POLIO GLOBAL ERADICATION INITIATIVE

# GPEI Action Plan 2026

## Annex B. Subnational plans



Last updated: 1 October 2025

# *WPV1 endemic countries*

WPV1 endemic country of **AFGHANISTAN**
Subnational areas include the **south region, east region and other regions (southeast, north and west)**.

**Table B1. Afghanistan subnational action plans**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **South region of Afghanistan** | | | | | |
| **Routine immunization**<br>• Very low routine immunization (RI) coverage. | • Global Polio Eradication Initiative (GPEI) to lead collaboration with Essential Programme on Immunization (EPI), Gavi, the Vaccine Alliance, and relevant humanitarian actors (as necessary) to improve RI coverage in major urban centres of Helmand and Kandahar and the four (4) provinces of the south region. | • Improve RI coverage, including for polio vaccines. | • 90% coverage in children under 5 years for three doses of oral polio vaccine (OPV3), inactivated polio vaccine (IPV), measles. | • Q4 2025–Q2 2026 | • GPEI country team |
| **Political commitment / advocacy**<br>• Authorities have restricted campaign modality and women's participation in the workforce and imposed other limitations. | • Continued advocacy through influencers and engagement of religious ulama and leaders. | • Achieve a lifting of restrictions. | • Supportive messages for campaigns issued by senior authorities. | • Q3/Q4 2025 | • GPEI partners: World Health Organization (WHO), United Nations Children's Fund (UNICEF), Gates Foundation (GF) |
| **Supplementary immunization activity (SIA) quality**<br>• Inability of teams to enter households.<br>• Low site penetration in some areas.<br>• Improper marking of locations.<br>• Improper recording of missed children. | • Track and analyze campaign performance by cluster (subdistrict level) to identify more localized interventions and strengthen accountability.<br>• *Push strategy*: increase site penetration and fine-tune timing based on caregivers' presence in the houses in the afternoons/evenings.<br>• *Pull strategy*: optimize the programme's ability to mobilize caregivers to bring eligible children to vaccination sites – e.g. leaders identified by district governors as 'enablers', community engagement with elders, grandmother committees for newborn tracking.<br>• Prioritize human resources (HR) in the highest risk-areas (e.g. shift district communications officers from low-risk to high-risk districts, re-hire/re-train social mobilizers to strengthen frontline capacity).<br>• Conduct frontline worker (FLW) focus groups to gain insights into challenges.<br>• Improve FLW trainings with insights from focus groups; synchronize to campaigns.<br>• Continue support of humanitarian actors to identify and vaccinate missed children. | • Maximize site penetration.<br>• Remove distance as a barrier to vaccination.<br>• Expand timing of teams' presence.<br>• Ensure all children are taken to vaccination sites.<br>• Ensure that refused/missed children are identified by humanitarian actors and vaccinated. | • ≤ 5 households-per-site ratio everywhere.<br>• Improved campaign coverage in low-performing clusters.<br>• Pluses are in use.<br>• Increased recruitment of women to the polio workforce (with their mahrams).<br>• Reductions in refusals/missed children. | • Ongoing 2025–2026 | • WHO, UNICEF, GF<br>• GPEI humanitarian actors<br>• Regional Emergency Operations Centre (REOC) |

EPI = Essential Programme on Immunization; FLW = frontline worker; GF = Gates Foundation; GPEI = Global Polio Eradication Initiative; HR = human resources; IPV = inactivated polio vaccine; OPV3 = three doses of oral polio vaccine; REOC = Regional Emergency Operations Centre; RI = routine immunization; SIA = supplementary immunization activity; UNICEF = United Nations Children's Fund; WHO = World Health Organization.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **South region of Afghanistan (continued)** | | | | | |
| **Vaccine hesitancy / refusals**<br>• Hard refusals in some areas, often linked to authorities and other groups who avoid vaccination (occasionally threatening teams). | • Work with community elders, leaders, high-level de facto authorities (DFA) to remove misconceptions around vaccine and vaccination.<br>• Deploy digital community engagement strategy, endorsed by National Emergency Operations Centre (NEOC), to promote accurate and culturally resonant messaging about the polio programme and immunization. | • Reduce pockets of refusals and community resistance. | • Reduced % of refusals observed in post-campaign monitoring (PCM). | • Ongoing 2025–2026 | • UNICEF/WHO<br>• Emergency Operations Centre (EOC) Communications Working Group |
| **Gender**<br>• Limited participation of women in the workforce.<br>• Few women participating in evaluation meetings with the authorities.<br>• Harassment of women by security forces. | • Maintain dialogue with authorities and other influencers about the importance of women to polio-related activities.<br>• Ensure training in preventing and responding to sexual exploitation, abuse and harassment (PRSEAH) and other soft skills. | • Maintain the role of women in the fight against polio. | • More women empowered to continue work.<br>• More men and other influencers supportive of their female colleagues. | • Ongoing 2025–2026 | • GPEI partners |
| **Surveillance**<br>• Need for improved surveillance quality. | • Conduct trainings in acute flaccid paralysis (AFP) surveillance focal points.<br>• Increase monitoring and supervision. | • Achieve a sufficiently sensitive and reliable surveillance system. | • Timely AFP investigation.<br>• Adequate samples.<br>• No long-chain or orphan viruses are detected. | • Ongoing 2025–2026 | • WHO |
| **Integrated service delivery (ISD) / EPI**<br>• Outdated microplans lead to significantly underestimated targets. | • Conduct census and microcensus, starting in Helmand and Kandahar. | • Ensure proper target for all health-related activities in Helmand and Kandahar. | • Updated population targets in Helmand and Kandahar. | • Q3 2025 for census | • Provincial Health Directors (PHDs), GF, UN Population Fund (UNFPA), NSI, WHO, UNICEF<br>• Humanitarian actors<br>• Gavi and National Essential Programme on Immunization (NEPI) |
| **Training of vaccinators**<br>• Very low RI coverage. | • Conduct refresher training of vaccine providers. | • Ensure well-trained vaccinators. | • Refresher training completed for vaccine providers. | • Ongoing 2025–2026 | • [WHO/EOC] |

AFP = acute flaccid paralysis; DFA = de facto authorities; EOC = Emergency Operations Centre; GF = Gates Foundation; GPEI = Global Polio Eradication Initiative; NEOC = National Emergency Operations Centre; NEPI = National Essential Programme on Immunization; PCM = post-campaign monitoring; PHD = Provincial Health Director; PRSEAH = preventing and responding to sexual exploitation, abuse and harassment; RI = routine immunization; UNICEF = United Nations Children's Fund; UNFPA = United Nations Population Fund; WHO = World Health Organization.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **East region of Afghanistan** | | | | | |
| **Political commitment / advocacy**<br>• Need to sustain political commitment and advocacy. | • Maintain rhythm of taskforce meetings and networking with PHDs. | • Maintain ongoing dialogue with local authorities about programme strategies. | • Supportive messages issued by senior authorities for campaigns. | • Q3/Q4 2025 | • PHDs, REOC, WHO, UNICEF and GF |
| **SIA quality**<br>• Need for demarcation of clusters, improved intra-campaign monitoring, independent PCM, improved FLW trainings, and engagement of verified religious influencers. | • Complete cluster mapping demarcation.<br>• Improve intra-campaign analysis.<br>• Ensure independence in PCM.<br>• Improve FLW trainings through the engagement of female volunteers and social mobilizers in refresher trainings; synchronize to campaigns.<br>• Conduct FLW focus groups to gain insights into challenges, improvements for trainings. | • Ensure programmatic course correction in clearly identified low-performing clusters, both during and after campaigns.<br>• Reduce risk of interference in PCM. | • Clear identification of low-performing clusters and demonstrated improvements in campaign coverage.<br>• Independently conducted PCM.<br>• Better trained FLWs. | • Q3/Q4 2025 | • WHO, UNICEF, GF, East REOC, PHDs |
| **Vaccine hesitancy / refusals**<br>• Soft refusals in some community pockets, hard refusals in de facto authorities associated communities and returnees (mainly in Mehterlam, Kunar). | • Track refusal families, reasons for refusals and programme activities to address resistance, including revisits and support from humanitarian actors who have developed strategies, particularly for early detection and prevention (EDP), in Jalalabad, Khost, Kunar, Mehterlam and Laghman.<br>• Identify, map and engage religious influencers in every district to build community acceptance and help address refusals. | • Reduce pockets of refusals and community resistance. | • Reduced % of refusals observed in PCM. | • Q3/Q4 2025 | • WHO, UNICEF, humanitarian actors, GF, REOC, NEOC |
| **Surveillance**<br>• Need for improved surveillance quality. | • Conduct internal surveillance reviews.<br>• Enhance active case search in all health facilities during the active surveillance visits. | • Ensure sufficiently sensitive, reliable surveillance system.<br>• Enhance health-facility and community capacity for surveillance. | • Timely AFP investigation.<br>• Adequate samples.<br>• No long-chain or orphan viruses are detected. | • Q4 2025, ongoing 2026 | • WHO |
| **Gender**<br>Need to maintain:<br>• the participation of women in the workforce, in operational and leadership positions.<br>• progress with women and girls' services offered through the Women and Girls Safe Spaces (WGSS) initiative. | • Maintain financial and technical support and vocational training.<br>• Maintain financial support to the WGSS. | • Ensure more women continue to work in polio eradication.<br>• Ensure more women and girls have unhindered access to WGSS. | • The number of women working in the polio teams increases.<br>• The number of women and girls with access to the WGSS increases (350 000 as of 2023). | • Ongoing 2025–2026 | • GPEI partners, UNICEF |
| **ISD / EPI**<br>• Low RI in key priority districts. | • Re-install new female mobilizer vaccinators (FMVs) in priority districts as part of frontline workforce reallocation.<br>• Identify locations with lowest RI coverage, provide refresher training of vaccinators in key facilities.<br>• Implement acceleration campaign with humanitarian actors to improve RI coverage in key districts. | • Ensure sufficient, well-trained frontline workforce in key districts, including FMVs in fixed facilities.<br>• Enhance RI coverage in key districts in east Afghanistan. | • Improved RI performance in priority districts. | • Q3/Q4 2025 | • UNICEF, NEPI, Gavi<br>• Humanitarian actors, GF, REOC, WHO, UNICEF |

EDP = early detection and prevention; EPI = Essential Programme on Immunization; FLW = frontline worker; FMV = female mobilizer vaccinator; GF = Gates Foundation; ISD = integrated service delivery; NEOC = National Emergency Operations Centre; PCM = post-campaign monitoring; PHD = Provincial Health Director; REOC = Regional Emergency Operations Centre; RI = routine immunization; UNICEF = United Nations Children's Fund; WGSS = Women and Girls' Safe Spaces; WHO = World Health Organization.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Other regions of Afghanistan (southeast, north, west)** | | | | | |
| **Political commitment / advocacy**<br>• Low political commitment in many geographies, particularly in Kabul and the southeast. | • Continue advocacy through influencers; engage religious ulama and leaders. | • Remove restrictions imposed on the programme by the authorities. | • Supportive messages for the campaign issued by senior authorities. | • Q3/Q4 2025 | • GPEI partners |
| **SIA quality**<br>• Unacceptable quality in many parts of the southeast, north and west, according to lot-quality assurance sampling (LQAS). | • Ensure stronger supervision to increase site penetration.<br>• Conduct community mobilization efforts to ensure all children are taken to vaccination sites. | • Ensure every child receives the oral polio vaccine (OPV) during campaigns.<br>• Ensure campaign quality (measured by LQAS) is high across all areas. | • ≤ 5 households-per-site ratio everywhere.<br>• Community elders and leaders engaged in every campaign. | • Q3/Q4 2025 | • WHO/UNICEF |
| **Vaccine hesitancy / refusals**<br>• Hard refusals in the southeast and other areas. | • Work with community elders, leaders, high-level DFA to remove misconceptions around vaccine and vaccination. | • Reduce refusals and community resistance. | • Lower refusals observed in PCM. | • Q3/Q4 2025 | • UNICEF/WHO |
| **Gender**<br>• Resistance to women working in polio teams. | • Work with elders, influencers and other leaders to facilitate the participation of women in the workforce as it has been successful in east Afghanistan. | • Ensure women are hired to work in polio teams. | • More male leaders, elders and influencers understand the importance of working with women to eradicate polio. | • Ongoing 2025–2026 | • UNICEF |
| **Surveillance**<br>• Detection of long-chain virus. | • Train AFP surveillance focal points, require refresher trainings.<br>• Increase monitoring and supervision of surveillance work in the southeast. | • Achieve and maintain a sufficiently sensitive and reliable surveillance system. | • Timely AFP investigation.<br>• Adequate samples.<br>• No long-chain or orphan viruses are detected. | • Ongoing 2025–2026 | • WHO |

AFP = acute flaccid paralysis; DFA = de facto authorities; GPEI = Global Polio Eradication Initiative; LQAS = lot quality assurance sampling; OPV = oral polio vaccine; PCM = post-campaign monitoring; SIA = supplementary immunization activity; UNICEF = United Nations Children's Fund; WHO = World Health Organization.

WPV1 endemic country of **PAKISTAN**
Subnational areas include **South Khyber Pakhtunkhwa, Karachi, Quetta block, Lahore, Peshawar, other subgeographies**.

**Table B2. Pakistan subnational action plans***

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **South Khyber Pakhtunkhwa (SKP)** | | | | | |
| **EPI / ISD**<br>• Suboptimal EPI coverage. Over the last three years, over 30% of non-polio AFP (NPAFP) cases in SKP (4-23 months) are zero-dose cases compared to 10% for rest of Khyber Pakhtunkhwa (KP).<br>• No regular cadence to measure impact of ISD interventions throughout SKP. | • GPEI to lead collaboration with EPI & Gavi to improve RI coverage in major urban centres of SKP.<br>• Immunization Roadmap for Khyber Pakhtunkhwa has been approved by the Chief Secretary's office. Conduct regular review to ensure compliance.<br>• Map ISD interventions (government and partners staff).<br>• Regularly report on impact of ISD interventions.<br>• Ensure interventions cover all Union Councils (UCs) characterized as access-compromised (black UCs) and UCs that use community vaccination initiative (ComVI). | • Increase rate of fully immunized children (FIC).<br>• Reduce zero-dose children (ZDC). | • FIC >80%.<br>• Consistent reduction in ZDC. | • Q3 2025–Q2 2026 | • GPEI country team<br>• ISD task team/Provincial Emergency Operations Centre (PEOC) KP |
| **Access / security challenges**<br>• Access challenges in SKP for FLWs and monitoring, with 97 000–171 000 persistently missed children (PMC) in last six SIAs.<br>• 26 black UCs (access-compromised) with frequently missed campaigns. 80 ComVI UCs with influencer-led campaigns. | • Improve ComVI.<br>• Ensure monitoring is a pre-requisite for all future campaigns that use ComVI methodology.<br>• Identify better influencers by using all available sources: deputy commissioner (DC), district health officer (DHO), law enforcement agencies (LEAs).<br>• Work with Chief Secretary and LEAs to have clear milestones to regain access in black UCs by year-end.<br>• Change WHO contracting modality to allow freedom of movement for WHO staff. | • Monitor campaigns in all green and ComVI UCs. Regain access in all black UCs. | • Post- and intra-campaign monitoring plan.<br>• 100% access in black UCs by December 2025. | • December 2025 | • PEOC KP |
| **SIA quality**<br>• Suboptimal SIA performance in green UCs (LQAS remained <80% in April/May 2025).<br>• Still missed children (SMC) increased (currently 10% of target). | • Update terms of references (ToRs) and reforms in tehsil and UC-level staff contracts to improve mobility to support UCs in joint microplanning, training, PCM.<br>• Label houses with permanent unique number for better microplanning, tracking of household-level results. | • Increase campaign quality as measured by PCM. | • PCM results >90%. | • December 2025 | • PEOC KP |
| **Boycotts**<br>• 18-44 boycotts reported in each campaign in last six SIAs. | • De-link polio from policy-level decision-making without entertaining demands.<br>• Effectively identify boycotts before campaigns and engage community elders for timely resolution. | • Reduce boycotts. | • Reduction in boycotts. | • Every campaign 2025–2026 | • PEOC KP |

AFP = acute flaccid paralysis; black UCs = access-compromised Union Councils; ComVI = community vaccination initiative; DC = deputy commissioner; DHO = district health officer; EPI = Essential Programme on Immunization; FIC = fully immunized children; FLW = frontline worker; green UCs = high-risk Union Councils with full access; ISD = integrated service delivery; KP = Khyber Pakhtunkhwa; LEA = law enforcement agencies; LQAS = lot quality assurance sampling; NPAFP = non-polio acute flaccid paralysis; PCM = post-campaign monitoring; PEOC = Provincial Emergence Operations Centre; PMC = persistently missed children; SIA = supplementary immunization activity; SKP = South Khyber Pakhtunkhwa; ToRs = terms of reference; UC = Union Council; WHO = World Health Organization; ZDC = zero-dose children.

*** NOTE: Additional district-level surveillance plans are available in Appendix B1.**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **SKP (continued)** | | | | | |
| **Gender**<br>• Female FLWs are poorly paid and trained.<br>• FLWs face challenges reaching PRSEAH structures before, during and after campaigns.<br>• Few fathers are involved in child immunization activities. | • Train female FLW in soft skills, PRSEAH.<br>• Engage with fathers and male religious leaders. | • Reduced vaccine hesitancy. | • More female FLWs are trained and supported before, during and after campaigns.<br>• More men are engaged in child immunization activities. | • Every campaign 2025–2026 | • UNICEF |
| **Surveillance**<br>• Notification within seven (7) days < 80%. Delayed AFP notification: Bannu, Tank.<br>• Stool adequacy < 80%. Deficiencies in: quantity collected, collection within 14 days, two samples at least 24 hours apart. Suboptimal stool adequacy: Tank, Wazir-S Upper.<br>• Cold chain gaps in sample transport to the laboratory. | • Train healthcare workers.<br>• Improve cold chain transportation logistics.<br>• Enhance community engagement to ensure timely and adequate stool sample collection. | • Effective virus detection.<br>• Achieve minimum of 80% cases are notified within seven (7) days and stool adequacy above 80%. | • Enhanced training material and standard operating procedures (SOPs) for adequate stool collection and cold chain transportation.<br>• Timely detection of AFP cases achieves above 80% with at least 80% stool adequacy. | • October 2025 | • PEOC KP |
| | • Improve quality and compliance of active visits.<br>• Conduct refresher trainings of health-care providers (HCPs), both formal and informal.<br>• Conduct refresher trainings on AFP surveillance of staff: area coordinator (AC), district surveillance officer (DSO), district surveillance coordinator (DSC).<br>• Improve reverse cold chain transportation logistics. Address reverse cold chain gaps in stool collection and sample transport to the laboratory. | | | • December 2025 | • AC//DSO/DSC |
| • Suboptimal surveillance in security-compromised UCs. | • Re-vamp, reprioritize community informants (CIs). | • Timely AFP case reporting. | • At least one AFP case reported in red, black UCs. | • December 2025 | • AC//DSO/DSC |
| **Karachi** | | | | | |
| **Political commitment / advocacy**<br>• Maintaining high-level support despite persistent transmission. | • Hold regular provincial taskforce (PTF) meetings convened by the Chief Minister (all of Sindh). | • Maintain political and administrative support for polio eradication. | • PTF meetings and action points. | • Before each SIA 2025–2026 | • Sindh coordinator |
| **Continuity of programming**<br>• Maintaining SIA quality amidst HR downsizing and transition related to community-based vaccination (CBV). | • Hold pre- and intra-campaign meetings with DCs, convened by the Karachi Commissioner.<br>• Complete campaign district scorecard for DCs and DHOs, reviewed with the Chief Secretary and Health Minister of Sindh. | • Ensure support from other ministries and departments, including education and police (for FLW security). | • Campaign scorecards completed. | • After each SIA 2025–2026 | • WHO Data Control Room |
| | • Engage Karachi DCs in CBV recruitment and performance management. | • Increase engagement from local administration and civil servants through UC-support teams. | • Notarized district recruitment committees where CBV remains in use. | • September 2025 | • District Emergency Operations Centres (DEOCs)<br>• WHO |

AC = area coordinator; AFP = acute flaccid paralysis; black UCs = access-compromised Union Councils; CBV = community-based vaccination; CI = community informant; DC = deputy commissioner; DEOC = District Emergency Operations Centre; DHO = district health officer; DSC = district surveillance coordinator; DSO = district surveillance officer; FLW = frontline worker; HCP = health-care provider; HR = human resources; KP = Khyber Pakhtunkhwa; PEOC = Provincial Emergency Operations Centre; PRSEAH = preventing and responding to sexual exploitation, abuse and harassment; PTF = provincial taskforce; red UCs = Union Councils with partial access; SIA = supplementary immunization activity; SKP = South Khyber Pakhtunkhwa; SOPs = standard operating procedures; UC = Union Council; UNICEF = United Nations Children's Fund; WHO = World Health Organization.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Karachi (continued)** | | | | | |
| **SIA quality**<br>• Weak FLW selection, capacity and motivation, including CBV. | • Strengthen recruitment guidelines.<br>• Increase district involvement, oversight of recruitment.<br>• Ensure provincial support on recruitment/training for areas transitioning from CBV. | • Improve FLW quality and performance, especially interpersonal communication (IPC) skills and OPV administration. | • FLW recruitment guidelines. | • August 2025 | • WHO provincial office |
| | • Revise training materials, strengthen supervisor training, increase post-training participant knowledge assessments. | | • Enhanced training materials. | • August 2025 | |
| | | | • Training knowledge assessments. | • Before each SIA 2025–2026 | |
| | • Upgrade team support centres, training venues. | | • Material upgrades to team support centres. | • November 2025 | • NEOC (and third-party support) |
| • Transitioning full-time community health workers (CHWs) to campaign-based special mobile teams (SMTs) without operational disruptions. | • Implement enhanced CBV performance management: key performance indicators (KPIs), workplans, district-level oversight, training, etc. | • Ensure good SIA performance in areas transitioning to SMT model.<br>• Ensure good SIA performance, increased polio/EPI activities in-between campaigns in CBV areas. | • District hiring and performance management committees, especially for CBVs. | • August 2025<br>• September 2025 | • WHO district offices<br>• WHO national and provincial offices |
| • Operational failures, missed children in some areas (average 5%, maximum 19%). | • Develop UC-level action plans and strengthen district and provincial oversight, where required.<br>• Adjust pre/intra-campaign monitoring to avoid missed children and strengthen supervision. | • Reduce missed children, especially in UCs with a high burden of disease. | • UC-level action plans.<br>• New monitoring SOPs. | • September 2025<br>• August 2025 | • WHO provincial office<br>• WHO and UNICEF provincial offices |
| • Effectively reaching highly diverse migrant and mobile population (MMP). | • Develop new microplans.<br>• Complete assessment of monitors, FLWs and community mobilizers on language skills and household access. | • Increase MMP coverage. | • New microplans.<br>• Assessment of worker appropriateness in MMP areas. | • Q3–Q4 2025 | • WHO provincial office |
| • Gaps in cold chain management at FLW level. | • Develop new supervisor checklists and SOP to monitor cold chain compliance.<br>• Implement post-campaign review starting from UC level. | • Increase confidence in cold chain management. | • Compliance SOP for cold chain.<br>• Post-campaign review process. | • September 2025<br>• After each SIA | • PEOC |
| **Vaccine hesitancy / refusals**<br>• High refusals in certain communities (higher-income areas, super high-risk Union Councils [SHRUCs], MMP). | • Develop KPIs for community mobilizer (CM) performance.<br>• Conduct listening to sessions with FLWs, local government and influencers. | • Strengthen CM with refusal households. | • KPIs and CM dashboard. | • September 2025 | • UNICEF provincial office |
| | • Conduct household surveys to identify opportunities to build trust; identify and pilot new strategies. | • Effectively address trust deficit. | • Report on surveys.<br>• Pilot with evaluation. | • September 2025<br>• October 2025 | |
| | • Implement specialized pre- and post-campaign engagement with refusal households. | • Increase refusal conversion, prevent PMC. | • Report and evaluation of pre- and post-engagement with refusal households. | • September 2025 | |

CBV = community-based vaccination; CHW = community health worker; CM = community mobilizer; FLW = frontline worker; IPC = interpersonal communication; KPI = key performance indicator; MMP = migrant and mobile population; NEOC = National Emergency Operations Centre; OPV = oral polio vaccine; PEOC = Provincial Emergency Operations Centre; PMC = persistently missed children; SHRUC = super high-risk Union Council; SIA = supplementary immunization activity; SMT = special mobile teams; SOPs = standard operating procedures; UC = Union Council; UNICEF = United Nations Children's Fund; WHO = World Health Organization.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Karachi (continued)** | | | | | |
| **Gender**<br>• Female FLWs are poorly paid and trained.<br>• FLWs face challenges reaching PRSEAH structures before, during and after campaigns.<br>• Few fathers are involved in child immunization activities. | • Train female FLW in soft skills, PRSEAH.<br>• Engage fathers and male religious leaders. | • Reduce vaccine hesitancy. | • More female FLWs are trained and supported before, during and after campaign.<br>• More men are engaged in child immunization activities. | • Every campaign 2025–2026 | • UNICEF |
| **Surveillance**<br>• Ongoing transmission in Karachi and other high-risk districts with AFP surveillance 'blind spots'; insufficient surveillance in MMP areas. | • Ensure weekly follow-up with 44 AFP 'blind spot' UCs to improve surveillance practices.<br>• Develop UC-level MMP surveillance action plans.<br>• Incorporate surveillance strengthening, oversight into district action plans.<br>• Increase sensitivity, tracking of community-based surveillance (CBS). | • Achieve and maintain sensitive, comprehensive surveillance systems. | • Monthly surveillance updates.<br>• District improvement plans with clear accountability and oversight mechanism.<br>• CBS performance reports. | • Monthly 2025–2026 | • Sindh surveillance task team |
| • Ongoing transmission in Mirpurkhas, Kambar and Karachi block with AFP surveillance blind spots; insufficient surveillance in MMP areas. | • Ensure weekly follow-up with 28 AFP 'blind spot' UCs to improve surveillance practices. (15 blind spot UCs have reported an AFP case to date).<br>• Develop UC-level MMP surveillance action plans by continuously tracking and mapping MMP.<br>• Incorporate surveillance strengthening into district plans. Conduct orientation of MMP focal persons as key CIs. Conduct on-job orientation of HCPs (formal and informal), paramedics, general practitioners (GPs), other CIs for timely case reporting. Track KPIs / case reporting from MMP areas, AFP blind spots.<br>• Increase sensitivity, tracking of CBS. | • Achieve and maintain sensitive, comprehensive surveillance systems. | • Monthly surveillance updates.<br>• District improvement plans with clear accountability and oversight mechanism.<br>• CBS performance reports. | | |
| • Low AFP case reporting of 13- to 15-year-olds from Civil and Jinnah Hospital of Karachi. | • Conduct targeted re-orientation sessions with doctors and paramedics of Medical, Neurology, Intensive Care Unit (ICU) and Orthopedic departments. | • Achieve and maintain sensitive, comprehensive surveillance systems. | • Robust feedback mechanism from health facility focal persons. | | |
| **ISD / EPI**<br>• Ineffective coordination to cover zero-dose and due/defaulter children. | • Enhance performance management of CBVs in between campaigns in SHRUCs.<br>• Develop clear SOPs on PCM of zero-dose coverage for rest of Sindh; include polio programme support in community mobilization. | • Increase % of FIC, especially in high-risk areas and those at increased risk. | • CBV performance reports. | • Monthly from September 2025–2026 | • WHO provincial team |
| • Low immunity in 211 UCs with suboptimal campaign and EPI coverage. | • Implement targeted OPV/IPV campaigns in hard-to-reach areas at high risk between campaigns. | • Reduce ZDC rates. | • Regular programme and monitoring reports on FIC, ZDC, IPV administration at permanent transit point (PTP), etc. | • Monthly 2025–2026 | • Polio Eradication Initiative (PEI)-EPI task team |

AFP = acute flaccid paralysis; CBS = community-based surveillance; CBV = community-based vaccination; CI = community informant; EPI = Essential Programme on Immunization; FIC = fully immunized children; FLW = frontline worker; HCP = health-care provider; GP = general practitioner; ICU = intensive care unit; IPV = inactivated polio vaccine; ISD = integrated service delivery; MMP = migrant and mobile population; OPV = oral polio vaccine; PCM = post-campaign monitoring; PEI = Polio Eradication Initiative; PRSEAH = preventing and responding to sexual exploitation, abuse and harassment; PTP = permanent transit point; SHRUC = super high-risk Union Council; SOPs = standard operating procedures; UC = Union Council; UNICEF = United Nations Children's Fund; WHO = World Health Organization; ZDC = zero-dose children.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Karachi (continued)** | | | | | |
| **ISD / EPI (continued)**<br>• Gaps in cold chain and RI service delivery. | • Implement cold chain assessments and develop follow-up action plans, led by EPI programme director in coordination with PEI.<br>• Increase oversight of IPV booster administration to children receiving nutritional support through the government of Sindh. | • Improve cold chain compliance and vaccine management. | • Improvements in cold chain infrastructure. | • September 2025 | • WHO provincial team |
| • Fractional IPV (fIPV) for extended age groups (up to age 15) in Karachi. | • Implement fIPV campaign with effective communication and community engagement. | • Reduce transmission among older age groups. | • fIPV campaign. | • November 2025 | • WHO / UNICEF / NEOC |
| **Other subgeographies**<br>*Interior Sindh*<br>• Poor quality microplans in Kambar, Kashmore, Khairpur, Mirpurkhas.<br>• Inaccessibility for teams, monitors.<br>• Operational failures in MMP areas.<br>• Gaps in FLW recruitment and training quality. | • Enhance pre-campaign activities and monitoring: microplan, FLW recruitment processes, training.<br>• Develop, implement improved strategies in MMP areas.<br>• Ensure strengthened monitoring in areas with poor SIA indicators or other concerns.<br>• Improve district-level post-campaign review and action tracking with provincial oversight. | • Enhance SIA performance.<br>• Enhance coverage of MMPs. | • Pre-campaign monitoring reports.<br>• Post-campaign review. | • Every SIA 2025–2026 | • PEOC |
| **Quetta block** | | | | | |
| **Political commitment / advocacy** | • Hold taskforce meetings; include Chief Secretary, Health Minister, secretary and coordinator. | • Ensure programme importance at all levels. | • Quarterly taskforce meeting held with action points and follow-up documented. | • Before SIAs 2025–2026 | • Coordinator |
| | • Arrange timely inaugurations and ensure visibility. | | | • In between campaigns 2025–2026 | • Core team |
| **SIA quality**<br>• Transition from full-time CHWs to SMT model.<br>• Fewer female FLWs in Killa Abdullah district.<br>• High turnover of FLWs, area in-charges (AICs) & Union Council medical officers (UCMOs) after implementation of Plan B (i.e. 100% volunteer-led approach). | • Conduct motivation sessions with current CHWs to encourage their retention in the programme. | • Retain experienced CHWs as SMTs. | • FLW recruitment guidelines. Revision of training module. | • September 2025 | • District health management team (DHMT), provincial and district WHO, UNICEF offices |
| | • Establish committees for merit-based local selection and recruitment. | • Ensure merit-based selection. | • District hiring and performance management committees (especially for CBVs). | | |
| | • Engage local influencers to identify, enroll female teams.<br>• Encourage couple-team initiatives. | • Increase in-house capacity to identify, vaccinate hidden children. | | | |
| | • Build in staff appreciation for good performance. | • Retain top-performing FLWs. | • Completion of team support centre, Phase 2. | | |
| | • Increase FLW remuneration.<br>• Reduce the pressure of 100%-indicator achievement. | • Ensure a good work. environment for FLWs. | • >90% female FLWs in urban settlements in the whole of Balochistan. | • October 2025 campaign | |
| **Vaccine hesitancy / refusals**<br>• High vaccine hesitancy in a few pockets. | • Develop, implement narrative-building through electronic print and local social media. | • Counter negative, false propaganda at all levels. | • Decease in misconceptions reported for chronic refusals. | • Continued 2025–2026 | • Provincial and district UNICEF, WHO offices |

AIC = area in-charge; CBV = community-based vaccination; CHW = community health worker; DHMT = district health management team; EPI = Essential Programme on Immunization; fIPV = fractional dose of inactivated polio vaccine; FLW = frontline worker; IPV = inactivated polio vaccine; ISD = integrated service delivery; MMP = migrant and mobile population; NEOC = National Emergency Operations Centre; PEI = Polio Eradication Initiative; PEOC = Provincial Emergency Operations Centre; RI = routine immunization; SIA = supplementary immunization activity; SMT = special mobile teams; UCMO = Union Council medical officer; UNICEF = United Nations Children's Fund; WHO = World Health Organization.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Quetta block (continued)** | | | | | |
| **Vaccine hesitancy / refusals (continued)**<br>• Grey houses (houses with children but marked as zero).<br>• Fake finger marking (FFM). | • Engage communities through appropriate influencers.<br>• Direct observed vaccination (DOV) in grey houses and refusal hotspots; use IPC with parents, caregivers to encourage behavioural change.<br>• Continue community listening to identify hidden children, build trust. | • Build trust and community ownership.<br>• Identify FLWs and community nexus.<br>• Identify FFM. | • 100% DOV in all refusal pockets. | • September 2025 campaign | • Provincial and district UNICEF, WHO offices |
| | • Track, vaccinate children in-between campaigns. | | • Coverage of at least 50% still missed children between campaigns. | • After September 2025 campaign | |
| **Gender**<br>• Female FLWs are poorly paid and trained.<br>• FLWs face challenges reaching PRSEAH structures before, during and after campaigns.<br>• Few fathers are involved in child immunization activities. | • Train female FLW in soft skills, PRSEAH.<br>• Engage fathers and male religious leaders. | • Reduce vaccine hesitancy. | • More female FLW are trained and supported before, during and after campaign.<br>• More men are engaged in immunization. | • Every campaign 2025–2026 | • UNICEF |
| **Surveillance**<br>• Silent UCs.<br>• Fewer cases reported by public network. | • Engage, train local community informants.<br>• Sensitize government, HCPs on for AFP surveillance.<br>• Develop an accountability and rewards mechanism for reporting and missed AFP cases. | • Develop a sensitive surveillance network in hard-to-reach areas of Balochistan.<br>• Increase reporting of true AFP cases | • Decrease in numbers of silent UCs.<br>• Reporting of more than 80% AFP cases with first contact. | • December 2025 | • DHMT and provincial and district WHO Surveillance Cell |
| **ISD / EPI**<br>• Very low RI coverages.<br>• High numbers of ZDC. | • Strengthen coordination with EPI to implement the Immunization Roadmap. | • Increase percentage of FIC OPV and IPV coverages across Balochistan. | • Universal coverage of EPI antigen in all areas of Balochistan. | • December 2025 | • Provincial EPI, EOC (PEI-EPI Task team) |
| | • Intensify implementation of synergy action plan. | • Increase coverage of ZDC and EPI. | • Identification and coverage of >90% ZDC. | • October 2025 | • DHMT & Aga Khan University (AKU) |
| | • Support quality implementation of GF-funded RI-strengthening plan in seven (7) high-risk districts (Quetta block, Zhob, Mastung and Sibi). | • Increase coverage in high-risk areas (Quetta and Zhob Division). | • Increase Penta 3 coverage in polio high-risk areas by 20% by December. | • December 2025 | |
| **Other subgeographies**<br>*Eastern Balochistan*<br>• Compromised monitoring in high-risk areas (Dera Bugti and Naseer Abad). | • Implement local, remote monitoring for insecure areas.<br>• Use ring fencing within these areas. | • Ensure campaign quality in access-compromised areas. | • Local campaign monitors recruited.<br>• CIs recruited for campaign and surveillance network. | • September 2025 | • DHMT, WHO provincial and district offices |
| • Complex boundaries between Balochistan, Sindh and Punjab. | • Hold cross-border meetings in districts that border Balochistan, Sindh and Punjab before campaigns.<br>• Conduct joint-border verification, analysis of MMP movement patterns and community mobilization for missed areas. | • Identify missed areas between districts and provinces. | • All missed areas included in microplans. | • September 2025 | • NEOC |

AFP = acute flaccid paralysis; AKU = Aga Khan University; CI = community informant; DHMT = district health management team; DOV = direct observed vaccination; EOC = Emergency Operations Centre; EPI = Essential Programme on Immunization; FFM = fake finger marking; FIC = fully immunized children; FLW = frontline worker; GF = Gates Foundation; grey houses = houses with children that are marked as zero; HCP = health-care provider; IPC = interpersonal communication; IPV = inactivated polio vaccine; ISD = integrated service delivery; MMP = migrant and mobile population; NEOC = National Emergency Operations Centre; OPV = oral polio vaccine; PEI = Polio Eradication Initiative; Penta 3 = third dose of pentavalent vaccine; PRSEAH = preventing and responding to sexual exploitation, abuse and harassment; RI = routine immunization; UC = Union Council; UNICEF = United Nations Children's Fund; WHO = World Health Organization; ZDC = zero-dose children.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Lahore** | | | | | |
| **Political commitment / advocacy**<br>• Sustaining political commitment of all parties. | • Conduct PTF meetings chaired by Chief Secretary, Minister of Health, Chief Minister's Focal Point (CMFP) and all Secretaries of Health, Interior/Home and Education Department. | • Maintain political commitment and build an enabling environment for polio eradication. | • TBD | • Before SIAs 2025–2026 | • Provincial coordinator |
| | • Arrange more than 12 inaugurations involving Chief Minister (CM), Health Minister, Information Minister. | | • TBD | • In-between campaigns 2025–2026 | • Core team |
| **SIA quality**<br>• Clusters of SMC, not available (NA) children. | • Conduct scheduled engagement of NAs.<br>• Strengthen same-day coverage.<br>• Ensure outreach sessions by vaccinators. | • Prioritize the protection of children through every available opportunity. | • TBD | • Intra-campaign 2025–2026 | • Social and Behavioural Change Communication (SBCC) Team |
| | • Use a daily tally sheet analysis to map SMCs and reach them during catch-up days.<br>• Redefine scope of catch-up days to approach recorded missed children instead of all houses. | | • TBD | • Pre-campaign 2025–2026 | • Operations (Ops) Team |
| • Missed ZDC among MMP communities. | • Conduct social profiling to proactively understand movement, anticipate guests' arrivals.<br>• Develop a strategic MMP engagement plan. | • Go beyond registration to ensure tactical engagement. | • TBD | • Pre-campaign 2025–2026 | • SBCC Team |
| | • Ensure robust monitoring of MMP registration (pre-campaign) and coverage (intra-campaign).<br>• Enhance RI vaccination for ZDC, defaulter children. | | • TBD | • Pre- and intra-campaign 2025–2026 | • Ops Team |
| **Capacity issues**<br>• UCMOs, AICs & FLWs. | • Utilize a human-centred design (HCD) approach to co-design eradication strategy.<br>• Conduct listening sessions with FLWs. | • Introduce HCD to revitalize trainings for better planning and monitoring. | • TBD | • Pre-campaign 2025–2026 | • SBCC Team |
| | • Develop pre-campaign trainings based on knowledge assessment of supervisors and FLWs.<br>• Incorporate previous campaign findings into district training of trainers (ToTs) and cascade trainings. | | • TBD | | • Ops Team |
| **Enhanced monitoring** | • Include communication activities in pre-campaign monitoring of all provincial- and district-level monitors. | • Redefine the scope of monitoring. | • TBD | • Pre-campaign 2025–2026 | • SBCC Team |
| | • Spotlight two quality drops in team trainings and intra-campaign monitoring (ICM). | | • TBD | • Intra-campaign 2025–2026 | • Ops Team |
| **Vaccine hesitancy / refusals**<br>• Potential hidden refusals in SMCs, PMCs or other vulnerable groups like 0/0, locked houses and MMP.<br>• Anticipate decline in acceptance, possible hesitancy. | • Conduct social profiling of SMC and PMC as part of regular pre-campaign engagement. | • Achieve maximum coverage, prevent hesitancy, sustain community demand until eradication is achieved. | • % of SMCs of previous campaign engaged and covered. | • Post-campaign 2025–2026 | • SBCC Team |
| | • Engage SMC during the in-between campaign phase.<br>• Vaccinate during EPI vaccinators' outreach plan. | | • # of SMCs vaccinated in outreach activities. | • In-between campaign 2025–2026 | • SBCC Team |
| | • Conduct focus groups with caregivers, FLWs to keep a check on acceptor sentiment and gauge the possibility of hidden refusals. | | • # of social listening activities (with findings embedded in plans). | | |

AIC = area in-charge; CM = Chief Minister; CMFP = Chief Minister's Focal Point; EPI = Essential Programme on Immunization; FLW = frontline worker; HCD = human-centred design; ICM = intra-campaign monitoring; MMP = migrant and mobile population; NA = not available; Ops = operations; PMC = persistently missed children; PTF = provincial taskforce; RI = routine immunization; SBCC = social and behavioural change communication; SIA = supplementary immunization activity; SMC = still missed children; TBD = to be determined; ToT = training of trainers; UCMO = Union Council medical officer; ZDC = zero-dose children.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Lahore (continued)** | | | | | |
| **Gender**<br>• Female FLWs are poorly paid and trained.<br>• FLWs face challenges reaching PRSEAH structures before, during and after campaigns.<br>• Few fathers are involved in child immunization activities. | • Train female FLW in soft skills, PRSEAH.<br>• Engage with fathers and male religious leaders. | • Reduce vaccine hesitancy. | • More female FLWs are trained and supported before, during and after campaign/<br>• More men are engaged in immunization. | • Every campaign 2025–2026 | • UNICEF |
| **Surveillance**<br>• AFP notification within seven (7) days of onset < 80% (currently 79%).<br>• Low AFP reporting from community.<br>• Low AFP reporting by first contact. | • Conduct an analysis of health-seeking behaviour (HSB).<br>• Identify and select pediatricians for AFP network.<br>• Include potential outside-network reporting.<br>• Review sites in silent areas. | • Enhance CBS reporting. | • >80% AFP case notification within seven (7) days | • December 2025 | • ACs<br>• DSO<br>• Immunization officers (IOs) |
| | • Select formal and informal HCPs at the UC level.<br>• Reinforce reporting by tehsil surveillance assistants (TSA) at the UC level.<br>• Ensure collection from MMP riverine, drainage areas.<br>• Increase participation of private health network | | • District improvement plan implemented as per Technical Advisory Group (TAG). | • December 2025 | • DHO<br>• Deputy district health officer (DDHO)<br>• DSO<br>• ACs |
| | • Conduct regular analysis of HSB.<br>• Conduct regular orientation, refresher trainings at health facilities.<br>• Involve medical associations.<br>• Ensure regular sensitization through social media. | | • >90% notification from first and second contact. | • December 2025 | • DHO<br>• DDHO<br>• DSO<br>• ACs |
| **ISD / EPI** | • Prioritize UCs for ISD / EPI. | • Identify priority UCs. | • 377 UCs identified. | • Q1 2025 | • PEI-EPI Synergy Task Team |
| | • Develop a PEI-EPI Integrated Plan for priority UCs. Include HR, governance, M&E, service delivery, surveillance and cold chain management. | • Identify issues and interventions to improve priority UCs. | • PEI-EPI Integrated Plan developed. | • February–June 2025 | |
| | • Enhance support and supervision in priority UCs. | • Ensure quality interventions. | • All 377 UCs supervised by DEOCs. | • March–June 2025 | |
| | • Conduct a first assessment to evaluate improvement. | • Measure impact. | • 45/208 assessed UCs not improved. | • July 2025 | |
| | • Conduct a second assessment to re-evaluate UCs in need of improvement. | • Re-evaluate unimproved UCs (45). | • Update Action Plan. | • August–December 2025 | |

AC = area coordinator; AFP = acute flaccid paralysis; CBS = community-based surveillance; DDHO = deputy district health officer; DEOC = District Emergency Operations Centre; DHO = district health officer; EPI = Essential Programme on Immunization; FLW = frontline worker; HCP = health-care provider; HR = human resources; HSB = health-seeking behaviour; ISD = integrated service delivery; M&E = monitoring and evaluation; MMP = migrant and mobile population; PEI = Polio Eradication Initiative; PRSEAH = preventing and responding to sexual exploitation, abuse and harassment; TAG = Technical Advisory Group; TSA = tehsil surveillance assistant; UC = Union Council; UNICEF = United Nations Children's Fund.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Peshawar** | | | | | |
| **SIA quality**<br>• Contract modality changes a to uncertainty, lack of motivation among FLWs.<br>• Management issues: hiring, training, ToRs, orientation, performance management.<br>• Large MMP, with 300 000 children under age 5.<br>• Reported FFM. | • Finalize, communicate new FLW contract modality.<br>• Institutionalize new FLW management system.<br>• Conduct FLW motivation and orientation sessions.<br>• Develop KPIs focused on activities, not just outputs.<br>• Develop, routinize a new performance management system.<br>• Revise FLW selection with strong district involvement.<br>• Strengthen FLW training; include needs-based assessments.<br>• Utilize CBVs to register MMP before every campaign.<br>• Instill 'red lines' for performance, including immediate termination for FFM.<br>• Establish a dedicated FLW hotline to build trust and facilitate the identification and reporting of FFM. | • Clarity around FLW jobs.<br>• Improve FLW motivation.<br>• Improve SIA quality as measured through PCM.<br>• Vaccinate MMP population. | • New FLW management model notified.<br>• Enhanced training material developed.<br>• FLW hotline launched.<br>• Registration and tracking of MMP included in CBV workplans. | • August–September 2025 | • NEOC/PEOC KP |
| **Political commitment / advocacy**<br>• Lack of political ownership. | • Hold a post-campaign review meeting, chaired by Minister of Health or Chief Minister (KP) to review progress and lend support with challenges.<br>• Hold periodic meet-and-greet sessions with political leadership of different areas in the city. | • Effectively engage the political machinery to resolve challenges such as access, refusals, etc. | • Post-campaign review chaired by Health Minister or Chief Minister.<br>• Meet-and-greet sessions held in every campaign. | • During and post every campaign 2025–2026 | • PEOC KP/ DEOC Peshawar |
| **Gender**<br>• Female FLWs are poorly paid and trained.<br>• FLWs face challenges reaching PRSEAH structures before, during and after campaigns.<br>• Few fathers are involved in child immunization activities. | • Train female FLWs in soft skills, PRSEAH.<br>• Engage fathers and male religious leaders. | • Reduce vaccine hesitancy. | • More female FLWs are trained and supported before, during and after campaign.<br>• More men are engaged in child immunization. | • During and after every campaign 2025–2026 | • UNICEF |
| **Consistently low performance**<br>• 18 low-performing Union Councils (LPUCs) based on campaign KPIs. | • Develop UC-specific plans to graduate LPUCs to high-performing UCs.<br>• Ensure district and provincial teams bring special focus to monitoring LPUCs. | • Reduce LPUCs. | • Zero LPUCs by December 2025. | • December 2025 | • District Peshawar |
| **Surveillance**<br>• Delayed case notification. AFP case notification within seven (7) days < 80%.<br>  ○ Peshawar: 71%<br>  ○ Khyber: 81% | • Conduct a diagnostic of underlying causes of delay.<br>• Improve quality and compliance of active visits.<br>• Conduct refresher trainings of HCPs, formal and Informal<br>• Conduct refresher trainings of staff: AC, DSO, DSC.<br>• Institute strict accountability measures. | • Timely case detection. | • Timely detection of AFP cases above 80%.<br>• Achieve ≥90% visits compliance (national target). | • December 2025 | • District Peshawar |

AC = area coordinator; AFP = acute flaccid paralysis; CBV = community-based vaccination; DEOC = District Emergency Operations Centre; DHO = district health officer; DSC = district surveillance coordinator; FFM = fake finger marking; FLW = frontline worker; HCP = health care provider; KP = Khyber Pakhtunkhwa; KPI = key performance indicator; LPUC = low-performing Union Council; MMP = migrant and mobile population; NEOC = National Emergency Operations Centre; PCM = post-campaign monitoring; PEOC = Provincial Emergency Operations Centre; PRSEAH = preventing and responding to sexual exploitation, abuse and harassment; SIA = supplementary immunization activity; ToRs = terms of reference; UC = Union Council; UNICEF = United Nations Children's Fund.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Peshawar (continued)** | | | | | |
| **ISD / EPI**<br>• Suboptimal rates for fully immunizing ZDC. | • Focus on improving EPI programme performance.<br>• Ensure input availability across Peshawar.<br>• Conduct regular review routines at the district and UC levels to identify and resolve challenges.<br>• Support EPI department in combined measles-rubella (MR)-OPV campaign in November 2025.<br>• ISD: supplement EPI programme with ISD interventions to improve coverage. | • Increase FIC.<br>• Reduce ZDC. | • FIC >95%<br>• Consistent reduction in ZDC.<br>• ISD progress (e.g. 15 health facilities in Peshawar SHRUCs run with Medical Emergency Resilience Foundation [MERF]) | • June 2025 to 2026 | • EPI dept KP<br>• PEOC KP |
| **Other subgeographies: Hazara division** | | | | | |
| **Surveillance**<br>Persistent positive samples via environmental surveillance (ES) with orphan viruses in Abbottabad and Mansehra. | • Conduct thorough investigation of programme gaps.<br>• Conduct regular meetings, reviews with Hazara Division Team.<br>• Develop divisional plan with UC-level details. | • Clean up virus. | • No positive ES sample. | • December 2025 | • Provincial surveillance officer (PSO) / provincial district surveillance officer (PDSO) / AC |
| | • Conduct active case search in drainage UCs. | • Rule out missed cases. | • Enhanced AFP surveillance. | • November 2025 | • DSO/AC |
| **Other subgeographies: Bordering districts** | | | | | |
| **Surveillance**<br>• Suboptimal surveillance in black UCs:<br>o D/Lower, Killa Saifullah area notification <80%.<br>o Zhob, Wazir-N stool adequacy <80%. | • Revamp, reprioritize CIs. | • Timely reporting of AFP cases. | • At least one AFP case reported in red and black UCs. | • December 2025 | • AC/DSO/DSC |
| • Repeated orphan virus in Peshawar, occasionally in Quetta, suggests possible undetected transmission. | • Conduct active case search In bordering UCs.<br>• Enhance active surveillance visits.<br>• Review, update surveillance network. | • Rule out missed cases. | • Enhanced AFP surveillance, including CI network. | • November 2025 | • DSO/AC |
| • Poor supervision and monitoring. | • Conduct supervisory visits by provincial office/ACs. | • Achieve and maintain sensitive, comprehensive surveillance systems. | • Quality monitoring visits. | • December 2025 | • PSO/PDSO/AC |
| • Suboptimal CBS in access-compromised areas (riverine belt of central Pakistan).<br>o Musakhel, Kashmore, Nsirabad stool adequacy <80%.<br>o Musakhel, Kashmore case notification <80%. | • Engage local UC-level staff to increase sensitivity, tracking of CBS. | | • CBS performance reports. | • Monthly 2025–2026 | • Sindh surveillance task team |
| | • Improve quality and compliance of active visits.<br>• Conduct refresher trainings of HCPs, formal and Informal<br>• Conduct refresher trainings of staff: AC, DSO, DSC. | | | | • Federal surveillance task team |

AC = area coordinator; black UCs = access-compromised Union Councils; CBS = community-based surveillance; CI = community informant; DSC = district surveillance coordinator; DSO = district surveillance officer; EPI = Essential Programme on Immunization; ES = environmental surveillance; FIC = fully immunized children; HCP = health care provider; ISD = integrated service delivery; KP = Khyber Pakhtunkhwa; MERC = Medical Emergency Resilience Foundation; MR = measles-rubella vaccine; OPV = oral polio vaccine; PDSO = provincial district surveillance officer; PEOC = Provincial Emergency Operations Centre; PSO = provincial surveillance officer; red UCs = Union Councils with partial access; SHRUC = super high-risk Union Council; UC = Union Council; ZDC = zero-dose children.

## *Nigeria and Lake Chad Basin countries*

Lake Chad Basin country of **NIGERIA**
Subnational areas include **Sokoto, Kebbi, Katsina, Zamfara, Kano and other high-risk areas**.

**Table B3. Nigeria subnational action plans**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Routine immunization**<br>• Very low RI coverage. (Current rates: OPV3 9%, two doses of inactivated polio vaccine (IPV2) 6%, measles 9%.) | • GPEI to lead collaboration with EPI & Gavi to improve RI coverage in the major urban centres of Sokoto. | • Improve RI coverage, including for polio vaccines. | • Improved coverage in children under 5 for OPV3/IPV/measles. | • Q4 2025–Q2 2026 | • GPEI country team |
| **Political situation**<br>• Political oversight insufficient to drive commitments at all levels.<br>• Low domestic financing. | • Ensure advocacy at the highest level to increase government funding and oversight on accountability.<br>• Engage local government areas (LGAs) at all stages.<br>• Sustain and expand engagement with ad hoc National Expert Committee (NEC) on Polio.<br>• Provide regular updates to governors through scorecards. Include recognition of performing LGAs and accountability for underperformance. Leverage NEC, State Expert Committee (SEC) and State Task Force on Immunization (STFI) as platforms.<br>• Work with states to convene LGA Chairmen and advocate the intensification strategy, secure buy-in and resourcing for the efforts. | • Increase domestic funding for polio response.<br>• Improve commitment of political leadership at all levels.<br>• Promote accountability by regularly updating governors on LGA performance, using scorecards and strategic platforms.<br>• Secure LGA Chairmen's commitment to intensification strategies through state-led advocacy. | • Timely release of counterpart funding.<br>• Expanded meetings of NEC with action points.<br>• Regular Governors' Scorecards with LGA performance shared via NEC, SEC, and STFI, with advocacy inputs.<br>• State-convened meetings with buy-in and resource pledges from LGA leadership. | • Ongoing 2025–2026 | • State and LGA governors and chairmen<br>• NEC chair and partners |
| **Access**<br>• 6.8K/18K insecure settlements not reached with two (2) rounds of novel oral polio vaccine type 2 (nOPV2) due to insecurity. | • Review, map and engage gatekeepers in insecure settlements.<br>• Conduct block-based approach method and bottom-up engagement to develop innovative plans to reach targeted populations in insecure settlements.<br>• Track quality of reach. | • Reduce number of unreached settlements and children.<br>• Enhance coordination with gatekeepers.<br>• Operationalize block-based approach for in-between round activities (IBRA) in insecure settlements. Strengthen state, LGA and ward engagement. | • Bottom-up microplanning.<br>• Collaboration/agreement with security officers.<br>• Block-based approach for IBRA implementation in insecure areas. | • Q4 2025 | • NEOC, State Emergency Operations Centre (SEOC) |
| **Campaign quality**<br>• Rapid build-up of susceptible and persistently low immunity profile despite several SIAs.<br>• Dividends on strategic shifts yet to mature to address missed populations and weak accountability. | • Sustain and expand on implementation of shifts (quality team selection; scaled-up mini-walk through microplan; Identify, Enumerate, Vaccinate (IEV) strategy; intensified supervision; advance deployment of senior officers and engagement of civil society organizations (CSOs) to support quality preparations).<br>• Implement high-impact IBRA interventions.<br>• Conduct four (4) Subnational Immunization Days (SNIDs) per year in high-risk states/core reservoirs. | • Interrupt circulating vaccine-derived poliovirus type 2 (cVDPV2) through enhanced quality planning, delivery and LQAS coverage of vaccination interventions. | • No. of quality campaigns conducted.<br>• Strategic shifts implemented and evaluated. | • Ongoing 2025–2026 | • NEOC<br>• SEOC |

CSO = civil society organization; cVDPV2 = circulating vaccine-derived poliovirus; EPI = Essential Programme on Immunization; GPEI = Global Polio Eradication Initiative; IBRA = in-between round activities; IEV = Identify, Enumerate, Vaccinate (strategy); IPV2 = two doses of inactivated polio vaccine; LGA = local government area; LQAS = lot quality assurance sampling; NEC = National Expert Committee on Polio; NEOC = National Emergency Operations Centre; nOPV2 = novel oral polio vaccine type 2; OPV3 = three doses of oral polio vaccine; RI = routine immunization; SEC = State Expert Committee on Polio; SEOC = State Emergency Operations Centre; SIA = supplementary immunization activity; SNID = Subnational Immunization Day; STFI = State Task Force on Immunization.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Population movement**<br>• High population movement by nomads, cross-border and internally displaced populations (IDPs). | • Engage, map migrant populations.<br>• Develop and implement targeted vaccination (nomadic and transit post vaccinations).<br>• Ensure synchronization and coordination of international and state boarder points for cross-border vaccination. | • Ensure availability of all migrant population service points and seasonal movement for vaccination planning.<br>• Reduce cVDPV2 cases among nomadic population.<br>• Ensure seamless cross-border vaccination through coordinated efforts at international and state border points. | • Migration populations mapped for IBRAs.<br>• Cases among nomadic population monitored.<br>• Jointly planned and synchronized vaccination activities at key border locations, with shared microplans and partner engagement. | • Ongoing 2025–2026 | • SEOC<br>• NEOC |
| **Demand generation**<br>• Poorly monitored interventions at subnational level and multiple expressed needs of population affecting vaccine acceptance. | • Digitize the implementation of demand-generation activities.<br>• Continue the strategic shifts for social and behavioural change (SBC), such as engagement by ward-level non-compliance resolution teams (NCRTs), CSO-led strategy.<br>• Deploy SBC monitors to all high-risk states and LGAs.<br>• Broaden focus beyond the traditional influencer networks to include alternative influencers such as local women's groups and "fathers for good health".<br>• Position polio within broader health priorities. Link messages with community priorities (nutrition, malaria, maternal health) so polio doesn't feel like a "one-off" external agenda.<br>• Develop formal partnerships with local leaders, faith-based groups, and civil society to co-own mobilization and establish community advisory mechanisms that feed back into campaign design (addressing issues like timing, fatigue, or rumor management).<br>• Leverage digital community engagement platforms and ads to maintain two-way communication, sustain awareness, and address rumors in areas where in-person mobilization is limited.<br>• Review funding mechanisms to facilitate implementation of activities. | • Increase in demand for vaccination services.<br>• Reduce burden of non-compliance by 80%.<br>• Sustain community engagement and rumor management through cost-effective digital approaches that complement limited in-person mobilization. | • More resources allocated for demand generation activities within GPEI funding.<br>• LQAS.<br>• SBC reports. | • October / December 2025 round | • SEOC |
| **Gender**<br>• Resistance of fathers to vaccination.<br>• Limited opportunities for female volunteer community mobilizers (VCMs). | • Maintain father engagement activities.<br>• Engage first ladies, leaders in polio campaigns.<br>• Train VCMs. | • Increase the involvement of fathers in polio response.<br>• Maintain female VCM motivation. | • More fathers engaged in polio campaigns in the Bauchi state ('Fathers for good health').<br>• Advocacy event held with first ladies. | • Ongoing 2025–2026 | • UNICEF |

CSO = civil society organization; cVDPV2 = circulating vaccine-derived poliovirus type 2; GPEI = Global Polio Eradication Initiative; IBRA = in-between round activity; IDP = internally displaced population; LGA = local government area; LQAS = lot quality assurance sampling; NCRT = non-compliance resolution team; NEOC = National Emergency Operations Centre; SBC = social and behavioural change; SEOC = State Emergency Operations Centre; VCM = volunteer community mobilizer; UNICEF = United Nations Children's Fund.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Surveillance**<br>• Increased detections of orphan viruses indicate surveillance gaps. | • Conduct comprehensive surveillance review in high-risk states.<br>• Review surveillance improvement plans and accountability measures.<br>• Improve capacity of community networks.<br>• Develop a risk prioritization of silent wards for reintroduction of healthy child sampling.<br>• Conduct comprehensive external surveillance review. | • Maintain surveillance sensitivity.<br>• Enhance community capacity for surveillance. | • Surveillance improvement plan and operations plan.<br>• Orphan virus detections reduced by at least 80% by 2026. | • Ongoing 2025–2026 | • SEOC<br>• NEOC |
| **Data quality**<br>• Fragmented data streams impacting decision-making. | • Review and update the current plan for setting data pipelines.<br>• Implement automated analysis platforms for timely dissemination of information products.<br>• Cross-validate social listening data with community feedback for stronger evidence-based action.<br>• Rationalize tools (e.g. eTally, paper tally).<br>• Optimize FIONET data collection. | • Enhance evidence generation and use for action.<br>• Improve efficiency and data quality by streamlining polio field team data collection tools and optimizing FIONET usage.<br>• Ensure triangulation of digital and offline community insights to strengthen accuracy and reliability of evidence for decision-making. | • Data quality improvement plan.<br>• Revised data collection protocol with rationalized tools (e.g. eTally, paper tally) and enhanced FIONET integration for real-time monitoring.<br>• Strengthened field capacity for integrated online–offline data use in real-time response. | • Ongoing 2025–2026 | • SEOC<br>• NEOC |

NEOC = National Emergency Operations Centre; SEOC = State Emergency Operations Centre.

Lake Chad Basin country of **CHAD**
Subnational areas include **N'Djamena, Chari-Baguirmi, Guéra, Logone Oriental and Ouaddaï**.

**Table B4. Chad subnational action plans**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Poor SIA quality**<br>• Suboptimal campaigns In urban centres and border districts, islands and refugee camps. | • Conduct comprehensive bottom-up microplanning exercises.<br>• Disaggregate data by islands and refugee camps for priority-setting and planning.<br>• Deploy geographic information system (GIS) mobile technology to track SIA quality by vaccination team and independent monitors in areas with pastoral and nomadic populations, fishermen, IDPs, refugees.<br>• Advocate for strong border collaboration.<br>• Develop intensified approach to create a realistic opportunity to halt the outbreak in areas where spread is likely (e.g. nomadic routes, chronically missed areas, international borders).<br>• Develop a special community engagement plan to address missed children and refusals. | • Improve SIA quality.<br>• Intensify focus in high-risk areas to halt poliovirus transmission.<br>• Address missed children and refusals through targeted SBC efforts. | • Percentage of accepted districts during LQAS ≧ 80%.<br>• Finalized microplans that incorporate activities and points of entry (PoE) from the nomadic health programme. | • October 2025 | • GPEI |

GPEI = Global Polio Eradication Initiative; GIS = geographic information system; IDP = internally displaced population; LQAS = lot quality assurance sampling; PoE = points of entry; SBC = social and behavioural change; SIA = supplementary immunization activity.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **HR capacity**<br>• Insufficient HR at central and operational levels to provide technical support to the GPEI. | • Advocate to increase HR capacity. | • Ensure adequate, well-trained HR, at all levels are available and equipped to support and implement activities. | • Surge plans revised to ensure correct capacity on the ground.<br>• Percentage of health districts with trained, deployed personnel meets requirements as per the microplan. | • As soon as possible | • Lake Chad Basin (LCB) coordinator / GPEI coordinator |
| **Delayed disbursement**<br>• Bottlenecks in transfer of SIA funds from rapid response team (RRT) to the country offices (WHO, UNICEF) and from the country offices (WHO, UNICEF) to Ministry of Health (MoH). | • Submit requests 45 days before SIAs start.<br>• Disburse funds at once for all approved SIAs.<br>• Advocate to MoH for WHO and UNICEF to migrate from direct financial cooperation (DFC) to mobile payment systems. Scoping mission in September 2025 represents a first step. | • Ensure timely disbursement of SIA funds.<br>• Improve response quality. | • Funds disbursed four (4) weeks before SIA.<br>• Memorandum of Understanding (MoU) signed between MoH and WHO to shift from DFC to direct implementation (DI). | • August 2025 and ongoing 2025–2026 | • WHO representative (WR)/ Digital Finance Team (DFT) |
| **Gender**<br>• Limited engagement of fathers.<br>• Limited collaboration with women's organizations that focus on health.<br>• Lack of sex-disaggregated data. | • Identify and work with fatherhood role models to boost vaccine uptake.<br>• Identify and work with women´s organizations to boost vaccine uptake.<br>• Provide sex-disaggregated data of ZDC and teams working during campaigns. | • Improve vaccine uptake.<br>• Increase engagement of fathers. | • More fathers are engaged in child vaccination activities.<br>• More women-led CSOs are engaged in immunization activities. | • Ongoing 2025–2026 | • UNICEF |
| **Data quality**<br>• The dashboard does not comply with items at each level (district, provincial, national). | • Adapt dashboard items to the implementation level. | • Improve the timely filling and quality of the dashboard. | • Preparedness dashboard adapted. | • Four (4) weeks before each SIA 2025–2026 | • NEOC/Data Management Team |
| **Surveillance**<br>• Detections of orphan viruses indicate surveillance gaps.<br>• Data not desegregated by population type: migrant, refugees, etc. | • Provide funds to complete cascade training of subnational focal points on electronic surveillance (eSURV) companion.<br>• Revise the accountability framework. | • Improve individual focal point accountability.<br>• Enhance the sensitivity of the surveillance system. | • Accountability framework revised.<br>• Surveillance performance report. | • Q4 2025 | • WHO surveillance technical lead |
| • Delayed sample shipment from district to national level. | • Establish local arrangement with a nongovernmental organization (NGO).<br>• Provide funds to MoH for shipment of samples. | • Ensure sample timeliness and quality. | • Proportion of stool samples received 72 hours after collection, from the operational to the central level. | | |
| **Weak incident management system (IMS)** | • Conduct high-level (external) advocacy for the delegation of full power and authority to the Chad Incident Manager for decision-making and implementation of outbreak response activities. | • Strengthen IMS leadership; document weekly IMS meetings.<br>• Improve technical guidance down to subnational level.<br>• Improve response timeliness. | • Advocacy report prepared. | • September 2025 | • Outbreak Response and Preparedness Group (ORPG) |

CSO = civil society organization; DFC = direct financial cooperation; DFT = digital financial team; DI = direct implementation; eSURV = electronic surveillance (tool); GPEI = Global Polio Eradication Initiative; HR = human resources; IMS = incident management system; LCB = Lake Chad Basin; MoH = Ministry of Health; MoU = Memorandum of Understanding; NEOC = National Emergency Operations Centre; NGO = nongovernmental organization; ORPG = Outbreak Response and Preparedness Group; RRT = rapid response team; SIA = supplementary immunization activity; UNICEF = United Nations Children's Fund; WHO = World Health Organization; WR = WHO representative; ZDC = zero-dose children.

Lake Chad Basin country of **Niger**
Subnational areas include **Diffa, Maradi, Niamey, Tahoua and Zinder**.

**Table B5. Niger subnational action plans**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Weak political commitment** | • Advocate for the creation of a national interministerial coordination led by the Prime Minister (PM), co-chaired by the MoH. | • Strengthen the involvement of influential officials who support polio activities. | • Coordination meeting chaired by PM. | • Continue 2025–2026 | • Polio Incident Management Support Team (IMST) |
| | • Organize a biannual review of the management of polio activities, including cross-border activities, in the presence of administrative, political authorities. | • Strengthen coordination, accountability and alignment with national and regional priorities. | • Report reviewed with authorities' participation. | • December 2025 | |
| **Hard-to-reach areas & special populations** | • Implement RI strengthening in hard-to-reach areas (e.g. markets, PoE, nomadic populations, insecure areas,).<br>• Arrange for logistical support to mitigate difficult terrain. | • Catch-up ZDC and under-vaccinated children. | • Number of ZDC and under-vaccinated children vaccinated. | • September 2025 | • Polio IMST |
| **Cross-border considerations** | • Reinforce cross-border collaboration in health initiatives through targeted advocacy efforts, regular updates with key stakeholders, and joint international cross-border plan-of-action development and implementation. | • Enhance coordinated interventions.<br>• Foster mutual accountability, high-level political and institutional support. | • Strengthened cross-border cooperation, collaboration with neighbouring countries. | • Continue 2025–2026 | • Polio IMST |
| | • Strengthen accountability mechanisms for active case search of AFP and other vaccine-preventable disease (VPDs) in border-area health districts via the open data kit (ODK) tool. | • Improve data quality, timely reporting and coordinated efforts across districts. | • Improved accountability of consultants, surveillance focal persons at all levels. | • Continue 2025–2026 | |
| **Suboptimal SIA quality**<br>Issues include:<br>• microplanning<br>• fund disbursement<br>• HR, other operational issues | • Improve team selection, training, supervision,<br>• Update microplans before each SIA for priority districts, using an inclusive process (administrative, religious, customary, education, livestock, agriculture, security, etc.). | • Improve SIA quality.<br>• Optimize border synchronization.<br>• Interrupt transmission. | • Training plan, budget developed.<br>• SOP for vaccinators, team supervisors developed for accountability framework. | • September 2025 | • Polio IMST |
| | • Map insecure areas in collaboration with security services, livestock services, humanitarian actors/NGOs or other organizations (IOM, UNHCR, WFP, OCHA, MSF, ICRC, ACF, etc.). Engage CIs to help negotiate and increase access. | | • Mapping of migrants (herdsmen, fishermen), IDPs, refugees and security-compromised areas for GIS implementation. | • September 2025 | • Polio IMST |
| | • Disaggregate data by border districts, security-compromised areas, islands, refugee camps for priority-setting and planning. | | • Data disaggregated to support tailored plans, interventions. | • September 2025 | • Polio IMST |
| | • Deploy GIS mobile technology to track SIA quality by vaccination team and independent monitors in areas with pastoral and nomadic communities, fishermen, IDPs, refugees and in security-compromised areas. | | • Enhanced technological monitoring: real-time tracking of quality for interventions in local contexts. | • September 2025 | • GPEI Coordinator / Polio IMST |
| | • Implement sweeps in areas that are insufficiently covered during independent monitoring (IM) & LQAS surveys. | | • Improved coverage in areas found to have insufficient coverage during IM and LQAS. | • September 2025 | • Polio IMST / RRT |
| | • Advocate to MoH for WHO and UNICEF to migrate from DFC to mobile payment systems. | | • Efficient payments made through mobile payment. | • September 2025 | • RRT |

ACF = The Administration for Children & Families; AFP = acute flaccid paralysis; CI = community informant; CSO = civil society organization; DFC = direct financial cooperation; GIS = geographic information system; ICRC = International Committee of the Red Cross; IDP = internally displaced population; IM = independent monitoring; IMS = incident management system; IMST = Incident Management Support Team; IOM = International Organization for Migration; LQAS = lot quality assurance sampling; MoH = Ministry of Health; MSF = Médecins Sans Frontières; NGO = nongovernmental organization; OCHA = United Nations Office for the Coordination of Humanitarian Affairs; ODK = open data kit; PM = Prime Minister; PoE = points of entry; RI = routine immunization; RRT = rapid response team; SIA = supplementary immunization activity; UNHCR = United Nations High Commissioner for Refugees; UNICEF = United Nations Children's Fund; VPD = vaccine-preventable disease; WFP = World Food Programme; ZDC = zero-dose children.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Vaccine hesitancy / refusals** | • Conduct SBC activities in inter-campaign period.<br>• Include CSO-led advocacy, communication and social mobilization (ACSM) activities with NCRTs to address refusals. | • Improve vaccination coverage during SIAs. | • Continuous implementation of SBC activities in the period between vaccination campaigns. | • Continue 2025–2026 | • Polio IMST |
| **Gender**<br>• Lack of sex-disaggregated data.<br>• Limited fathers' engagement.<br>• Women´s limited decision-making power. | • Provide sex-disaggregated data, including data of women working in the polio programme.<br>• Engage fathers to boost their involvement, building on lessons learned from the “School of husband” project. | • Improve vaccine uptake. | • More sex-disaggregated data.<br>• More fathers are engaged in immunization activities. | • 2026 | • GPEI partners |
| **Surveillance** | • Conduct external polio surveillance reviews to assess surveillance performance, quality and effectiveness. | • Identify strengths, weaknesses, gaps, opportunities for improvement.<br>• Provide evidence-based recommendations to inform national strategies. | • Completed external polio surveillance review. | • December 2025 | • RRT / National Surveillance Working Group (NSWG) |
| | • Maintain surveillance HR capacity.<br>• Provide funds to complete cascade training of subnational focal points on eSURV companion<br>• Develop SOPs for surveillance and outbreak response officers. | • Enhance surveillance system sensitivity.<br>• Improve focal point accountability. | • Training plan, budget developed for 350 DSOs.<br>• SOPs developed to support accountability framework. | • September 2025 | • RRT / NSWG |
| | • Arrange for sample transport to Nigerian polio lab using land transport. | • Improve timeliness of transport from the national level to regional lab. | • Courier services mapped and identified.<br>• Shipment of samples tracked. | • Q4 2025 | • RRT / NSWG |
| **Weak incident management system (IMS)** | • Conduct high-level (external) advocacy for the delegation of full power and authority to the IM of Niger in decision-making and implementation of outbreak response activities. | • Strengthen IMS leadership.<br>• Improve timeliness of response.<br>• Improve technical guidance down to subnational level, document weekly IMS meetings. | • GPEI advocacy mission in collaboration with country representatives of UNICEF and WHO to the MoHs. | • September 2025 | • RRT |
| | • Train (brief) IMS members.<br>• Provide office accommodation for EOC members. | | • Orientation of the top MoH management on IMS. | • Continue 2025–2026 | • RRT |

ACSM = advocacy, communication and social mobilization; DSO = district surveillance officer; EOC = Emergency Operations Centre; eSURV = electronic surveillance (tool); GPEI = Global Polio Eradication Initiative; HR = human resources; IMS = incident management system; IMST = Incident Management Support Team; MoH = Ministry of Health; NCRT = non-compliance resolution team; NSWG = National Surveillance Working Group; RRT = rapid response team; SBC = social and behavioural change; SIA = supplementary immunization activity; SOPs = standard operating procedures; UNICEF = United Nations Children’s Fund; WHO = World Health Organization.

## *Somalia and countries in the Horn of Africa*

Horn of Africa country of **SOMALIA**
Subnational areas include the **south-central core reservoir, key states (Benadir Regional Administration [BRA], Galmudug, Hirshabelle, Jubaland, Southwest) and other high-risk areas (Somaliland and Puntland)**.

**Table B6. Somalia subnational action plans**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **SIA-related challenges** | | | | | |
| **Delayed and/or staggered campaign implementation**<br>• Often due to weak coordination between national and subnational government, and delays in vaccine arrival. | • Bolster multi-partner coordination and high-level engagements (ahead of the campaign).<br>• Achieve full commitment from the government to ensure timely implementation across the country.<br>• Strengthen preparedness tracking and pre-campaign monitoring.<br>• Continue direct shipment of vaccine. | • Ensure timely implementation of campaigns. | • All planned SIAs implemented in 2025 and 2026. | • November 2025 | • Federal Ministry of Health (FMoH), WHO and UNICEF |
| **Microplanning challenges**<br>• Often due to high-risk mobile populations (HRMPs), such as IDPs, nomads, refugees, etc., and weak coordination at the field level during microplan preparations. | • Update training on microplanning, focusing on HRMPs and other key challenges.<br>• Train polio workers on microplanning.<br>• Update mapping of HRMPs.<br>• Collaborate with on-ground partners (UN and non-UN agencies) to develop comprehensive microplans.<br>• Deploy technology (e.g., GIS) to develop and track microplans for better use and improvements. | • Update and improve microplanning. | • Updated, realistic microplans for all districts. | • October 2025 | • FMoH, WHO and UNICEF |
| **Supervision issues**<br>• Often due to complacency, suboptimal monitoring/oversight on weak supervisors. | • Ensure robust ICM to identify weak teams/areas.<br>• Leverage technology (e.g. GIS) in field to inform more evidence-based monitoring.<br>• Identify weak supervisors based on past performance reviews.<br>• Conduct training to build capacity of supervisors.<br>• Conduct supportive supervision. | • Enhance campaign supervision. | • District-wide list of supervisors requiring additional training.<br>• All identified supervisors trained well ahead of the campaign.<br>• Monitoring support provided to all weak supervisors. | • November 2025 | • FMoH and WHO |
| **Variable accountability among South-Central states**<br>• Often due to challenges of insecurity, inaccessibility, hard-to-reach areas and suboptimal government control. | • Strengthen the accountability framework.<br>• Monitor campaign preparedness daily, supported by dashboard.<br>• Assign weak-performing districts to national supervisors for closer oversight.<br>• Ensure greater use of technology (e.g. GIS) in field.<br>• Document issues and corrective actions taken at the district level.<br>• Implement transparent feedback mechanism. | • Strengthen accountability within the programme, focusing on south-central Somalia. | • Stronger accountability mechanisms in every district.<br>• Prompt corrective actions issued by assigned supervisors. | • November 2025 | • FMoH, WHO and UNICEF |

FMoH = Federal Ministry of Health; GIS = geographic information system; HRMP = high-risk mobile population; ICM = intra-campaign monitoring; IDP = internally displaced population; SIA = supplementary immunization activity; UN = United Nations; UNICEF = United Nations Children's Fund; WHO = World Health Organization

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **SIA-related challenges (continued)** | | | | | |
| **Capacity and commitment issues among FLWs**<br>• Often indicated by: persistent problems in some geographies in South-Central Somalia; non-replacement of defaulter FLWs; poor implementation of corrective actions. | • Conduct SIA program review at the district and subdistrict levels to identify weak/defaulter teams and supervisors.<br>• Replace defaulter team members and supervisors with local, female and trained workers.<br>• Encourage supervisors and DFAs to report team's performance issues towards timely interventions during the campaign.<br>• Train weak FLWs.<br>• Ensure proper selection of trained teams before deployment to ensure better results. | • Ensure motivated and trained FLWs as team members and supervisors. | • Parameters set and implemented for replacing poor-performing/defaulter team members and supervisors.<br>• Trained FLWs are fully aware of the actions in case of any default or other persistent issues. | • Q1 2026 | • FMoH, WHO and UNICEF |
| **Suboptimal campaign quality (indicated through failed LQAS)**<br>• Often due to teams not visiting households, refusals, NA children, etc. | • Conduct mop-ups for missed children.<br>• Use real-time data for interventions.<br>• Map transit points, marketplaces and borders for better coverage.<br>• Target SBC activities in low-performing areas.<br>• Remove 'intermediate category' in LQAS results.<br>• Review team performance more closely in all areas with persistent LQAS failures.<br>• Implement accountability measures with teams demonstrating poor performance, including teams that are not visiting households. | • Improve campaign quality. | • LQAS pass rate = >90%. | • November 2025 | • WHO, UNICEF |
| **SBC-related challenges** | | | | | |
| **Continued refusals among ZDC**<br>• Often due to safety concerns or fear of side effects, mistrust in vaccinators, or cultural and religious reasons. | • Increase community involvement.<br>• Strengthen community dialogues, religious leader engagement at the lower level. | • Target root issues of vaccine hesitancy. | • Community engagement sessions conducted. | • December 2025 | • FMoH, SMoH and UNICEF |
| **Data management issues**<br>• Often due to difficulty in obtaining disaggregated SBC data from the district level. | • Develop digital data reporting tools. | • Strengthen SBC data management system. | • SBC disaggregated data available at lower levels. | • December 2025 | • FMoH, SMoH and UNICEF |
| • Weak SBC data archiving; minimal follow-up in post-campaign evaluation reports. | • Provide data storage facilities with registers and tally sheets. | • Streamline data reporting tools. | • Strengthened SBC data archiving system.<br>• Post-campaign completed. | | |
| **Gender**<br>• Lack of sex-disaggregated data of missed children and ZDC.<br>• Limited engagement of fathers in immunization activities. | • Engage community leaders to boost the vaccination of children. | • Empower more men to step in as caregivers. | • A percentage (TBD) of 470 000 under-five children are sex-disaggregated.<br>• More men and community leaders are engaged in polio activities. | • 2025–2026 | • GPEI partners |

DFA = district field assistant; FLW = frontline worker; FMoH = Federal Ministry of Health; GPEI = Global Polio Eradication Initiative; HRMP = high-risk mobile population; LQAS = lot quality assurance sampling; NA = not available; SBC = social and behavioural change; SIA = supplementary immunization activity; SMoH = State Ministry of Health; TBD = to be defined; UN = United Nations; UNICEF = United Nations Children's Fund; WHO = World Health Organization; ZDC = zero-dose children.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Vaccine supply & logistics challenges** | | | | | |
| • High cost of supply transport (air lifting) while operating amidst security constraints. | • Increase resource mobilization.<br>• Negotiate access.<br>• Integrate supply delivery, where possible.<br>• Use road transportation, where possible. | • Ensure uninterrupted supplies. | • Funds available for supply transportation.<br>• Access negotiation framework developed. | • December 2025 | • FMoH, WHO and UNICEF |
| • Difficulty in obtaining post-campaign stock data; delayed destruction of vaccine vials. | • Ensure timely availability of post-campaign stock data to facilitate reverse logistics and destruction of vaccine vials. | • Improve campaign quality and timely stock submission. | • Post-campaign stock data is available. | • December 2025 | • FMoH and UNICEF |
| • Poor vaccine management (VM) practices at lower levels, leading to high vaccine wastage rates. | • Train staff on effective vaccine management.<br>• Engage in supportive supervision. | • Build capacity of the VM staff through training, supervision. | • Vaccine management practices improved. | • Continues 2025–2026 | • FMoH and UNICEF |
| • Difficulty in obtaining tax exemption letter for vaccine delivery. | • Continue high-level advocacy from the government. | • Ensure timely delivery to the last mile. | • Support to fast-track the tax exemption process is assured. | • Continues 2025–2026 | • FMoH and UNICEF |
| **Inaccessibility challenges** | | | | | |
| • Slow progress in access negotiation. | • Collaborate with the existing local NGOs/partners to facilitate access negotiation.<br>• Hold quarterly review meetings for a deep dive on inaccessibility challenges and progress.<br>• Strengthen progress monitoring.<br>• Expand the scope of access negotiations to include supervision, monitoring for SIAs and surveillance operations. | • Gain new access.<br>• Maintain access. | • Access Task Force formed.<br>• Two short interval additional doses (SIADs) implemented for newly accessible children.<br>• Access Negotiation Framework developed. | • Q1 2026 | • FMoH, WHO, UNICEF and Access Task Force |
| • Approx. 470 000 under-five children in inaccessible areas (~200K inaccessible to programme). | • Implement activities with SIADs.<br>• Strategically position transit point vaccinators (TPVs) to ensure coverage of children coming out of the inaccessible areas.<br>• Coordinate with other UN and non-UN agencies implementing humanitarian assistance in such areas for polio plus or ISD. | • Gain new access.<br>• Maintain access. | • Two SIADs implemented for newly accessible children (polio plus). | • Q1 2026 | • FMoH, WHO, UNICEF and Access Task Force |
| **Surveillance challenges** | | | | | |
| • Limited access and insecurity affecting case detection and response quality, as well as supervision of AFP surveillance activities. | • Strengthen village polio volunteers (VPVs) capacity.<br>• Integrate with local NGOs and local faith/traditional healers for greater support. | • Increase operational quality in inaccessible areas. | • Improved enterovirus (EV) detection in AFPs from inaccessible areas. | • December 2025 | • WHO |
| | • Expand access negotiation scope to facilitate surveillance supervision.<br>• Validate AFP cases for quality assurance.<br>• Track samples through various tools like mobile apps, LogTags. | | • Timely case notification and investigation by trained health workers.<br>• All AFPs reported from inaccessible areas validated.<br>• Achieve 100% telephonic AFP validation from inaccessible areas. | • Continue process 2025–2026 | • WHO |
| • A few ES sites with consistently low EV detection. | • Conduct field investigations.<br>• Build team capacity.<br>• Improve monitoring.<br>• Consider moving or closing poor-performing ES sites and opening new sites. | • Improve ES sample quality and consistency.<br>• Ensure appropriateness of ES sites. | • ES surveillance network reviewed and strengthened. | • December 2025 and ongoing in 2026 | • WHO |

AFP = acute flaccid paralysis; ES = environmental surveillance; EV = enterovirus; FMoH = Federal Ministry of Health; ISD = integrated service delivery; NGO = nongovernmental organization; SIA = supplementary immunization activity; SIAD = short interval additional dose; TPV = transit point vaccinator; UN = United Nations; UNICEF = United Nations Children's Fund; VM = vaccine management; VPV = village polio volunteers; WHO = World Health Organization.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Surveillance challenges (continued)** | | | | | |
| • Low surveillance sensitivity levels (NPAFP rate) in a few districts (e.g. Bakool and South Mudug). | • Conduct AFP sensitization training with health facility focal persons, health workers.<br>• Expand AFP reporting network based on Health Facility Contact Analysis. | • Improve AFP detection and timely investigation at facilities in low-performing districts. | • AFP reporting and investigation.<br>• NPAFP rate >3 in at least 80% districts. | • December 2025 | • WHO |
| **Cross-border and cross-cutting challenges** | | | | | |
| • Need for strong cross-border coordination with neighbouring countries. | • Hold regular bilateral meetings and conduct joint planning with Djibouti, Kenya and Ethiopia (update previous plans).<br>• Reach agreements for joint field investigations following evidence of cross-border transmission.<br>• Conduct cross-border meetings, facilitated by the IMST and Regional Outbreak Response Group (RORG). | • Strengthen regional cooperation to ensure coordinated outbreak response in Horn of Africa (HoA). | • At least one (1) cross-border coordination meeting per quarter. | • December 2025 and ongoing in 2026 | • FMoH, WHO and UNICEF in Somalia, and IMST & RORG at regional level |
| • Need for strong government ownership and leadership. | • Improve capacity-building/training of subnational stakeholders.<br>• Strengthen State Polio Coordination Cell (SPCC) operations and track progress at the National Polio Coordination Cell (NPCC).<br>• Develop a progress tracker to monitor participation and quality of SPCC meetings. | • Enhance programme ownership at the district level. | • At least one pre- and one post-campaign review meeting at decentralized levels.<br>• Monitoring tracker developed. | • December 2025 | • FMoH, WHO and UNICEF |
| • Campaigns in the HoA are not synchronized. | • Ensure regular, early cross-sharing of SIA schedule among Djibouti, Ethiopia, Kenya and Somalia to support SIA synchronization.<br>• Build upon joint HoA risk assessment coordination and participation. | • Ensure synchronized campaigns in the HoA. | • Synchronized campaigns between Somalia and neighbouring countries.<br>• Cross-sharing of SIA coverage outputs. | • December 2025 | • FMoH, WHO and UNICEF in Somalia, and IMST & RORG at regional level |
| **EPI-related challenges** | | | | | |
| • High numbers of ZDC. | • Leverage polio microplan to strengthen EPI microplans, particularly by including all areas (villages/towns/settlements) and addressing HRMPs in EPI microplans.<br>• Map locations/pockets with significantly higher numbers of ZDC to monitor towards progress.<br>• Use integrated outreach/mobile services to reach IDPs, nomadic groups and other vulnerable populations in insecure/hard-to-reach areas.<br>• Strengthen SBC and social mobilization activities in areas with pockets of ZDC. | • Identify and vaccinate zero-dose and under-immunized children. | • A validated list/estimate of zero-dose and under-immunized children at district level.<br>• Number and % of zero-dose children vaccinated.<br>• Monthly progress report. | • Q1–Q2 2026 | • FMoH, WHO and UNICEF |
| • Non-financial resource requirements (non-FRR) activities to strengthen routine immunization. | • Implement BCU in south and central states.<br>• Implement two rounds of campaigns in Puntland and one round in Somaliland in 2025. | • Strengthen immunization coverage and equity in planned areas. | • All planned SIAs implemented in 2025. | • December 2025 | • FMoH, WHO and UNICEF |

AFP = acute flaccid paralysis; BCU = Big Catch-Up; EPI = Essential Programme on Immunization; FMoH = Federal Ministry of Health; HoA = Horn of Africa; HRMP = high-risk mobile population; IDP = internally displaced population; IMST = Incident Management Support Team; non-FRR non-financial resource requirements; NPAFP = non-polio acute flaccid paralysis; NPCC = National Polio Coordination Cell; RORG = Regional Outbreak Response Group; SBC = social and behavioural change; SIA = supplementary immunization activity; SPCC = State Polio Coordination Cell; UNICEF = United Nations Children's Fund; WHO = World Health Organization; ZDC = zero-dose children.

Horn of Africa country of **DJIBOUTI**
Subnational areas include Djibouti and Arta regions.

**Table B7. Djibouti subnational action plans**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Political commitment / advocacy** | • Conduct advocacy efforts with the MoH to reach agreement on a response plan for circulating vaccine-derived poliovirus type 1 (cVDPV1). | • Advocate for the implementation of two rounds of bivalent oral polio vaccine (bOPV). | • Implementation of campaigns. | • September–October 2025 | • WR and UNICEF representative |
| **SIA quality issues**<br>• Microplanning<br>• Fund disbursement<br>• HR and other operational issues | • Strengthen microplanning process.<br>• Focus HR training on campaign gaps.<br>• Develop a dashboard for pre-campaign activities. | • Improve campaign quality.<br>• Monitor campaign preparation. | • Updated microplans.<br>• ICM.<br>• Improved campaign implementation indicators. | • August–October 2025 | • EPI coordinator and country office of WHO and UNICEF |
| **Interventions in hard-to-reach areas and high-risk communities** | • Identify influencers from migrant communities.<br>• Select appropriate volunteers from the area.<br>• Strengthen RI among high-risk population groups and migrant population. | • Improve access in high-risk communities.<br>• Build immunity among high-risk population groups. | • List of community influencers per area.<br>• Communication plan per area. | • September – November 2025<br>• Ongoing in 2026 | • Communication and operation teams |
| **Gender**<br>• Limited engagement of fathers in immunization activities.<br>• Lack of meaningful collaboration with CSOs. | • Engage in advocacy efforts with the Imams to boost fathers' engagement.<br>• Train and utilize mobile cinemas through Community Management Centres (CMCs) and women-focused NGOs.<br>• Continue collaboration with National Union of Djiboutian Women, Tadjourah women's association, Obock women's association and the CMC. | • Improve vaccine uptake. | • Number of advocacy activities by imams, the CMC and women-focused NGOs. | • Q3 2025 | • UNICEF |
| **Surveillance interventions** | • Identify and train community informants in high-risk communities.<br>• Train field staff on case investigation to identify the source of the viruses and assess risk of spread. | • Strengthen the surveillance system among migrant communities.<br>• Collect field data for decision-making. | • # of AFP cases reported from migrant communities.<br>• # of field investigation reports. | • September–November 2025<br>• Ongoing in 2026 | • National EPI in coordination with WHO technical team |
| **Cross-border coordination (CBC)** | • Establish and sustain CBC between Djibouti, Somalia and Ethiopia. | • Track population movement and transmission of the virus between countries. | • Annual interministerial meeting.<br>• CBC plans. | • Ongoing 2025–2026 | • Focal point of country support team (CST) and country team (MoH, WHO and UNICEF) |

bOPV = bivalent oral polio vaccine; CBC = cross-border coordination; CMC = Community Management Centre; CSO = civil society organization; CST = country support team; cVDPV1 = circulating vaccine-derived poliovirus type 1; EPI = Essential Programme on Immunization; HR = human resources; ICM = intra-campaign monitoring; MoH = Ministry of Health; NGO = nongovernmental organization; RI = routine immunization; UNICEF = United Nations Children's Fund; WHO = World Health Organization; WR = WHO representative.

Horn of Africa country of **ETHIOPIA**
Subnational areas include **Oromia, Somali, Addis Ababa, Tigray, Amhara and Gambella**.

**Table B8. Ethiopia subnational action plans**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Political situation**<br>• Limited capacity of EOC structure and competing priorities at all administrative levels. | • Strengthen EOC.<br>• GPEI partners to continue advocating to government to uphold polio eradication as a public health priority and to prioritize and continue to support polio eradication efforts. | • Empower EOC for coordination of polio activities.<br>• Implement timely, quality polio activities.<br>• Strengthen coordination among GPEI partners. | • Regular sensitization / advocacy meetings with subnational government officials.<br>• Updated information shared with GPEI partners and government. | • During outbreak and vaccination campaign on regular basis as needed, 2025–2026 | • Ethiopia Public Health Institute (EPHI) / MoH and GPEI partners. |
| **Insecurity / insecurity**<br>• Increased security challenges due to internal conflict that is affecting service delivery. | • Conduct regular mapping of access constraints.<br>• Coordinate with actors/sectors experienced with managing inaccessibility.<br>• Develop special strategies (BCU, integrated life-saving intervention, etc.) to access inaccessible locations.<br>• Review best practices from other countries and adapt strategies to country and local context. | • Increase access in insecure and hard-to-reach areas.<br>• Reduce chronically missed children. | • Insecure areas mapped.<br>• Special strategy developed for insecure areas.<br>• Best practice reviewed and documented. | • Every quarter, 2025–2026 | • WHO and EPHI / MoH |
| **Poor campaign quality**<br>• Late response to cVDPV2 outbreaks; poor quality SIAs in some areas; multiple competing priorities; delay and shortage of funds and vaccines. | • Design context-specific strategies for specific areas.<br>• Develop clear SBC plans to vaccinate missed children including refusals.<br>• GPEI partners provide adequate funds and vaccines on-time. | • Ensure faster interruption of new outbreaks/reinfections.<br>• Ensure detection supports timely responses.<br>• Improve community participation in AFP surveillance.<br>• Ensure prompt delivery of funds and vaccine supply to country and operational levels.<br>• Identify and implement targeted context-driven strategies.<br>• Ensure timely payment to FLWs. | • Timely detection and reporting of cases, including community surveillance.<br>• Adequate number of frontline vaccinators received training to ensure quality vaccination campaigns.<br>• IM and LQAS monitoring. | • Ongoing, based on the outbreak response SOPs, 2025–2026 | • EPHI / MoH<br>• WHO and UNICEF |
| **Population movements**<br>• Mass population movements: highly mobile and nomadic populations; natural and man-made disasters; porous and un-checked borders; and weak cross-border surveillance. | • Mobilize funds for special activities/strategies to reach HRMP.<br>• Map all domestic and international border, noting nomadic communities and transit routes.<br>• Plan and implement targeted special interventions/community mobilization activities.<br>• Ensure functional cross-border surveillance. | • Reduce missed children at the border among communities in transit.<br>• Reduce transmission of the virus along all border communities.<br>• Interrupt cVDPV2 transmission. | • Non-FRR funds mobilized to implement activities. | • TBD | • EPHI/MoH<br>• GPEI partner |

AFP = acute flaccid paralysis; BCU = Big Catch-Up; cVDPV2 = circulating vaccine-derived poliovirus type 2; EOC = Emergency Operations Centre; EPHI = Ethiopia Public Health Institute; FLW = frontline worker; GPEI = Global Polio Eradication Initiative; HRMP = high-risk mobile population; IM = independent monitoring; LQAS = lot quality assurance sampling; MoH = Ministry of Health; non-FRR = non-financial resource requirements; SIA = supplementary immunization activity; SBC = social and behavioural change; SOPs = standard operating procedures; UNICEF = United Nations Children's Fund; WHO = World Health Organization

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **HR**<br>• Many critical areas are without SBC/VM/surveillance officers. Additional HR/surge support is needed. | • Position additional surge team members at subnational level to support.<br>• Build capacity for SBC, VM and surveillance activities.<br>• Ensure timely release of surge funds. | • Improve SIA quality and vaccine management.<br>• Increase community awareness and reduce missed children.<br>• Improve overall quality of AFP surveillance.<br>• Issue contracts to officers in a timely manner. | • Required surge staff deployed on time. | • Every quarter 2025–2026 | • GPEI/HQ/Country Office |
| **Logistics**<br>• Shortage of lab supplies.<br>• Inadequate funds for sample transportation and shipment. | • Continue logistics support to ensure adequate supplies and reagents.<br>• Allocate enough funds for stool and environmental samples transport.<br>• Ensure adequate, timely vaccine and supplies.<br>• Continue providing funds for vaccine/supplies delivery and retrieval in and around insecure areas. | • Ensure timely transportation of samples, processing and feedback for action.<br>• Implement larger-scale campaigns with adequate vaccines and funds.<br>• Ensure vaccines and supplies reach all targeted areas for the campaigns. | • Funds available at implementation areas.<br>• Lab reagents, supplies available at required levels.<br>• Vaccine and other supplies made available on time as per the microplan. | • As per the SOPs and microplan, 2025–2026 | • WHO/UNICEF/HQ |
| **Financial challenges**<br>• Administrative bottlenecks in processing funds.<br>• Late arrival of funds/supplies for the response to country office. | • Simplify the funds release process.<br>• Ensure all logistics and supplies are available via the timely budget release as per the SOPs and microplans. | • Ensure funds are available on time as per the microplan. | • Funds made available on time. | • As and when required based on activities 2025–2026 | • WHO/UNICEF and HQ |
| **Gender**<br>• More ZDC are living with single mothers.<br>• Limited engagement of fathers in vaccination. | • Work with a sample of single mothers in innovative ways to boost vaccine uptake.<br>• Identify and work with fathers as role-models to boost children vaccination. | • Sustain engagement with fathers. | • Number of fathers acting as role-models to boost vaccine uptake. | • 2026 | • UNICEF |

AFP = acute flaccid paralysis; ; GPEI = Global Polio Eradication Initiative; HQ = headquarters; HR = human resources; SBC = social and behavioural change; SIA = supplementary immunization activity; SOPs = standard operating procedures; UNICEF = United Nations Children's Fund; VM = vaccine management; WHO = World Health Organization; ZDC = zero-dose children.

Horn of Africa country of **SUDAN**
Subnational areas include **Kordofan Regions, Khartoum, Darfur and Gezira States**.

**Table B9. Sudan subnational action plans**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Political commitment / advocacy** | • Conduct advocacy efforts to build political commitment for polio eradication with one of the parties in Sudan. | • Sustain political commitment. | • Political support for polio eradication programme.<br>• GPEI letter to the new assigned H/E MoH, PM. | • Continues 2025–2026 | • Leadership of MoH and federal EPI<br>• WHO and UNICEF country and regional offices |
| **Suboptimal SIA quality**<br>Due to issues with:<br>• microplanning<br>• HR<br>• fund disbursement<br>• vaccine supply, cold chain management<br>• community engagement, and<br>• operational issues. | • Update guidelines for bottom-up microplanning.<br>• Retain and recruit qualified HR in hard-to-reach areas.<br>• Conduct ToT and cascade trainings.<br>• Ensure timely fund disbursement to states, localities.<br>• Ensure availability of vaccines, with pre-positioning of supplies in insecure areas.<br>• Implement quick cold chain assessments and address gaps.<br>• Participate in community engagement activities to sustain high demand for vaccination. | • Improve SIA quality. | • ≥95% planned coverage for each round.<br>• ≥95% coverage for PCM. | • Before each round of planned SIAs in 2025 and 2026 | • Federal EPI Manager and country office of WHO and UNICEF |
| **Hard-to-reach areas** | • Integrate officers of polio, WHO Health Emergencies (WHE) and health system as integrated public health officers (IPHOs).<br>• Provide integrated training on polio activities by using opportunities from EPI, WHE and other programmes.<br>• Establish, train and deploy rapid response teams for outbreak investigation and mop-up vaccinations, when needed. | • Increase immunity to prevent further outbreaks.<br>• Enhance AFP surveillance sensitivity. | • Planned coverage for each round = ≥95%.<br>• RI coverage for IPV & OPV = 95% coverage.<br>• NPAFP rate = ≥3. | • Integration of staff by November 2025.<br>• Continue the integration in 2026 | • Federal EPI Manager and country office of WHO and UNICEF |
| **Inaccessibility**<br>• Ensuring the access needed to maintain sensitive surveillance and optimal immunization coverage / equity is difficult in security-compromised localities. | • Negotiate access and humanitarian corridors in conflict-affected states.<br>• Conduct robust mapping of IDP settlements.<br>• Ensure involvement of international and national NGOs (INGOs, NNGOs) and transportation LTAs holders through integrated service delivery of immunization, nutrition and LLINs in high-risk states.<br>• Implement targeted vaccination interventions during campaign and routine immunizations. | • Reach all children with vaccines. | • No children missing vaccination. | • Ongoing 2025–2026 | • Federal EPI Manager and country office of WHO and UNICEF |

AFP = acute flaccid paralysis; EPI = Essential Programme on Immunization; GPEI ; H/E = His Excellency; HR = human resources; IDP = internally displaced population; INGO = international nongovernmental organization; IPHO = integrated public health officers; IPV = inactivated polio vaccine; LLINs = long-lasting insecticidal nets; LTA = long-term agreement; MoH = Ministry of Health; NNGO = national nongovernmental organization; NPAFP = non-polio acute flaccid paralysis; OPV = oral polio vaccine; PCM = post-campaign monitoring; PM = Prime Minister; RI = routine immunization; SIA = supplementary immunization activity; ToT = training of the trainer; UNICEF = United Nations Children's Fund; WHE = WHO Health Emergencies (Programme); WHO = World Health Organization.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Cross-border considerations** | • Sustain CBC between Sudan, Chad and Ethiopia; expand to other neighbouring countries.<br>• Strengthen cross-border vaccination programme (through the establishment of vaccination posts). | • Stop cross-border transmission between Chad and Sudan. | • Planned national annual CBC meeting in January.<br>• Subnational bi-annual CBC meetings in June and December. | • Meetings held three times each year, 2025–2026 | • Focal point of CST and country team (FMoH, WHO and UNICEF) |
| **Gender**<br>• Limited male engagement.<br>• Limited mobility of some mothers.<br>• Health facilities do not provide special spaces for nursing mothers. | • Work with women religious leaders to boost immunization (based on lessons learned from White Nile and Red Sea states).<br>• Utilize mobile cinemas to raise awareness about immunization. | • Boost immunization of children and families. | • Number of sessions organized by Murshidats.<br>• Number of mobile cinemas sessions. | • Each year 2025–2026 | • UNICEF |
| **Surveillance** | • Establish national polio lab in Port Sudan.<br>• Benefit from Early Warning, Alert and Response Network (EWARN) system in Darfur.<br>• Expand network of CBS informants.<br>• Facilitate sample collection and timely transport. | • Strengthen surveillance sensitivity for the early detection of poliovirus. | • Weekly tracking of AFP and ES indicators.<br>• NPAFP rate = ≥3. | • Weekly 2025–2026 | • Central surveillance unit of FMoH and WHO country office |
| **Non-FRR activities to strengthen immunization**<br>• Over 800k U<1 children in Sudan are zero-dose; close to 1.6 million U<5 are zero-dose and/or under-vaccinated. | • Conduct periodic intensification routine immunization (PIRI) campaigns in low-performing localities through support from Gavi.<br>• Implement BCU campaign to strengthen immunization coverage and equity among left-out cohort following COVID-19. | • Strengthen immunization coverage and equity in low-performing geographic areas. | • Technical SIA reports.<br>• PCM data to verify coverage. | • Q4 of 2025–2026.<br>• 2025 for accessible states; 2026 for hard-to-reach areas. | • MoH, WHO, and UNICEF country offices |

AFP = acute flaccid paralysis; BCU = Big Catch-Up; CBC = cross-border coordination; CBS = community-based surveillance; CST = country support team; ES = environmental surveillance ; EWARN = Early Warning, Alert and Response Network; FMoH = Federal Ministry of Health; MoH = Ministry of Health; non-FRR = non-financial resource requirements; NPAFP = non-polio acute flaccid paralysis; PCM = post-campaign monitoring; PIRI = periodic intensification of routine immunization; SIA = supplementary immunization activity; U<1 = under age one; U<5 = under five-years-old; UNICEF = United Nations Children's Fund; WHO = World Health Organization.

Horn of Africa country of **YEMEN**
Subnational areas include the **Northern and Southern Governorates**.

**Table B10. Yemen subnational plans**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Northern Yemen Governorates** | | | | | |
| **Political commitment / advocacy** | • WHO and UNICEF representative both meet with Health Minister of the North. | • Advocate for the Health Emergency Expansion Response plan; (HEER) plan. | • Approval letter from MoH North.<br>• Vaccine requisition form (VRF) and budget breakdown. | • January–June 2026 | • WR and UNICEF representative |
| **nOPV2 campaign not currently approved by government in the north.** | • Engage in advocacy efforts that point to the number of paralyzed children; contrast current context with the excellent response to cVDPV1 and WPV1 outbreaks; encourage EPI outreach.<br>• Modify the HEER1 or BCU methodology to include nOPV2. | • Improve the immunity profile of the community.<br>• Ensure a proper response to the cVDPV2 outbreak. | • Data of the current cVDPV2 outbreak showing the number of paralyzed children.<br>• Data showing past polio outbreaks and effective responses.<br>• Modified strategy to guide on including nOPV2. | • October 2025–June 2026 | • WHO regional and country office<br>• UNICEF country office |
| **Hard-to-reach areas (H2R)** | • Identify H2R areas using: outbreak epidemiological data and EPI outreach monitoring reports.<br>• Identify factors impeding access: geography, community barriers, quality of the plan, selection of the staff, etc. | • Improve access and implement activities in H2R areas. | • List of H2R areas with factors impeding access. | • October 2025–June 3026 | • Government communication and operation teams in coordination with partners |
| **Vaccine hesitancy / refusals**<br>• MoHs have refused access to the community. | • Use data obtained from outreach and BCU activity to identify areas of community refusals. | • Get clarity on community behaviour to improve vaccination coverage. | • Checklist with indirect questions on the community developed with the help of the communication team. | • October 2025–June 2026 | • Communication team in coordination with operation team |
| **Surveillance**<br>• Payment issues. | • Maintain ES collection and resolve the distribution of funds to ES collectors. | • Maintain a sensitive surveillance system. | • SOPs for payment. | • August 2025–June 2026 | • WCO YEM finance |
| • Sample shipment issues. | • Engage in negotiations to regularly send samples to the Oman lab. | • Ship samples on time to get timely results for prompt responses. | • Sample shipment indicators across the region. | • August 2025–June 26 | • WHO regional office and polio lab coordinators |
| • Laboratory data flow. | • Advocacy: Clarify the purpose of direct detection (DD) lab time.<br>• Guideline: Encourage use of the online version of data to facilitate sharing information. | • Foster a better understanding of the pilot DD lab.<br>• Regularly analyze data and respond accordingly. | • Global guidelines on the DD lab.<br>• Presentation comparing the online data system to the old system. | • August 2025–June 2026 | • WHO regional office and polio lab coordinators |
| **Non-FRR (immunity gap)** | • Conduct integrated outreach activities (HEER1).<br>• Achieve BCU targets in children under 5 years. | • Increase immunity profile. | • Approved plan and budget breakdown for the activity. | • August 2025–June 26 | • MoH, WHO, and UNICEF country office |

BCU = Big Catch-Up; cVDPV1 = circulating vaccine-derived poliovirus type 1; cVDPV2 = circulating vaccine-derived poliovirus type 2; DD = direct detection; EPI = Essential Programme on Immunization; ES = environmental surveillance; H2R = hard-to-reach; HEER = Health Emergency Expansion Response plan; HEER1 = Health Emergency Expansion Response plan (version 1); HEER2 = Health Emergency Expansion Response plan (version 2); MoH = Ministry of Health; nOPV2 = novel oral polio vaccine type 2; non-FRR = non-financial resource requirements; SOPs = standard operating procedures; VRF = vaccine requisition form; UNICEF = United Nations Children's Fund; WCO YEM = WHO Country Office for Yemen; WHO = World Health Organization ; WPV1 = wild poliovirus type 1; WR = WHO representative.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Southern Yemen Governorates** | | | | | |
| **Political commitment / advocacy** | • Continue advocacy through the HoA interministerial platform for sustaining surveillance system and improve the quality of campaigns. | • Sustain AFP surveillance and improve SIA performance. | • > 90% coverage achieved in planned campaigns in South Yemen. | • October–November 2025 | • WR and UNICEF representative<br>• IMST |
| **Suboptimal SIA quality**<br>Due to:<br>• microplanning<br>• HR<br>• fund disbursement and<br>• operational issues. | • Identify gaps using poliovirus surveillance data.<br>• Update the microplan in high-risk areas (HRAs).<br>• Recruit local teams.<br>• Work with MoH to speed up their request and distribute the budget.<br>• Develop a dashboard to monitor pre-campaign activities. | • Improve campaign quality.<br>• Distribute funds on time.<br>• Monitor campaign preparation. | • Guidelines on using surveillance data to improve immunity.<br>• Guidelines on developing microplans.<br>• Establish UN monitors with specific checklist and target areas. | • August–October 2025 | • South Yemen WHO, UNICEF and MoH |
| **Hard-to-reach (H2R) areas** | • List H2R areas.<br>• Identify community influencers.<br>• Select appropriate volunteers.<br>• Study community culture and prepare a comprehensive community engagement plan. | • Improve access and implement activities in H2R areas. | • List of community influencers per area.<br>• Report on community characteristics per area.<br>• Communication plan per area. | • August–October 2025 | • Communication and operation teams |
| **Vaccine hesitancy / refusals** | • Differentiate between missed children and community refusals.<br>• Develop a community engagement / influencer engagement plan for the coverage and conversion of refusals. | • Increase vaccination coverage. | • List of reasons for refusals by area.<br>• List of targeted communication activities to address refusals. | • June–July 2025 | • Communication team in coordination with operation team |
| **Gender**<br>• Limited engagement of fathers.<br>• Limited mobility and decision-making power of mothers. | • Maintain father-to-father (F2F) and mother-to-mothers (M2M) approaches in some districts in the south.<br>• Expand the SMS-reminder system to boost vaccine uptake in the south. | • Increase vaccination coverage. | • Number of fathers engaging other fathers about vaccination. | • Q3 and Q4 2025 | • UNICEF |
| **Surveillance**<br>• Limited capacity for field investigations. | • Train field staff on field investigation to identify the source of the viruses and assess the risk of spread. | • Collect appropriate data from the field for decision-making. | • Template for field investigation to be filled by the investigators. | • October 2025–June 2026 | • WHO regional office |
| • Sample shipment issues. | • Improve timeliness of transport. | • Streamline samples shipments to polio lab. | • Shipment of samples once or twice per month. | • August 2025–June 2026 | • WHO regional office and polio lab coordinators |
| **Non-FRR (immunity gap)** | • Conduct integrated outreach activities (IOR).<br>• BCU targets children under 5 years. | • Increase immunity profile. | • More children vaccinated.<br>• Integrated health services provided. | • April 2025–June 2026 | • MoH, WHO, and UNICEF country office |

AFP = acute flaccid paralysis; BCU = Big Catch-Up; F2F = father-to-father; H2R = hard-to-reach; HoA = Horn of Africa; HRA = high-risk area; IMST = Incident Management Support Team; IOR = integrated outreach; M2M = mother-to-mother; MoH = Ministry of Health; non-FRR = non-financial resource requirements; SIA = supplementary immunization activity; SMS = short message service; UN = United Nations; UNICEF = United Nations Children's Fund; WHO = World Health Organization; WR = WHO representative.

## *Southern and central African countries*

Southern and central African country of **DEMOCRATIC REPUBLIC OF THE CONGO**
Subnational areas include **Haut-Katanga, Haut-Lomami, Tanganyika, Tshopo and Kinshasa provinces**.

**Table B11. Democratic Republic of the Congo (DRC) subnational action plans**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Overall** | | | | | |
| **Political situation**<br>With declining aid and the uncertainty of funding, support for all immunization is particularly low. | • Raise domestic funds to support immunization.<br>• Diversify immunization funding.<br>• Efficiently use existing funding by developing strategic immunization plans (Mashako 3.0, biannual poliovirus variant interruption plan). | • Achieve the commitment of political authorities to raise funds for immunization.<br>• Reduce VPD outbreaks. | • Funds mobilized by local government for immunization related to Kinshasa declaration. | • By end of December 2025 | • Provincial government |
| **Insecurity**<br>Rising insecurity in the country, with parts of country inaccessible. | • Map hard-to-reach, security-compromised areas.<br>• Identify NGOs with which activities can be collaboratively implemented.<br>• Deploy special teams to cover these areas during campaigns and routine immunizations.<br>• Implement a geospatial tracking system (GTS) in priority health zones (HZ), including hard-to-reach and security-compromised areas.<br>• Implement polio activities among migrant, internally displaced and border populations through a joint project of the GPEI and IOM. | • Increase vaccine coverage in hard-to-reach and security-compromised areas. | • # of NGOs involved in these activities.<br>• # children vaccinated in hard-to-reach areas and security compromise areas by NGOs and local actors. | • By end of November 2025 | • EPI director and provincial EPI leaders |
| **Campaign quality**<br>Campaigns are generally of good quality if they can be implemented. Remote areas remain expensive to reach. | • Streamline administrative procedures to ensure SIAs are implemented on time.<br>• Conduct comprehensive microplanning.<br>• Leverage community demand for measles vaccination to increase polio immunization coverage through integrated campaigns. | • Implement all campaigns within 14 days upon confirmation of variant poliovirus.<br>• Increase vaccine coverage in remote areas. | • # of campaigns organized in 14 days upon confirmation of variant poliovirus.<br>• 95% children in remote areas vaccinated (validated through IM/LQAS). | • By the end of 2025 | • EOC coordinator |
| **Core reservoir: Haut-Katanga, Haut-Lomami, Tanganyika provinces** | | | | | |
| **Political situation**<br>• Extensive cross-border population movements.<br>• Far southeast of DRC capital Kinshasa. | • Engage local government authorities.<br>• Decentralize decision-making.<br>• Ensure intersectoral cooperation.<br>• Promote cross-border coordination during and between SIAs. | • Ensure timely decision-making and implementation of polio activities.<br>• Involve other sectors in addition to health that have proven to be effective in implementation of activities and obtaining results. | • # of cross-border meetings organized by local government involvement.<br>• Name of other sectors involved in cross-border activities. | • October 2025 | • EPI responsible |
| **Inaccessibility**<br>Parts of the country are inaccessible during the rainy season. Likely to impact operations across all three provinces. | • Assess and map accessibility for all three provinces for SIAs and other polio activities such as surveillance. | • Access all locations. | • # of inaccessible areas mapped and reached by polio activities. | • During each campaign and in-between campaigns, 2025–2026 | • EOC and GPEI |

EOC = Emergency Operations Centre; EPI = Essential Programme on Immunization; GPEI = Global Polio Eradication Initiative; GTS = geospatial tracking system; HZ = health zone; IM = independent monitoring; IOM = International Organization for Migration; LQAS = lot quality assurance sampling; NGO = nongovernmental organization; SIA = supplementary immunization activity; VPD = vaccine-preventable disease.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Core reservoir: Haut-Katanga, Haut-Lomami, Tanganyika provinces (continued)** | | | | | |
| **Campaign quality**<br>• Microplanning and microplans require improvement.<br>• Non-compliance.<br>• Digital technologies yet to be fully utilized. | • Develop quality improvement plans (QIPs); ensure high-quality implementation with M&E to monitor impact.<br>• Replicate microplanning enhancements from Tanganyika in Haut-Katanga and Haut-Lomami.<br>• Ensure proper management of refusals.<br>• Implement digital technologies such as GTS, as infrastructure is available. | • Achieve realistic target population in all locations of Tanganyika by performing walkthrough microplanning and enumeration.<br>• Eliminate or minimize non-compliance.<br>• Enhance monitoring and supervision of pre- and intra-campaign activities. | • # of provinces with QIP available and implemented properly.<br>• Data of microplanning and use for needs estimation.<br>• % of refusals addressed per campaign.<br>• % of missed children due to refusal.<br>• % of areas covered by GTS during campaign. | • Pre and post campaign 2025–2026 | • Provincial coordination |
| **Epidemiology**<br>Co-circulation of types 2 and 1. | • Co-administer nOPV2 and bOPV with children under five (5) years of age. | • Stop circulation and transmission within three provinces. Mitigate escape risks within and beyond country border. | • # of co administration campaign organized<br>• 95% of children vaccinated (IM & LQAS). | • By the end of year | • EOC / GPEI |
| **Surveillance**<br>Active AFP search done largely in campaigns may lead to 'black spots' | • Rationalize ES.<br>• Complete DD pilot, institutionalize and implement in-country. | • Ensure timely detection and investigation of detections. | • # AFP and ES cases notified during polio cases.<br>• NPAFP rate. | • SIAs organized during the 2nd Semester | • EOC / EPI / WHO |
| **HR**<br>Delays in hiring surge staff at both WHO and UNICEF. | • Ensure timely deployment of HR surge staff with aligned rates. | • Align HR surge with campaign schedule to ensure right staff in the right place. | • HR roster. | • By end of August 2025 | • UNICEF, WHO |
| **Financial challenges**<br>• Delays in paying frontline staff.<br>• Delays in getting payments out for previous campaigns. | • Clear all payment disputes with actors from previous campaigns in the country five (5) weeks before the campaign starts up.<br>• Monitor and track the deployment of funds to the lowest admin level. | • Track weekly payment of FLWs. | • Unique frontline staff database for all partners.<br>• 0% nonpayment prior to upcoming SIAs. | • Before each campaign, 2025–2026 | • UNICEF, WHO |
| **High-risk areas: Tshopo, Kinshasa provinces** | | | | | |
| **Political situation**<br>• Frequent mass population movement in-country and cross-border into Brazzaville and other areas in Congo Republic.<br>• Large populous capital. | • Map population movements and routes.<br>• Facilitate intersectoral cooperation.<br>• Promote cross-border coordination; plan and implement vaccination at border crossing ports and points. | • Involve other sectors (in addition to health) that have been proven to be effective in implementation of activities and obtaining results. | • Microplan.<br>• Risk assessment. | • Two (2) weeks before campaign<br>• Q3 2025 | • WHO, UNICEF, EOC |
| **Insecurity / inaccessibility**<br>Rising insecurity; parts of country inaccessible during rainy season. | • Assess and map accessibility for SIAs and other polio activities such as surveillance. | • Access all locations. | • Microplan. | • RI and before campaign, 2025–2026 | • EOC |

AFP = acute flaccid paralysis; bOPV = bivalent oral polio vaccine; DD = direct detection; EOC = Emergency Operations Centre; EPI = Essential Programme on Immunization; ES = environmental surveillance; FLW = frontline worker; GPEI = Global Polio Eradication Initiative; GTS = geospatial tracking system; HR = human resources; IM = independent monitoring; LQAS = lot quality assurance sampling; M&E = monitoring and evaluation; nOPV2 = novel oral polio vaccine type 2; NPAFP = non-polio acute flaccid paralysis; QIP = quality improvement plan; RI = routine immunization; SIA = supplementary immunization activity; UNICEF = United Nations Children's Fund; WHO = World Health Organization.

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **High-risk areas: Tshopo, Kinshasa provinces (continued)** | | | | | |
| **Campaign quality**<br>• Campaigns are generally of good quality if they can be implemented.<br>• Microplanning and microplans require improvement.<br>• Non-compliance.<br>• Digital technologies yet to be fully utilized. | • Reinforce monitoring of QIP implementation and evaluation of impact.<br>• Replicate microplanning enhancement in Tanganyika in Haut Katanga.<br>• Ensure proper management of refusals.<br>• Implement digital technologies such as GTS, as infrastructure is available via ODK. | • Achieve realistic target population in all locations of Tshopo and Kinshasa by performing walkthrough microplanning and enumeration (replicate approaches used in Tanganyika).<br>• Eliminate or minimize non-compliance.<br>• Enhance monitoring and supervision of pre- and intra-campaign activities. | • Data of microplanning and use for needs estimation.<br>• % of refusals managed during campaign.<br>• Date of supervisor deployment at all levels.<br>• % of missed children due to refusal.<br>• % of areas covered by GTS during campaign.<br>• IM & LQAS conducted.<br>• List of FLWs involved in the campaign, as planning, and publicly posted. | • Before, during and after campaigns, 2025–2026 | • EOC |
| **Epidemiology**<br>Co-circulation of types 2 and 1. | • Co-administer nOPV2 and bOPV. | • Stop circulation and transmission within the two provinces. Mitigate escape risks within the country and cross-border areas. | • 95% of kids vaccinated with nOPV2 & bOPV (validated by IM & LQAS). | • During SIAs | • EOC |
| **Gender**<br>• Majority of fathers are the decision-makers with regards to vaccination. | • Plan more engagement activities for fathers.<br>• Adapt vaccination time to the farmers 'work and agenda increase advocacy efforts that target young parents especially mothers. | • Stop circulation and transmission within the two provinces. | • Vaccination coverage increased. | • Q4 2025 | • UNICEF |
| **Surveillance**<br>• Active AFP search done largely in campaigns may lead to ‘black spots’. | • Enhance polio surveillance.<br>• Rationalize ES.<br>• Complete DD pilot, institutionalize and implement DD in-country. | • Ensure timely detection and investigation of detections. | • NPAFP rate.<br>• # AFP and ES cases notified during polio cases. | • SIAs organized during the second semester | • EOC / EPI / WHO |
| **HR**<br>Delays in hiring surge staff at both WHO and UNICEF. | • Ensure timely deployment of HR surge staff with aligned rates. | • Align HR surge with campaign schedule to ensure right staff in the right place. | • HR roster. | • End of August 2025 | • UNICEF, WHO |
| **Financial**<br>• Delays in paying frontline staff.<br>• Delays in getting payments out for previous campaigns. | • Clear all payment disputes with actors from previous campaigns in the country five (5) weeks before the campaign starts up.<br>• Monitor and track the deployment of funds to the lowest admin level. | • Motivate frontline staff to perform duties and fulfil the requirements as per SOPs through timely payment. | • Unique staff database. | • End of August 2025 | • EOC |

bOPV = bivalent oral polio vaccine; DD = direct detection; EOC = Emergency Operations Centre; ES = environmental surveillance; FLW = frontline worker; GTS = geospatial tracking system; HR = human resources; IM = independent monitoring; LQAS = lot quality assurance sampling; nOPV2 = novel oral polio vaccine type 2; NPAFP = non-polio acute flaccid paralysis; ODK = open data kit; QIP = quality improvement plan; SIA = supplementary immunization activity; SOPs = standard operating procedures; UNICEF = United Nations Children’s Fund; WHO = World Health Organization.

# *Appendix B1. District-level surveillance plans for Pakistan*

## Table B1.1. Lahore district plans

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| Notification within seven (7) days < 80% (currently 79%). | • Expand existing AFP surveillance network based on an analysis of health-seeking behaviour (HSB) of inadequate cases, missed from first contact and late-notified cases. | • Achieve the required indicator. | • >80% AFP case notification within seven (7) days. | • January 2026 | • DSOs/IOs/ACs |
| | • Improve the quality and quantity of active site visits. | | | • August 2025–April 2026 | • DSOs/IOs/DSCs |
| | • Conduct refresher trainings of HCPs, formal and informal. | | | | • DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs |
| | • Conduct refresher trainings of surveillance staff: DSOs, IOs, DSCs/HBSOs, ACs. | | | | • Provincial Surveillance Unit |
| Reporting by first and second contact is < 90% (currently 78%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network. | • Improve AFP notification by first and second contact. | • >90% notification from first and second contact. | • August 2025–April 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs |
| | • Reprioritize existing surveillance network. Focus on rapidly growing hospitals and clinics, especially in facilities with high turnover, and facilities identified in HSB analysis. | | | • January 2026 | • DSOs/IOs/ACs |
| Non-polio enterovirus (NPEV) isolation at the district level is < 10% (currently 8%). | • Ensure provision of frozen ice packs in all tehsils.<br>• Conduct refresher trainings of DSVs, ASVs, vaccinators, lady health workers (LHWs) and focal persons of hospitals.<br>• Enhance monitoring of stool samples and upload assigned form on NEOC app. | • Achieve the required indicator for NPEV isolation. | • 10% NPEV isolation. | • August 2025–April 2026 | • Government<br>• DSOs/IOs/DSCs<br>• DSOs/IOs/ACs |
| Low reporting from community. | • Reinforce reporting by TSA at the UC level.<br>• Identify and prioritize CIs based on risk assessment: slums, riverine areas, silent and blind spot UCs. | • Strengthen CBS and reporting. | • Reprioritization of CIs.<br>• Enhanced CI reporting sensitivity. | • August 2025–April 2026 | • DSOs/IOs/DSCs<br>• TSAs/TPOs/DSOs/IOs |
| | • Hold regular coordination meetings of TSAs with CIs.<br>• Maintain a laser focus on MMP/slum surveillance. | | | | • TSAs/TPOs |
| | • Ensure supervision of TSAs activities within community.<br>• Involve medical associations.<br>• Promote regular sensitization through social media. | | | | • DSOs |

AC = area coordinator; AFP = acute flaccid paralysis; ASV = assistant superintendent vaccinator; CBS = community-based surveillance; CI = community informant; DSC = district surveillance coordinator; DSO = district surveillance officer; DSV = district superintendent vaccinator; HCP = health-care provider; HSB = health-seeking behaviour; HBSO = health facility-based surveillance officer; IO = immunization officer; LHW = lady health worker; MMP = migrant and mobile population; NEOC = National Emergency Operations Centre; NPEV = non-polio enterovirus; TSA = tehsil surveillance assistant; TPO = tehsil polio officer; UC = Union Council; UCPO = Union Council polio officer; UCSP = Union Council support person.

## Table B1.2. Rawalpindi district plans

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| AFP case reporting by first and second contacts < 90% (currently 78%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network. | • Improve AFP notification by first and second contact. | • >90% notification from first and second contact. | • August 2025–April 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs |
| | • Reprioritize existing AFP surveillance network. | | | • January 2026 | • DSOs/IOs/Acs |
| | • Focus on rapidly growing hospitals and clinics, especially with high turnover and those identified in HSB analysis. | | | • August 2025–April 2026 | • DSOs/IOs/ACs |
| | • Conduct refresher trainings for AFP Surveillance for DSOs, IOs, DSCs/HBSOs, ACs. | | | | • Provincial Surveillance Unit |
| Two (2) silent Union Councils. | • Scan records in all health facilities that are part of the existing surveillance system | • Ensure timely identification and reporting of AFP cases. | • Ensure AFP case reporting from identified silent UCs. | • August 2025–April 2026 | • DSOs/IOs/DSCs |
| | • Conduct active case searches in slums and among vulnerable populations. | | | | • DSOs/IOs/DSCs/TSAs/UCPOs/UCSPs |
| | • Re-sensitize CIs and HCPs, both formal and informal. | | | | • DSOs/IOs/DSCs/TSAs/UCPOs/UCSPs |
| | • Conduct periodic field surveillance reviews. | | | • March–June 2026 | • Provincial/Federal Surveillance Unit |
| NPEV isolation below 10% (currently 5.5%). | • Ensure provision of frozen ice packs in all tehsils.<br>• Conduct refresher trainings for DSVs, ASVs, vaccinators, LHWs and hospital focal persons.<br>• Enhance monitoring of stool samples and upload assigned form on NEOC app. | • Achieve the required indictor for NPEV isolation. | • 10% NPEV isolation. | • August 2025–April 2026 | • Government<br>• DSOs/IOs/DSCs<br>• DSOs/IOs/ACs |

AC = area coordinator; AFP = acute flaccid paralysis; ASV = assistant superintendent vaccinator; CI = community informant; DSC = district surveillance coordinator; DSO = district surveillance officer; DSV = district superintendent vaccinator; HCP = health-care provider; HSB = health-seeking behaviour; HSBO = health facility-based surveillance officer; IO = immunization officer; LHW = lady health worker; NEOC = National Emergency Operations Centre; NPEV = non-polio enterovirus; UC = Union Council; USPO = Union Council polio officer; UCSP = Union Council support person.

## Table B1.3. Faisalabad district plans

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| NPEV isolation below 10% (currently 6.8%). | • Ensure provision of frozen ice packs in all tehsils. | • Achieve the required indicator for NPEV isolation. | • 10% NPEV isolation. | • August 2025–April 2026 | • Government |
| | • Conduct refresher trainings of DSVs, ASVs, vaccinators, LHWs and hospital focal persons. | | | | • DSOs/IOs/DSCs |
| | • Enhance monitoring of stool samples and upload assigned form on NEOC app. | | | | • DSOs/IOs/ACs |
| Eight (8) silent UCs. | • Scan records in all health facilities that are part of the existing surveillance system | • Ensure timely identification and reporting of AFP cases | • AFP case reporting from identified silent UCs. | • August 2025–April 2026 | • DSOs/IOs/DSCs |
| | • Conduct an active case search in slums and among MMPs and other underserved populations. | | | | • DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs |
| | • Re-sensitize CIs and HCPs, both formal and informal. | | | | • DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs |
| | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network in silent UCs. | | | | • TSAs/TPOs/DSOs/Ios |
| | • Conduct periodic field surveillance reviews. | | | • March–June 2026 | • Provincial/Federal Surveillance Unit |
| AFP case reporting by first and second contact < 90% (currently 80%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network.<br>• Reprioritize the existing surveillance network.<br>• Focus on rapidly growing hospitals and clinics with high turnover and facilities identified in HSB analysis.<br>• Refresher Trainings for AFP Surveillance for DSOs, IOs, DSCs/HBSOs, Acs | • Improve AFP notification by first and second contact | • >90% notification from first and second contact. | • August 2025–April 2026<br>• January 2026<br>• August 2025–April 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs<br>• DSOs/IOs/Acs<br>• DSOs/IOs/ACs<br>• Provincial Surveillance Unit |

AC = area coordinator; AFP = acute flaccid paralysis; ASV = assistant superintendent vaccinator; CI = community informant; DSC = district surveillance coordinator; DSO = district surveillance officer; DSV = district superintendent vaccinator; HCP = health-care provider; HSB = health-seeking behaviour; HSBO = health facility-based surveillance officer; IO = immunization officer; LHW = lady health worker; MMP = migrant and mobile population; NEOC = National Emergency Operations Centre; NPEV = non-polio enterovirus; TPO = tehsil polio officer; TSA = tehsil surveillance assistant; UC = Union Council; UCPO = Union Council polio officer; UCSP = Union Council support person.

## Table B1.3. Central Pakistan district plans

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **1. Rajanpur district** | | | | | |
| AFP case reporting by first and second contact < 90% (currently 88%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network. | • Improve AFP notification by first and second contact. | • >90% notification from first and second contact. | • August 2025–April 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/ UCPOs/UCSPs |
| | • Reprioritize existing surveillance network. | | | • January 2026 | • DSOs/IOs/Acs |
| | • Conduct refresher trainings of HCPs, formal and Informal. | | | • August 2025–April 2026 | • DSOs/IOs/ACs |
| | • Improve quality of active site visits. | | | | • DSOs/IOs/DSCs |
| | • Conduct refresher trainings in AFP surveillance for DSOs, IOs, DSCs/HBSOs, ACs. | | | | • Provincial Surveillance Unit |
| Challenges in riverine UCs and five (5) security-compromised UCs. (To date: 27 cases reported from security-compromised UCs.) | • Identify, prioritize CIs based on risk assessment. | • Ensure sensitivity of AFP surveillance in vulnerable UCs. Identify effective CIs, HCPs along informal routes. | • Sensitive AFP reporting from vulnerable UCs. | • June 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/ UCPOs/UCSPs |
| | • Ensure a laser focus on UCs with interprovincial boundaries, positive orphan ES and human case(s). | | | | • DSOs/IOs/DSCs/TSAs/TPOs/ UCPOs/UCSPs |
| | • Hold coordination meetings with CIs in vulnerable areas. | | | | • TSAs/TPOs |
| | • Ensure supportive supervision of surveillance activities. | | | | • ACs |
| | • Conduct periodic field surveillance reviews. | | | | • Provincial/Federal Surveillance Unit |
| **2. Dera Ghazi Khan district** | | | | | |
| AFP case reporting by first and second contact < 90% (currently 87%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network. | • Improve AFP notification by first and second contact. | • >90% notification from first and second contact. | • August 2025–April 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/ UCPOs/UCSPs |
| | • Reprioritize the existing surveillance network. | | | • January 2026 | • DSOs/IOs/Acs |
| | • Conduct refresher trainings of HCPs, formal and Informal. | | | • August 2025–April 2026 | • DSOs/IOs/ACs |
| | • Conduct refresher trainings in AFP surveillance for DSOs, IOs, DSCs/HBSOs, ACs. | | | | • Provincial Surveillance Unit |
| Challenges in riverine UCs, one (1) security-compromised UC, and tribal UCs. (To date: one case reported from security-compromised UC, 15 cases from tribal UCs.) | • Identify, prioritize CIs based on risk assessment. | • Ensure sensitivity of AFP surveillance in vulnerable UCs. Identify effective CIs, HCPs along informal routes. | • Sensitive AFP reporting from vulnerable UCs. | • August 2025–April 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/ UCPOs/UCSPs |
| | • Ensure a laser focus on UCs with interprovincial boundaries, positive ES and human case(s). | | | | • DSOs/IOs/DSCs/TSAs/TPOs/ UCPOs/UCSPs |
| | • Hold coordination meetings with CIs in vulnerable areas. | | | | • TSAs/TPOs |
| | • Ensure supportive supervision of surveillance activities. | | | • June 2026 | • ACs |
| | • Conduct periodic field surveillance reviews. | | | • March–June 2026 | • Provincial/Federal Surveillance Unit |
| **3. Rahim Yar Khan district** | | | | | |
| AFP case reporting by first and second contact < 90% (currently 86%). *(Other KPIs: notification 67%, stool adequacy 67%, NPEV isolation 6%.)* | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network. | • Improve AFP notification by first and second contact. | • >90% notification from first and second contact. | • August 2025–April 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/ UCPOs/UCSPs |
| | • Reprioritize existing surveillance network. | | | • January 2026 | • DSOs/IOs/Acs |
| | • Conduct refresher trainings of HCPs, formal and Informal. | | | • August 2025–April 2026 | • DSOs/IOs/ACs |
| | • Conduct refresher trainings in AFP surveillance for DSOs, IOs, DSCs/HBSOs, ACs. | | | | • Provincial Surveillance Unit |
| Challenges in riverine UCs and four (4) security-compromised UCs. (One case reported from security-compromised UC.) | • Identify, prioritize CIs based on risk assessment. | • Ensure sensitivity of AFP surveillance in vulnerable UCs. Identify effective CIs, HCPs along informal routes. | • Indicators in security-compromised UCs. | • August 2025–April 2026 | • DSOs/IOs/DSCs/TPOs/UCSPs |
| | • Ensure a laser focus on UCs with interprovincial boundaries, positive orphan ES and human case(s). | | | | • DSOs/IOs/DSCs/TPOs/UCSPs |
| | • Hold regular meetings with CIs in vulnerable areas. | | | | • TPOs/UCSPs |
| | • Ensure supportive supervision of surveillance activities. | | • Sensitive AFP reporting from vulnerable UCs. | • June 2026 | • ACs |
| | • Conduct periodic field surveillance reviews. | | | • March–June 2026 | • Provincial/Federal surveillance unit |

AC = area coordinator; AFP = acute flaccid paralysis; CI = community informant; DSC = district surveillance coordinator; DSO = district surveillance officer; ES = environmental surveillance; HBSO = health facility-based surveillance officer; HCP = health-care provider; IO = immunization officer; KPI = key performance indicator; NPEV = non-polio enterovirus; TPO = tehsil polio officer; TSA = tehsil surveillance assistant; UC = Union Council; UCPO = Union Council polio officer; UCSP = Union Council support person.

**Table B1.3. Central Pakistan district plans (continued)**

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **4. Bahawalpur district** | | | | | |
| NPEV isolation below 10% (currently at 9%). | • Ensure provision of frozen ice packs in all tehsils.<br>• Conduct refresher trainings of DSVs, ASVs, vaccinators, LHWs and hospital focal persons.<br>• Enhance monitoring of stool samples and upload assigned form on NEOC app. | • Achieve the required indicator for NPEV isolation. | • 10% NPEV isolation | • August 2025–April 2026 | • Government<br>• DSOs/IOs/DSCs<br>• DSOs/IOs/ACs |
| **5. Multan district** | | | | | |
| AFP case reporting by first and second contact < 90% (currently 87%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network.<br>• Reprioritize existing surveillance network.<br>• Conduct refresher trainings of HCPs, formal and Informal.<br>• Conduct refresher trainings in AFP Surveillance for DSOs, IOs, DSCs/HBSOs, ACs. | • Improve AFP notification by first and second contact. | • >90% notification from first and second contact. | • August 2025–April 2026<br>• January 2026<br>• August 2025–April 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs<br>• DSOs/IOs/Acs<br>• DSOs/IOs/ACs<br>• Provincial Surveillance Unit |
| NPEV isolation below 10% (currently at 9%). | • Ensure provision of frozen ice packs in all tehsils.<br>• Conduct refresher trainings of DSVs, ASVs, vaccinators, LHWs and hospital focal persons.<br>• Enhance monitoring of stool samples and upload assigned form on NEOC app. | • Achieve the required indicator for NPEV isolation. | • 10% NPEV isolation. | • August 2025–April 2026 | • Government<br>• DSOs/IOs/DSCs<br>• DSOs/IOs/ACs |
| One (1) silent UC. | • Scan records at health facilities in surveillance system.<br>• Conduct active case searches in Slums and with MMPs and other underserved populations.<br>• Resensitize CIs and HCPs, formal and informal.<br>• Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network in silent UCs.<br>• Conduct periodic field surveillance reviews. | • Ensure timely identification and reporting of AFP cases | • AFP case reporting from identified Silent UCs. | • August 2025–April 2026<br>• March–June 2026 | • DSOs/IOs/DSCs<br>• DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs<br>• DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs<br>• TSAs/TPOs/DSOs/Ios<br>• Provincial/Federal Surveillance Unit |
| **6. Muzaffargarh district** | | | | | |
| AFP case reporting by first and second contact < 90% (currently 86%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network.<br>• Reprioritize existing surveillance network.<br>• Conduct refresher trainings of HCPs, formal and Informal.<br>• Conduct refresher trainings in AFP surveillance for DSOs, IOs, DSCs/HBSOs, ACs. | • Improve AFP notification by first and second contact. | • >90% notification from first and second contact. | • August 2025–April 2026<br>• January 2026<br>• August 2025–April 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs<br>• DSOs/IOs/Acs<br>• DSOs/IOs/ACs<br>• Provincial Surveillance Unit |

AC = area coordinator; AFP = acute flaccid paralysis; ASV = assistant superintendent vaccinator; CI = community informant; DSC = district surveillance coordinator; DSO = district surveillance officer; DSV = district superintendent vaccinator; HCP = health-care provider; HBSO = health facility-based surveillance officer; ES = environmental surveillance; IO = immunization officer; LHW = lady health worker; MMP = migrant and mobile populations; NEOC = National Emergency Operations Centre; NPEV = non-polio enterovirus; TPO = tehsil polio officer; TSA = tehsil surveillance assistant; UC = Union Council; UCPO = Union Council polio officer; UCSP = Union Council support person.

## Table B1.4. Balochistan district plans

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Quetta block** | | | | | |
| **1a. Quetta** | | | | | |
| Notification within seven (7) days < 80%. | • Improve quality and compliance of active visits.<br>• Conduct refresher trainings of HCPs, formal and informal.<br>• Conduct refresher trainings on AFP surveillance of staff: AC, DSO, DSC. | • Achieve minimum of 90% visit compliance. | • >80% AFP case notification within seven (7) days. | • December 2025 | • AC//DSO/DSC |
| AFP case reporting by first and second contact < 90% (currently 86%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network.<br>• Identify and sensitize informal HCPs outside the network who missed AFP cases. | • Improve AFP case reporting on first contact. | • 90% of cases reported by the second contact. | • December 2025 | • AC//DSO/DSC |
| **1b. Chaman** | | | | | |
| AFP case reporting by first and second contact < 90% (currently 84%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network.<br>• Identify and sensitize informal HCPs outside the network who missed AFP cases. | • Improve AFP case reporting on first contact. | • 90% of cases reported by the second contact. | • December 2025 | • AC//DSO/DSC |
| Blind spots. | • Engage and train key CIs. | • Develop a sensitive surveillance network in hard-to-reach areas. | • Decrease in numbers of silent UCs. | • January 2026 | • TSAs/TPOs |
| **1c. Killa Abdullah** | | | | | |
| NPEV isolation below 10% (currently at 0%). | • Ensure validation of AFP cases by staff via NEOC app.<br>• Conduct an analysis for action(s) to be taken due to any breached RCC case. | • Achieve a system for validating and tracking all shipments. | • 10% NPEV isolation. | • December 2025 | • AC//DSO/DSC |
| **Central Pakistan** | | | | | |
| **Musakhail** | | | | | |
| Delayed detection and stool adequacy <80%. | • Conduct refresher trainings on AFP surveillance of staff: AC, DSO, DSC.<br>• Ensure supervisory support to staff carrying out surveillance activities.<br>• Improve quality and compliance of active visits.<br>• Conduct refresher trainings of HCPs, formal and informal. | • Achieve minimum of 90% visits compliance. | • >80% AFP case notification within seven (7) days.<br>• >80% stool adequacy. | • December 2025 | • Provincial office / DC/DSO/DSC |
| AFP case reporting by first and second contact < 90% (currently 86%) | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network.<br>• Identify and sensitize informal HCPs outside the network who missed AFP cases. | • Improve AFP case reporting on first contact. | • 90% of cases reported by the second contact. | • December 2025 | • AC//DSO/DSC |
| **Bordering districts (other than Quetta)** | | | | | |
| **Killa Saifullah** | | | | | |
| Notification within seven (7) days < 80%. | • Conduct refresher trainings on AFP surveillance of staff: AC, DSO, DSC.<br>• Ensure supervisory support to staff carrying out surveillance activities.<br>• Improve quality and compliance of active visits.<br>• Conduct refresher trainings of HCPs, formal and informal. | • Achieve minimum of 90% visit compliance. | • >80% AFP case notification within seven (7) days.<br>• >80% stool adequacy. | • December 2025 | • Provincial office / DC/DSO/DSC |
| AFP case reporting by first and second contact < 90% (currently 71%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network.<br>• Identify and sensitize informal HCPs outside the network who missed AFP cases. | • Improve AFP case reporting on first contact. | • 90% of cases reported by the second contact. | • December 2025 | • AC//DSO/DSC |

AC = area coordinator; AFP = acute flaccid paralysis; CI = community informant; DC = deputy commissioner; DSC = district surveillance coordinator; DSO = district surveillance officer; HCP = health-care provider; NEOC = National Emergency Operations Centre; NPEV = non-polio enterovirus; RCC = Regional Certification Commission; TPO = tehsil polio officer; TSA = tehsil surveillance assistant; UC = Union Council/

## Table B1.4. Balochistan district plans (continued)

| Critical challenge | Solution / activity | Objectives | Deliverables | Timelines | Responsibility |
|---|---|---|---|---|---|
| **Bordering districts (other than Quetta) - continued** | | | | | |
| **Zhob** | | | | | |
| Stool adequacy <80%. | • Investigate all inadequate cases.<br>• Ensure all samples are properly tracked.<br>• Improve quality and compliance of active visits.<br>• Conduct refresher trainings of HCPs, formal and informal. | • Achieve timely detection of cases and proper sample management. | • 80% AFP cases with adequate stools. | • December 2025 | • AC/DSO/DSC |
| AFP case reporting by first and second contact < 90% (currently 78%). | • Conduct orientations of formal HCPs and informal HCPs outside the AFP reporting network.<br>• Reprioritize existing surveillance network.<br>• Focus on rapidly growing hospitals and clinics, especially those with high turnover, and facilities identified in HSB analysis. | • Improve AFP notification by first and second contact. | • >90% notification from first and second contact. | • January 2026 | • DSOs/IOs/DSCs/TSAs/TPOs/UCPOs/UCSPs<br>• DSOs/IOs/Acs |
| **Chaghai and Noshki** | | | | | |
| NPEV isolation below 10%. | • Validate AFP cases.<br>• Conduct an analysis for action(s) to be taken due to any breached RCC case.<br>• Investigate to find out the reasons for low NPEV isolation and take actions accordingly. | • Achieve a system for validating and tracking all shipments. | • 10% NPEV isolation. | • December 2025 | • AC//DSO/DSC |

AC = area coordinator; AFP = acute flaccid paralysis; DSC = district surveillance coordinator; DSO = district surveillance officer; HCP = health-care provider; HSB = health-seeking behaviour; IO = immunization officer; NPEV = non-polio enterovirus; RCC = Regional Certification Commission; TPO = tehsil polio officer; TSA = tehsil surveillance assistant; UC = Union Council; UCPO = Union Council polio officer; UCSP = Union Council support person.