization schedules and POL-3 reported, and WHO-UNICEF estimated coverage 2009-2012

Country/Area	Polio Immunization Schedules	POL-3-2009 WHO-UNICEF (Official)	POL-3-2010 WHO-UNICEF (Official)	POL-3-2011 WHO-UNICEF (Official)	POL-3-2012 WHO-UNICEF (Official)
Egypt	OPV: B, 1w, 2m, 4m, 6m, 12m, 18m IPV: 2m, 4m, 6m, 9m, 12m, 18m	97% (97%)	97% (97%)	96% (97%)	93% (93%)
Iraq	OPV: B, 2m, 4m, 6m, 18m, 4y DTwP-Hib-HepB-IPV: 2m, 4m, 6m	78% (86%)	74% (83%)	80% (89%)	70% (79%)
Jordan	OPV: 4m, 5m, 9m, 18m, 6y DTap-Hib-IPV: 3m, 4m, 5m	98% (98%)	98% (98%)	98% (98%)	98% (98%)
Lebanon	OPV: 4m, 6m IPV: 2m	76% (93%)	76% (94%)	77% (96%)	77% (96%)
The Syrian Arab Republic	OPV: 6m, 12m, 18m IPV: 2m, 4m	83% (99%)	83% (99%)	75% (91%)	52% (68%)
Turkey	OPV: 6m, 18m DTap-Hib-IPV: 2m, 4m, 6m, 18m DTap-IPV: 6y	96% (96%)	97% (96%)	97% (97%)	97% (97%)
The West Bank and Gaza Strip	OPV: 2m, 4m, 6m, 18m, 6y IPV: 1m, 2m	100%‡	100%‡	100%‡	98%‡

Source: WHO-UNICEF estimates 2012

* WHO-UNICEF estimate is provided with the official coverage in parenthesis.

‡ Coverage from the West Bank and Gaza Strip is self-reported.

Data as of 30 April 2014

Table 7. GPEI costing framework for response to polio outbreak in the Syrian Arab Republic and Iraq (in US$)

Country/Area	OPV	Ops costs/Social mobilization	Ops cost/ Strengthening RI	Ops cost/ surveillance	Op cost/SIAs implementation	Ops cost/ coordination	Total costs
	UNICEF	*UNICEF*	*UNICEF*	*WHO*	*WHO*	*WHO*	
Syria	2 350 000	200 000	385 000	100 000	1 150 000	110 000	4 295 000
Iraq	4 400 000	5 000 000	1 000 000	1 000 000	15 000 000	300 000	26 700 000
Lebanon	345 000	2 300 000	600 000	400 000	2 730 000	100 000	6 475 000
Jordan	460 000	500 000	250 000	750 000	2 740 000	80 000	4 780 000
Egypt	4 500 000	600 000	100 000	300 000	5 600 000	1 000	11 101 000
Iran	670 000	40 000	510 000	36 500	350 000	2 500	1 609 000
West Bank and Gaza Strip	300 000	50 000	600 000	50 000	700 000	20 000	1 720 000
Turkey	1 500 000	500 000	300 000	250 000		415 000	2 965 000
Total	**14 525 000**	**9 190 000**	**3 745 000**	**2 886 500**	**28 270 000**	**1 028 500**	**59 645 000**

Data as of 30 April 2014

Figure 4. Subnational NPAFP rates for Phase II countries, October 2013–March 2014

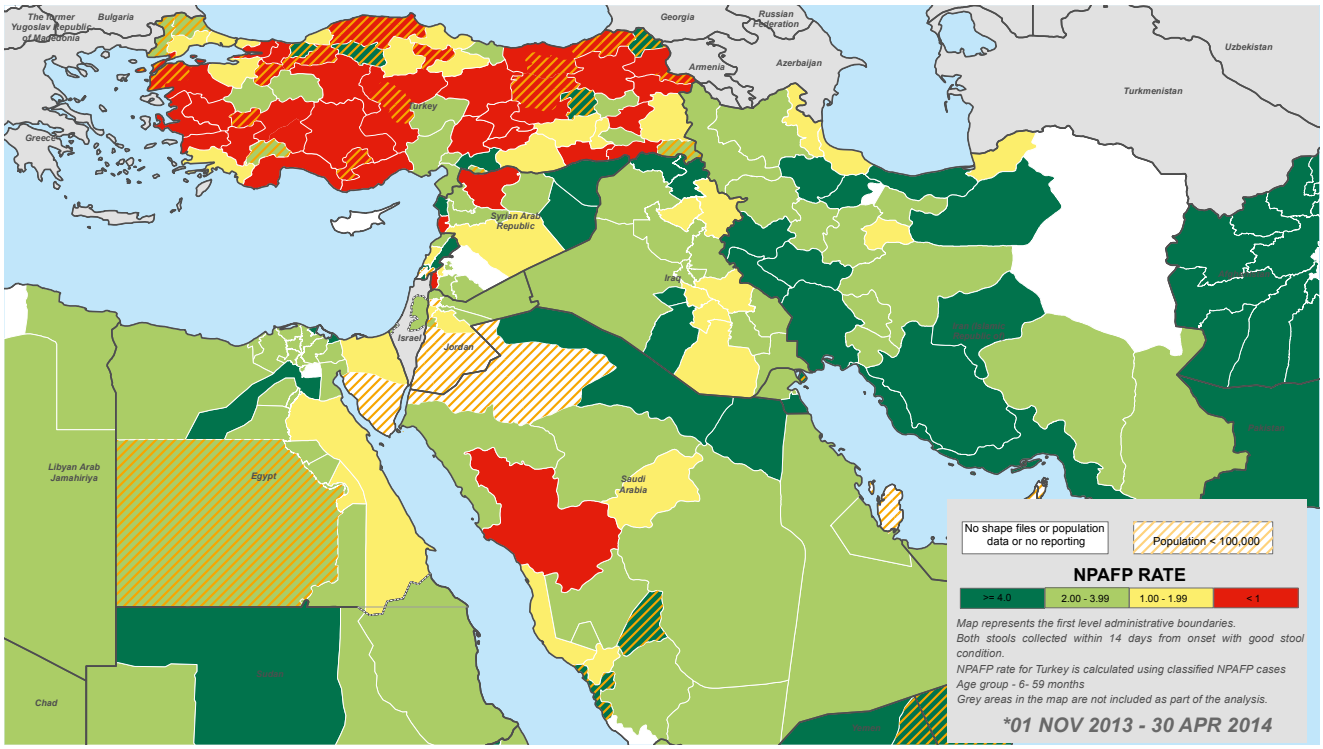


Figure 5. Syrian refugee movements as of 30 April 2014

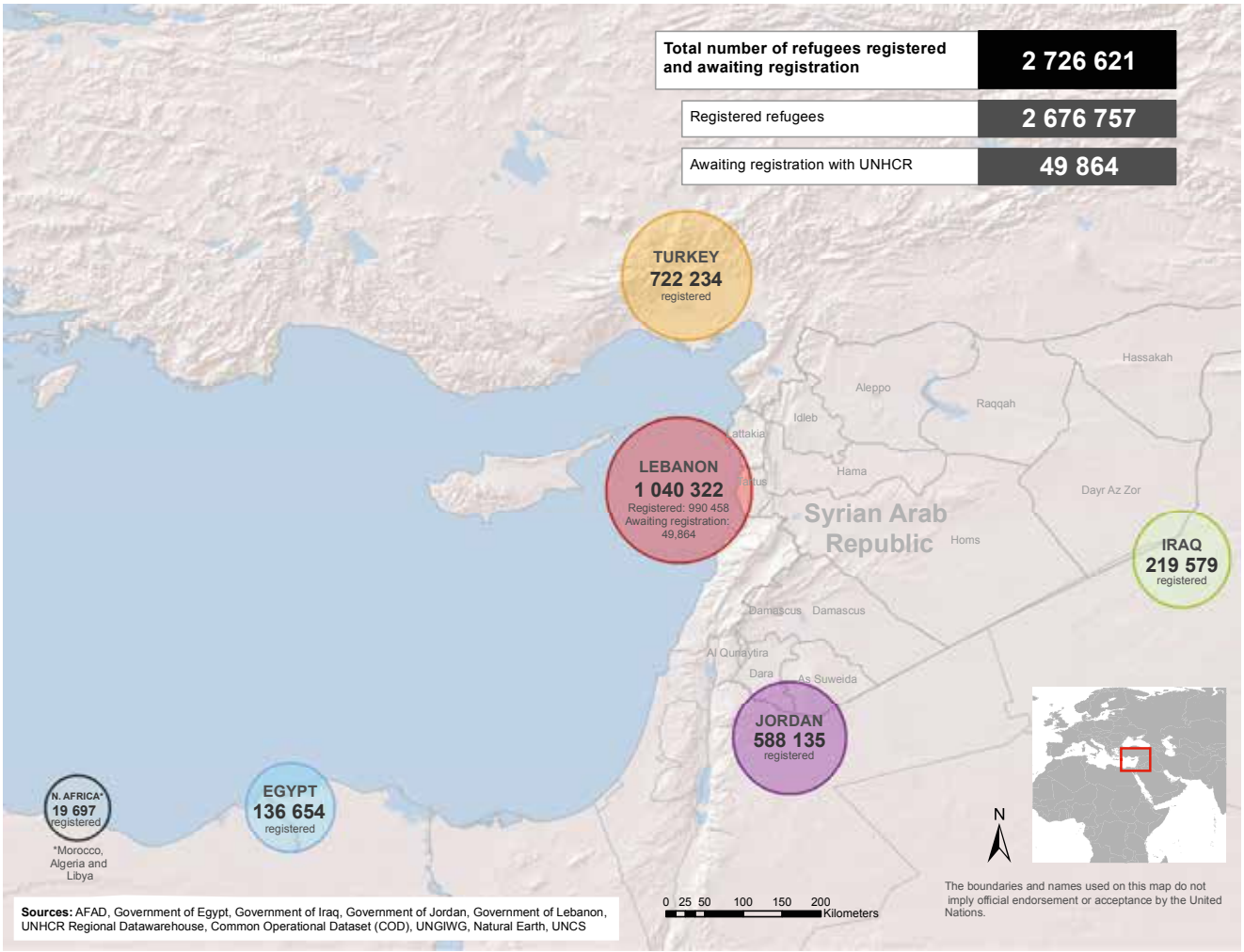
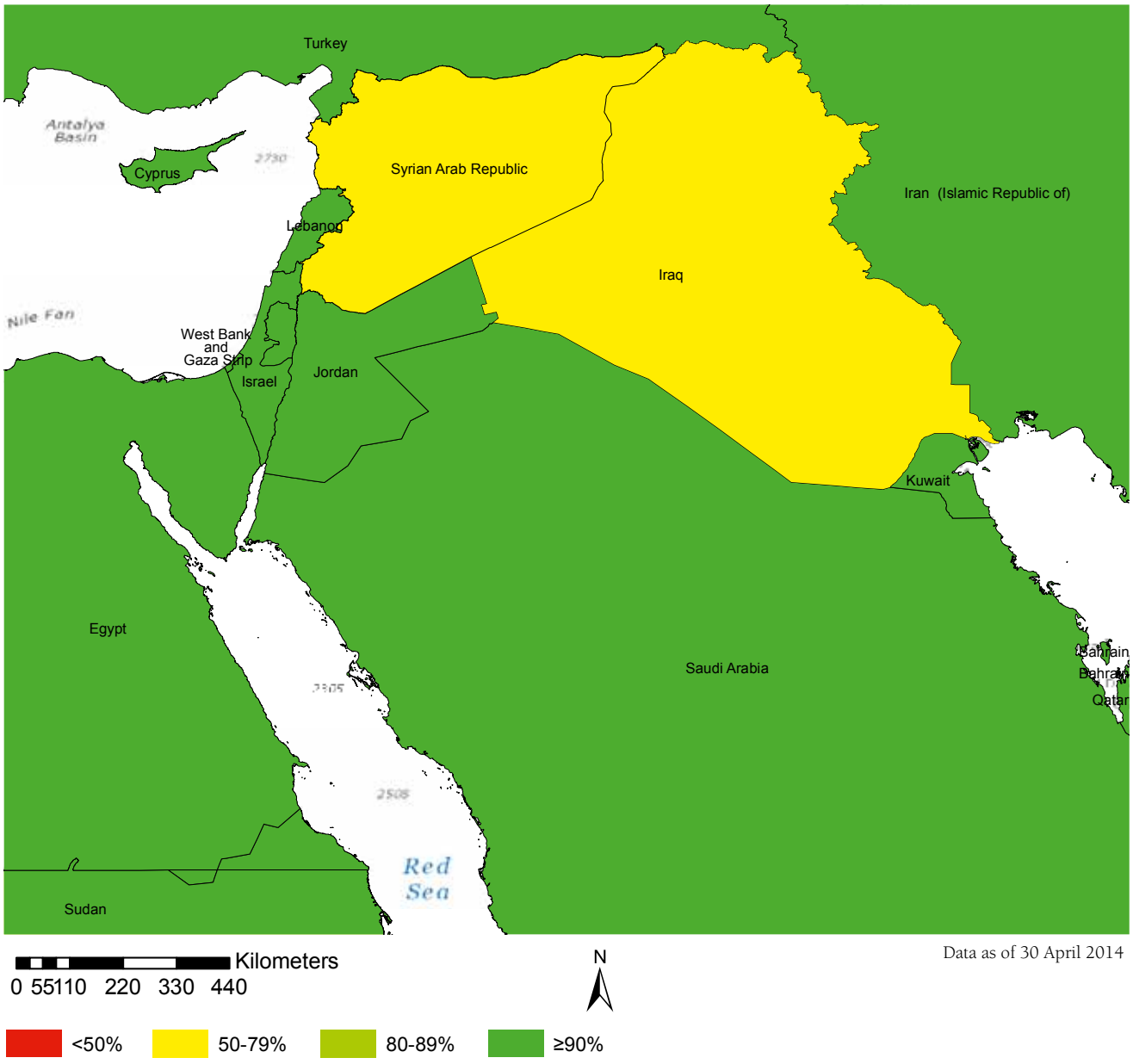


Figure 6. Estimated POL-3 routine immunization coverage, 2012



Data as of 30 April 2014

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