



NATIONAL EMERGENCY ACTION PLAN

For Polio Eradication

2015 – 2016

Quarterly Review

November 2015

National Emergency Operations Centre, Islamabad, Pakistan



صحت محافظ





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We are grateful to the millions of Pakistani families who protected their children and the children of the world by participating in the monthly polio vaccination campaigns conducted in the past three months. We are also grateful to the tens of thousands of Frontline Workers – the true heroes of polio – who every month help protect the children of Pakistan by leading the eradication effort from the front. This report is produced by the National Polio Emergency Operations Centre (EOC), Islamabad, Pakistan. The information presented is based on the most recent and best available data. The EOC will continually update and, where necessary, modify the analysis and data provided, in order to ensure the most current and accurate view is available to all.

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Abbreviations

AFP	Acute flaccid paralysis
AIC	Area in-charge
AOW	Area of Work
BMGF	Bill and Melinda Gates Foundation
bOPV	Bivalent live oral poliovirus vaccine
CCPV	Continuous community-protected vaccination
CDC	Centers for Disease Control and Prevention
DPCR	District Polio Control Room
DPEC	District Polio Eradication Committee
EOC	Polio Emergency Operations Centre
EPI	Expanded Programme on Immunizations
ERC	Expert Review Committee
ERT	Emergency Response Team
ERU	Emergency Response Unit
ES	Environmental surveillance
FATA	Federally Administered Tribal Areas
FLW	Frontline worker
GPEI	Global Polio Eradication Initiative
IDIMS	Integrated Disease Information Management System
IMB	International Monitoring Board
IPV	Inactivated poliovirus vaccine
KP	Khyber Pakhtunkhwa province
LQAS	Lot Quality Assurance Sampling
NEAP	National Emergency Action Plan for polio eradication
NID	National Immunization Days
NPAFP	Non-polio acute flaccid paralysis
NPMT	National Polio Management Team
OPV	Live oral poliovirus vaccine
PCM	Post-campaign monitoring
PEI	Polio Eradication Initiative
POB	Polio Oversight Board
SIA	Supplementary immunization activities
SNID	Sub-national Immunizations Days
TAG	Technical Advisory Group
tOPV	Trivalent live oral poliovirus vaccine
UC	Union Council
UNICEF	United Nations Children's Fund
UPEC	Union Council Polio Eradication Committee
VDPV	Vaccine-derived poliovirus
WHO	World Health Organization
WPV	Wild poliovirus

Executive Summary

As the world approaches the end of 2015, Pakistan and Afghanistan are now the last countries with ongoing wild polio virus (WPV) transmission. In Pakistan, the virus is now highly localised to four epidemiological zones – the **Peshawar/Khyber corridor**, the **Quetta block**, **Karachi** and **Central Pakistan**. These are the “**virus nurseries**” that sustain poliovirus infection and continue to re-seed the virus across the country. As of end of November, Pakistan reported **50 confirmed cases of WPV in 2015 – a decline of 84%** compared to a similar period in 2014. The **number of infected districts reduced from 40 in 2014 to 21 in 2015**. The proportion of WPV cases reported in Pakistan represented **75% of the global case load**; Afghanistan, the only other remaining WPV infected country, reported 17 cases in 2015.

The **2015/2016 National Emergency Action Plan (NEAP)** for polio eradication published earlier this year and endorsed by the National Task Force is the bedrock of the eradication programme. On 18 November 2015 the **National Polio Management Team** met in Islamabad with only one overarching agenda – to conduct a **Quarterly Review** of the implementation of the 2015/2016 NEAP.

In the first implementation quarter, the programme made significant progress in the realisation of NEAP strategic objectives. In programme **management**, a lot of work was done to improve the capacity of polio Emergency Operations Centres (EOCs). **Political engagement was enhanced** and **oversight and accountability** at all levels strengthened. The District Polio Control Rooms (DPCRs) for all tier 1 districts were refurbished and reinvigorated by re-establishing district-level coordination structures in a “one team, under one roof” approach. One major achievement has been the streamlining of the payments systems for Frontline Workers. This has substantially improved morale where it matters most.

The programme has successfully conducted three of the nine planned **supplementary immunization campaigns** with quality measurably increasing after every round. For example, the **number of inaccessible children has declined from 57,000 at the beginning of the year to 35,000 children and the proportion of children recorded by teams as remaining unvaccinated children has decreased to a new record low of 3%**. Compared to the September NID, the proportion of children vaccinated during the November NID increased from 91% to 95% in KP, 85% to 94% in Sindh, and 97% to 98% in Punjab. Performance in Balochistan and FATA has remained stable at 88% and 96% respectively. In high risk union councils (UCs) where lot quality assurance sampling (LQAS) is used to assess campaign quality, the proportion of UCs passing has increased from 40% to 66% in Balochistan, 68% to 74% in FATA, 45% to 75% in KP, 44% to 50% in Sindh, and 83% to 93% in Punjab. **Despite the increasing quality, performance especially in the most important UCs remains below the NEAP target**. Gaps in microplanning, inadequate micro-synchronisation, disjointed transit vaccination strategy, and poorly structured selection, training and supervision of front-line workers are now the main barriers to achieving the necessary performance needed for eradication by May 2016. **Worryingly performance in Karachi has been sub-optimal and urgent remedial measures to address governance, security and operational coordination and performance is required**.

Global benchmark surveillance indicators are being met and every day, both the quality and reach of **surveillance programmes** continues to increase. However, surveillance strengthening plans that were drafted following thorough surveillance reviews have not been implemented in timely manner. More work is needed to reach eradication-level performance particularly in key reservoir areas.

A revamped communication strategy targeting vaccinator and promoting vaccination **acceptance** was rolled-out. This strategy includes partnerships with religious networks, professional associations, civil society, media, telecom companies and the Pakistan Telecom Authority. The **programme aimed to deliver effective messaging**

with one single objective – increase the chances of success for the vaccinator at the door-step of the unreached child. Programme implemented qualitative and quantitative research in reservoir areas to measure impact of the revamped approach.

In implementing the NEAP, the programme has made **progress in every area of work**. However, the overarching goal of NEAP remains the same – to stop poliovirus transmission in every pocket in the country. The major hurdles towards that goal remain unchanged – continued low-incidence transmission in Karachi, the Peshawar-Khyber corridor, the Quetta block, and Central Pakistan. **Karachi** is still acting as an ‘amplifier’ and a ‘centrifuge’ of WPV transmission. There is substantial evidence from genetic sequencing data of active unimpeded transmission within this city also infecting other districts across the country. In the **Peshawar-Khyber corridor**, local transmission continues to simmer in Peshawar district, FR Peshawar, Khyber agency, and parts of neighbouring Nangarhar province of Afghanistan. In the **Quetta block**, local transmission continues to smoulder. The transmission has shifted from district to district and into Afghanistan in the past 2 years. In **Central Pakistan**, evidence of local transmission can be seen in the genetic linkages of viruses isolated from this region. In addition, the area continues to sprout viruses with close genetic relationship with WPV in the Quetta block, Peshawar-Khyber corridor, and Karachi indicating continued vulnerability to re-importation from outside districts.

In its most recent report, the International Monitoring Board (IMB) **praised Pakistan for improving the management and governance structures** for the polio programme. However, it noted that the level of improvement is “not yet” enough to result in eradication by **May 2016**. **Peak performance in every aspect of implementation is now a prerequisite to success**. In all four special epidemiological zones, the data suggests **campaign quality is below eradication-level threshold**. Without additional improvements in the operational efficiency of DPCRs and the quality of campaigns, we are unlikely to achieve our goals. **Aggressive concerted efforts needed at all levels to ensure the programme keeps its promise of polio-free Pakistan by May 2016**. As a result of this review the programme has outlined **supplementary plan of action for the next NEAP implementation quarter**. The programme must actively pursue the implementation of all listed actions in every area of work. Progress on implementation must be assessed on the next quarterly review in January 2016.

A young girl is vaccinated on a train in Quetta, Balochistan. Photo credit: Waseem Niaz/UNICEF



Background

As the world approaches the end of 2015, transmission of wild polio virus (WPV) has been successfully interrupted in all countries except Pakistan and Afghanistan. In Pakistan, the virus is now highly localised to four epidemiological zones where it has remained endemic. These zones either straddle the borderlands of Afghanistan and Pakistan (Peshawar – Khyber corridor and the Quetta block) or are located in other areas also facing security challenges within the densely populated heartland (Karachi and Central Pakistan). These are the “virus nurseries” that sustain poliovirus infection and continue to re-seed the virus across the country.

Since the establishment of the National and Provincial Polio Emergency Operations Centres (EOCs) in late 2014, the Pakistan Polio Eradication Initiative (PEI) has been able to gain new momentum. These centres have now become the operational hubs for both the government and the global partnership (GPEI). They have unified and galvanized all stakeholders towards the goal of finally stopping transmission.

The 2015/2016 National Emergency Action Plan (NEAP) for polio eradication published earlier this year is the bedrock of the eradication programme. This document and the strategic objectives contained within it was presented and endorsed by the Pakistan Technical Advisory Group (TAG) meeting in June. The programme then embarked on an implementation process that commenced with a detailed work planning process and culminated in a three-day workshop in Lahore at the end of the July 2015.

One major outcome of the workshop that was endorsed by all the EOCs was to conduct an internal review of progress made in the implementation of NEAP every quarter. Following a review process that lasted for two weeks, the National Polio Management Team met in Islamabad on 18th November 2015 with only one overarching agenda – to conduct the Quarterly Review of the implementation of the 2015/2016 NEAP. Summarized below is the outcome of that review.

Current polio situation

As of end of November, Pakistan reported 50 confirmed cases of WPV in 2015 – a decline of 84% compared to a similar period in 2014 (**Figure 1**). The number of infected districts reduced from 40 in 2014 to 21 in 2015. The districts reporting cases in 2015 were Killa Abdullah, Loralai and Quetta in Balochistan province, FR Peshawar, Khyber, North Waziristan and South Waziristan agencies in the Federally Administered Tribal Areas (FATA), Charsada, Lakki Marwat, Nowshera, Peshawar and Tank in Khyber Pakhtunkhwa (KP), Chakwal in Punjab, and Dadu, Kambar, Karachi, Khaipur, and Sukkur in Sindh (**Figure 2**).

The proportion of WPV cases reported in Pakistan represented 75% of the global case load; Afghanistan, the only other remaining WPV infected country, reported 17 cases in 2015 (**Figure 2**).

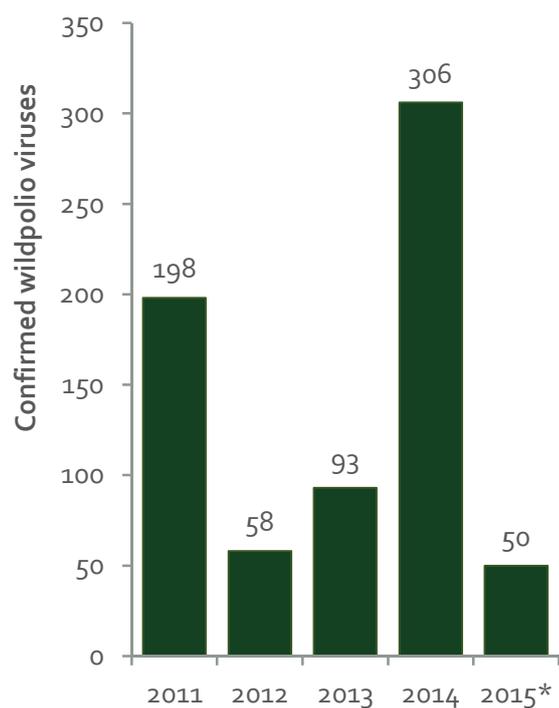
Data from the country-wide acute flaccid paralysis (AFP) surveillance indicates the risk of polio is highest for children <2 years. While the overall proportion of children <2 years among reported non-polio AFP (NP/AFP) cases was 30%, the proportion with confirmed WPV was 78%.

Compared to the non-Pashtu speakers, children from Pashtu speaking families were 3.4 times (relative risk) more likely to be positive for WPV.

Countrywide, previous vaccination with one or more OPV doses among NP/AFP cases improved from 95% in 2014 to 97% in 2015. In tier 1 districts, that proportion increased from 73% in 2014 to 91% in 2015. In FATA, epicentre of the explosive outbreak of 2014, the proportion of NP/AFP cases with history of at least 1 dose of OPV improved from 54% in 2014 to 94% in 2015.

From the environmental surveillance data, of the 389 samples collected in 2015 that have results, WPV was detected in 78 (20%) specimens. At a similar point in time in 2014, 127 (36%) of 353 specimens were positive for WPV.

Figure 1 – Confirmed polio cases reported in Pakistan, 2011/2015



*data as of December 2015

Figure 2 – Map of Pakistan and neighbouring Afghanistan showing the case distribution of wild polioviruses (red dots), 2014/2015

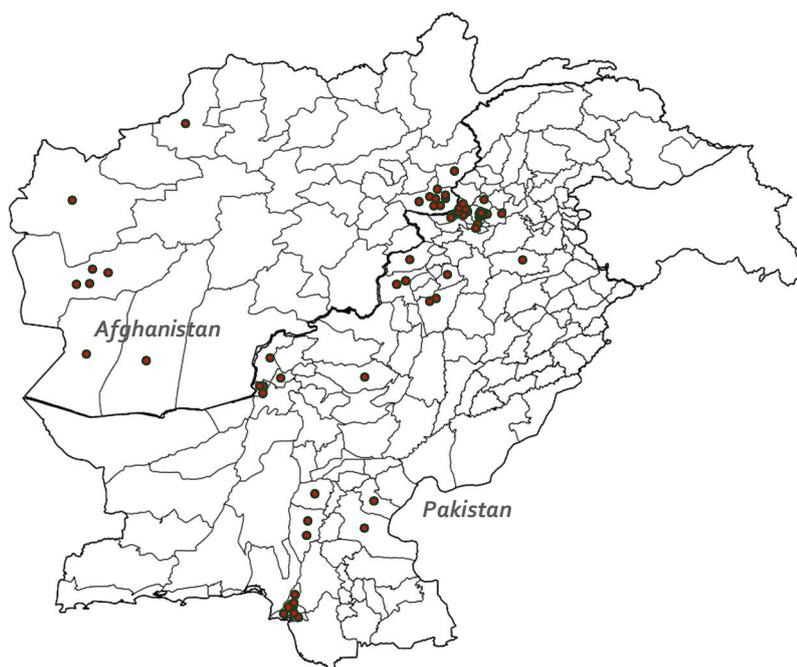


Table 1 – Comparing location of wild poliovirus (WPV) detection within Pakistan in 2015 and location with closest genetic relative

Zone	WPV Cases reported in 2015	Linked cases in 2015	WPV in Environ samples	Linked ES WPV clusters*
Khyber-Peshawar corridor	24	24	11	12
Other areas of FATA	3	2	0	1
Other areas of KP	3	0	3	3
Quetta block	6	6	17	16
Other areas of Balochistan	1	0	0	0
Karachi centrifuge	7	10	21	32
Interior Sindh	5	3	12	10
Punjab	1	0	12	3
Islamabad	0	0	2	0
Greater Nangarhar	NA	1	NA	2
Greater Kandahar	NA	1	NA	8

*more than 1 cluster can be isolated from an environmental sample; ES – Environmental sample;

Data as of December 2015

As of November 2015, the virus in Pakistan is primarily sequestered in the four zones of special epidemiological significance. These are the Peshawar – Khyber corridor, the Quetta block, Karachi, and Central Pakistan. Genetic sequencing data however suggests three zones of primary transmission. WPV identified in the Khyber-Peshawar corridor which geographically extends into the eastern Afghanistan provinces (Greater Nangarhar) was primarily linked to transmission from within the same region (**Table 1**). WPV isolated from specimens in the Quetta block was primarily linked to transmission in a broad region that includes the Quetta block and the Southern Afghanistan provinces (Greater Kandahar) (**Table 1**). In the South of the country, Karachi continues to act as a hub of WPV transmission. Even though, for most of the year, few cases were reported directly from the city, there has been substantial evidence from genetic sequencing data of active unimpeded transmission ongoing in Karachi throughout the year. In 2015, 7 AFP cases and 21 environmental surveillance samples from Karachi were positive for WPV, however, WPV detected in 10 AFP cases and 32 environmental clusters were linked to transmission in Karachi (**Table 1**).

Arslan, 5, with his mother waiting for his turn to get vaccinated during the campaign, Children's hospital, Peshawar city, Khyber Pakhtunkhwa. Photo credit: Asad Zaidi/UNICEF



Progress on NEAP Implementation

In order to achieve the overall NEAP goal of eradicating poliovirus by May 2016, the NEAP outlines four clear strategic principles and four overarching guiding principles (**Panel**). To actualize these principles, the program developed a one-year work plan that is structured into seven areas of works (AOWs) at national, provincial and district level. The finalized plan was approved in July 2015. The seven AOWs are:

- Management, coordination and oversight
- Supplementary immunizations
- Surveillance
- Communications
- Access and security
- Information management, monitoring and evaluation
- PEI – EPI synergy

Panel – NEAP strategic principles and overarching guiding principles

Strategic approach	Guiding Principles
<ul style="list-style-type: none"> ▪ Maintain and increase population immunity against polio throughout Pakistan by implementing high quality campaigns ▪ Stop poliovirus transmission in all reservoirs and prevent establishment of poliovirus circulation in the rest of the country ▪ Detect, contain and eliminate poliovirus from newly-infected areas ▪ Sustain polio interruption through increased routine immunization coverage 	<ul style="list-style-type: none"> ▪ Increased quality of all polio eradication activities; including campaigns, AFP Surveillance and routine immunization ▪ Increased programmatic access and reach with a focus on continuously missed children ▪ Integration and coordinated planning and implementation of Operations, Security and Communications through Federal and Provincial EOCs and District Polio Control Rooms/Teams ▪ Enhanced/real time monitoring of performance and increased accountability at all levels



President Mamnoon Hussain, President of Pakistan, vaccinates a young girl during a mass vaccination drive, Peshawar, Pakistan. Photo credit: Asad Zaidi/UNICEF

At the time of the NEAP review, the country had completed the implementation of three of the nine planned campaigns. With the completion of a third of the supplementary immunization activities (SIAs), the NPMT reviewed progress made in the implementation of the work plan in each AOW at both national and provincial level.

- 1) **Management, Oversight & Coordination** – Implementation is on track. Further work needs to be done to strengthen accountability, refine management structures and human resources at all levels.

- a. Political Engagement Oversight and Accountability
 - i. National and provincial task force meetings held but there have been delays at all levels.
 - ii. The drafting and review of the accountability and Performance Management Framework was completed in late August however, rollout to the districts not completed.
 - b. Policy, strategy and planning
 - i. All provinces and districts completed work plans but monitoring and reporting needs improvement.
 - ii. Payments system reviewed and streamlined but there are still delays in the payment of Frontline Workers.
 - c. International Oversight Bodies. The Pakistan Technical Advisory Group (TAG) meeting was successfully concluded in June 2015. In order to help review the quality and gaps in the implementation of the SIAs, the programme hosted the TAG chairman in September. Timely submissions to the Polio Oversight Board (POB) and the International Monitoring Board (IMB) done in late September and early October respectively.
 - d. Support to provincial EOCs and tier 1 districts
 - i. All tier 1 district polio control rooms (DPCRs) have been refurbished and are now fully operational, however, management systems and performance varies from one district to another. An objective of the next quarter should be to better support and improve the operational efficiency of the DPCRs.
 - ii. Emergency Response Teams to support the provinces and the districts not yet established. Urgent action needed.
 - e. EOCs management systems have benefited from the fluidity of the task team structure, however there is need for further refinement of roles and responsibilities.
 - f. Transit and cross-border strategy
 - i. Cross-border coordination with Afghanistan is critical to eradication. Cross-border coordination has improved since the June 2015 cross-border meeting in Islamabad. Annex 4 below highlights the key interactions along the common border. However, more alignment of operational plans and closer coordination on the ground needed to achieve peak performance.
 - ii. National Transit and Cross border strategy to be reviewed.
- 2) **Supplementary Immunization** – Progress has been made across the board. All campaigns have been conducted as planned and campaign quality has measurably increased; the number of inaccessible children has declined and the proportion of recorded unvaccinated children has decreased (**Figure 3**). Compared to the September NID, the proportion of children vaccinated during the November NID as measured by third-party monitoring has increased from 91% to 95% in KP, 85% to 94% in Sindh, and 97% to 98% in Punjab (**Figure 4**). Performance in Balochistan and FATA have remained stable at 88% and 96% respectively (**Figure 4**). In high risk UCs where LQAS is used to assess campaign quality, the proportion of UCs passing has increased from 40% to 65% in Balochistan, 68% to 74% in FATA, 45% to 75% in KP, 44% to 50% in Sindh, and 83% to 93% in Punjab (**Figure 5**). Despite the increasing quality, performance especially in the most important UCs remains below the NEAP target. Gaps in microplanning, inadequate micro-synchronisation, disjointed transit vaccination strategy, and poorly structured selection, training and supervision of front-line workers are the main barriers to achieving the necessary performance needed for eradication by May 2016. Worryingly performance in Karachi has been sub-optimal and urgent remedial measures to address governance, security and operational coordination and performance is required (**Figure 6**).
- a. Operational Planning: effectiveness of operational planning at district polio eradication committees (DPEC) and UC polio eradication committees (UPEC) in a number of critical districts/UCs remain below standard.
 - b. Microplanning: strong evidence from monitoring that still pockets of children are not included in microplans.

Figure 3 – Proportion of recorded unvaccinated children during National Immunization Days (NID), 2014 – 2015. For children included in microplans, the programme performance has improved.

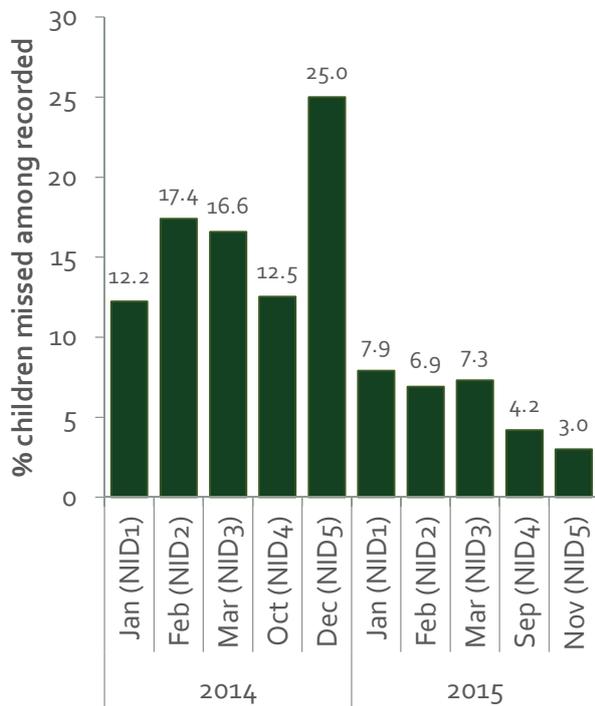


Figure 4 – Third-party post-campaign monitoring showing vaccination coverage by province, September and November 2015. The NEAP target is 90%

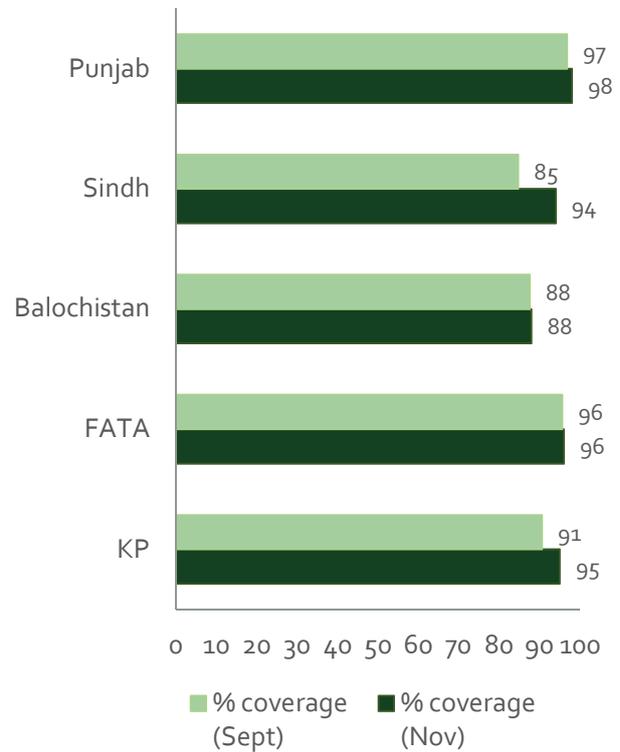


Figure 5 – Proportion of Union Councils passing LOAS during the September and November NIDs, Pakistan, 2015. The NEAP target is 80%

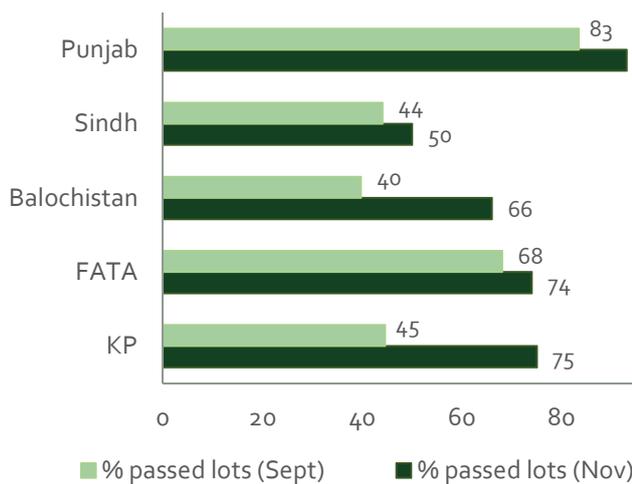
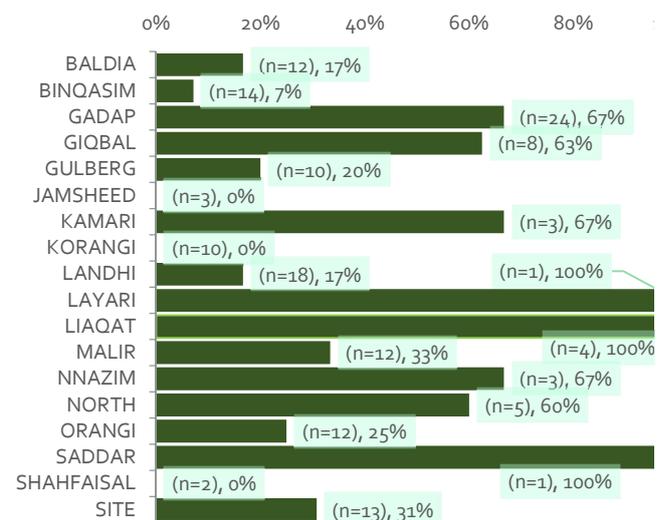


Figure 6 – Proportion of Union Councils passing LOAS during the September, October and November campaigns, Karachi, 2015. The NEAP target is 80%





*Young girl proudly shows her marked finger as evidence of receiving a vaccine during a monitoring exercise.
Photo credit: Asad Zaidi/UNICEF*

- a. Selection, training and supervision of FLWs
 - i. Continued evidence of non-local, non-adult, insufficient females, and with very high turnover.
 - ii. Selection, recruitment and retention of high quality AICs and FLWs needs further improvement.
 - iii. Inadequate supportive supervision also hampering quality.
 - b. Continuous community-protected vaccination (CCPV) has now become a core strategy of delivering vaccination to high risk areas that have not been successful at implementing vaccination through more traditional mobile teams. It has been successfully implemented in Balochistan, FATA, KP and Sindh.
 - c. Tracking and vaccinating missed children: progress made, however the goal coming to close to zero missed children will not be attained as long as chunks of territory or population remain unmapped during the microplanning process (**Figure 3**).
 - d. IPV vaccination has remained small-scale. The limited global supply has hampered the capacity of the programme to adequately plan and use this vaccine strategically in critical places. Currently, the programme only has a supply level that will not meet the needs of the programme as determined by the evolving epidemiology in Karachi and the Khyber-Peshawar corridor.
- 3) **Surveillance** – Global benchmark surveillance indicators are being met in almost all districts and agencies in the country however surveillance strengthening plans have not been implemented in timely manner particularly in key reservoir areas.
- a. Enhancing surveillance quality
 - i. The implementation of the improvement plan developed following the surveillance reviews has started but not completed.
 - ii. AFP surveillance infrastructure and the work force workforce expanded
 - iii. Environmental surveillance sampling sites reviewed for expansion. A new site in Pishin has now being included into the network.

- iv. The Expert Review Committees (ERCs) for KP and FATA has recently been reconstituted.
 - v. The number of reporting sites has been increased but more required.
 - vi. Zero-reporting from facilities still an issue especially in high-risk UCs.
 - vii. Additional work needed to further strengthen involvement of District Surveillance Coordinators in the AFP surveillance.
- b. Community surveillance lagging behind NEAP targets – more needed especially in areas of special epidemiological interest. A low hanging fruit is expansion to CCPV areas.
 - c. Training of trainers and training of district-based staff on AFP Surveillance completed in three provinces. training of district based staff done in 3 provinces
 - d. Supervision has improved, however, a gulf in quality still remains. There is need to improve supervision at all levels.
- 4) **Communications** – implementation is on track.
- a. Revamped communication strategy promoting vaccination acceptance and vaccinators rolled-out. This strategy includes partnerships with religious networks, professional associations, civil society, media, telecom companies and the Pakistan Telecom Authority. More precise targeting of our mass media, partnerships and community social mobilization towards clusters and individual parents of missed children needed.
 - b. External communication strategy, media spokesperson training of government, partner and civil society implemented.
 - c. Effective mechanism of delivering messages and real-time feedback from FLWs (Rapid-Pro) instituted. Further improvement to operational delivery and scheduling of front-line training in tiers 1-2 required.
 - d. Enhanced IPC materials to strengthen vaccinator performance at the door-step developed.
 - e. Qualitative and quantitative research in reservoir areas to measure impact of the revamped approach implemented. A new Knowledge Attitude Practice Harvard study is scheduled for December.
 - f. While tremendous progress has been towards pro-active communications, less reactive and more predictive planning and management of events and opportunities still needed.
- 5) **Access and security** – Implementation is on track.
- a. Accessibility: inaccessibility reduced to 16,000 children. Persistent inaccessibility in North Waziristan, South Waziristan, and Khyber agency reduced to small geographies and pockets. Temporary inaccessibility has been managed through campaign re-scheduling; there have be no cancellations due to inaccessibility. Access and security dashboard with security incident management reporting system has been rolled out to provincial level.
 - b. Security-protected campaigns proceeding as planned in all areas except Karachi where security needs vs actual availability result in phased campaigns. This is a major concern to the programme.
 - c. Incidents against front line workers (FLWs) remain at very low levels.
- 6) **Information management, monitoring and evaluation** – Implementation is on track.
- a. Quality of campaign monitoring has improved. Pre-campaign third-party monitoring has highlighted gaps in the pre-campaign preparedness in many districts. Both third-party post-campaign monitoring (conducted in all districts) and LQAS (targeted to high risk UCs) are now collecting primary data using electronic handheld devices. This has improved the speed of programmatic review and utility of data. More needs to done to increase the footprint of LQAS in epidemiological hotspots.
 - b. EOC Online Portal launched. Portal is linked to AFP and environmental surveillance, SIAs, and communication databases, however further utilization of data to drive improvements is required especially in the critical virus nurseries.
 - c. Data Support Centre: detailed information from tally sheets collected from high risk UCs captured within the system. This provides granular knowledge of missed children in these critical areas. It provides secondary data that further clarifies the primary reasons for non-vaccination.

- d. Integrated Disease Information Management System (IDIMS) rolled out. This primarily captures administrative campaign data from all areas.
 - e. National Information Management Working Group established bringing together the National and Provincial Data Teams. Formal endorsement through the circulation of official letter needed.
- 7) **EPI – PEI Synergy** - On track. PEI commitments being met.
- a. Programme supported routine immunization in many ways including during the recently completed measles SIAs, training and introduction of IPV, and the tOPV switch plan.
 - b. Feedback from communities on routine immunization incorporated into an updated Social Mobilization Toolkit for FLWs
 - c. Introduced IPV in campaign mode in selected areas of the country and 1.7 million children vaccinated; other routine immunization antigens were provided during the IPV SIA.
 - d. 1,878 health camps were organized reaching 453,679 beneficiaries. 80,000 under 5 children were vaccinated.
 - e. UNICEF and WHO given flexibility in terms of selecting target districts for the EPI-PEI synergy project implementation under GAVI funded project, however the absence of adequate health infrastructure in some agencies/districts continues to affect the ability of both the EPI and PEI programs to reach required targets

Progress made against NEAP targets

Although it is significant to achieve high population immunity throughout Pakistan, the success of global polio eradication depends on clearing the 11 remaining core reservoirs through finding and vaccinating the chronically missed subpopulations with multiple and repeated doses of OPV. Table 2 below summarizes the progress made in achieving NEAP targets in tier 1 and non-tier 1 districts

Table 2 – Progress made against targets outline in the NEAP 2015/2016

NEAP Target	Progress in Tier 1* districts	Progress in non-Tier 1 districts
Monthly supplementary immunization activities (SIAs) starting September 2015	Done as planned	Done as planned
Case response: conduct three largescale SIAs in newly infected areas. Coverage target for each SIA is 90% by third-party monitoring	Not applicable	Case response was carried out in line with guidelines in FR Peshawar (FATA), and Chakwal district (Punjab). Case response was inadequate in Karachi. Coverage by third party monitoring was not implemented
SIA coverage: ≥90% by third-party independent monitoring	Coverage was 88% in September and 92% in November	Coverage was 92% in September and 95% in November
SIA coverage: ≥80% of lots** passing following assessment by Lot Quality Assurance Sampling (LQAS)	Proportion passed was 39% in September and 62% in November	Proportion was 62% in September and 78% in November
SIA coverage: in areas implementing community-protected continuous vaccination (CCPVs), ≥95% of lots** passing following assessment by Lot Quality Assurance Sampling (LQAS)	The proportion passing was 63% (n=8), 57% (n=7), and 65% (n=2) in September, October, and November SIAs respectively	
Implement IPV vaccination in high risk areas and core reservoirs requiring additional immunity boost	1.7 million children vaccinated	

NEAP Target	Progress in Tier 1* districts	Progress in non-Tier 1 districts
Reduce number of children recorded as remaining unvaccinated to zero	Proportion of children recorded as remaining unvaccinated following each campaign decreased from 8% in January, 7% in March 2015, to 3% in November NID	
Annualized non-polio acute flaccid paralysis (NPAFP) rate of ≥ 2 per 100,000 children <15 years	All achieved target of ≥ 2 per 100,000. Rates were between 2 and <5 in Baldia town, Pishin, Quetta, and North Waziristan. All other agencies had NPAFP rate ≥ 5 per 100,000 (Annex Table 1).	NPAFP for Balochistan 5, FATA 13, Islamabad 4, KP 8, Sindh 5, and Punjab 6. National average was 6. Except for Jamsheed and Site towns of Karachi city (Sindh), and Sujawal district (Sindh), all other districts in the four provinces, FATA and Islamabad have achieved target (Annex Table 2)
Adequate stool specimen in $\geq 80\%$ of samples collected from AFP cases	4 of the 12 districts/districts/agencies didn't meet target. These were Gadap town (71%), Peshawar (77%), South Waziristan agency (69%), and Tank (78%) (Annex 2).	All provinces had adequacy above target. At district level, there were gaps in Barkhan, Bolan, Khuzdar, Lasbela, Mastung, Noshki, Sharani, and Ziarat districts of Balochistan; Bajour, FR DIKhan, FR Lakki, FR Tank, and Kurram of FATA; Kambar, Matiari, Sujawal districts of Sindh, Bin Qasim, Korangi, North Nazimabad, and Site towns of Karachi (Sindh), Karak, Kohistan, Nowshera, Swat, districts of Khyber Pakhtunkhwa (Annex 3).

*Tier 1 districts/agencies are Killa Abdullah, Pishin and Quetta districts of Balochistan; FR Bannu, Khyber, North Waziristan, South Waziristan agencies of FATA; Bannu, Peshawar, and Tank districts of Khyber Pakhtunkhwa; and Baldia and Gadaap towns of Karachi city in Sindh.

*A polio vaccinators immunizes children in the Cholistan desert (also locally known as Rohi), Bahawalpur, Punjab.
Photo credit: Waseem Niaz/UNICEF*



Progress on key programmatic milestones in 2015

Table 3 – Current status of key NEAP programmatic milestones.

Milestone	Timeline	Current status
Conduct AFP surveillance review	2015 Quarter 2	Done in Sindh, Balochistan, KP and FATA
Review implementation of low season plan	2015 Quarter 2	Done
Implement monitoring in all phases of campaign	2015 Quarter 2	Done
Finalize joint operational, security and communication plan	2015 Quarter 3	Done. Implemented through detailed work planning process
Microplans for all High Risk Union Councils and all Union Councils in tier 1 districts are updated, and validated	2015 Quarter 3	Microplans only partially updated and validated. Third-party monitoring and other reviews of the microplans and the microplanning process has highlighted serious shortcomings. More work needs to be done especially in key epidemiological zones
Front-line workers and Community Health Volunteers are selected and trained	2015 Quarter 3	Completed. However, quality in some areas still needs improvement
Report on progress against objectives and targets	2015 Quarter 4	Done. This report summarizes progress made against objectives and targets during the first implementation quarter of the 2015/2016 NEAP work plan

Lessons Learnt in Quarter 1

- With the help of EOC network, program **management, coordination and oversight** has improved significantly. The progress can be clearly seen in the capacity of the EOCs to leverage national, provincial, and local authorities to achieve programmatic goals. This has been clearly visible in the turnaround observed in Balochistan, FATA and KP. The EOC networks need to continue to harness every opportunity with the highest levels of government to achieve eradication-level performance in every district.
- While the quality of **SIAs** has steadily improved in many parts of the country, in key epidemiological blocks, the performance remains below what is need to eradicate polio. For example, significant recorded and unrecorded missed children remain, quality of supervision of frontline workers has not improved substantially, and while the payments system for FLWs has improved considerably, delays continue to be reported.
- With the roll-out of third party pre-campaign monitoring, enhanced intra-campaign monitoring, post-campaign monitoring using LQAS and third-party monitors, evaluation of campaign quality has improved dramatically. However, there is need to increase footprint in zones of special epidemiological interest.

Conclusion

The program has made progress in every area of work. However, the overarching goal of NEAP remains the same – to stop poliovirus transmission in every pocket in the country. The major hurdles towards that goal remain unchanged – continued low-incidence transmission in the Peshawar-Khyber corridor, the Quetta block, Central Pakistan, and Karachi.

Karachi is still acting as an ‘amplifier’ and a ‘centrifuge’ of WPV transmission. Even though, for most of the year few cases were reported directly, there has been substantial evidence from genetic sequencing data of active unimpeded transmission in the city. In the **Peshawar-Khyber corridor**, local transmission continues to simmer in Peshawar district, FR Peshawar, Khyber agency, and parts of neighbouring Nangarhar province of Afghanistan. In Khyber agency, following extended transmission in Jamrood and Bara tehsils last year, the new epicentre is in the mountainous Landhi kotal tehsil bordering Afghanistan. In the **Quetta block**, local transmission continues to smoulder. The transmission has shifted from district to district and into Afghanistan in the past 2 years. In **Central Pakistan**, evidence of local transmission can be seen in the genetic linkages of viruses isolated from this region. In addition, the area continues to sprout viruses with close genetic relationship with WPV in the Quetta block, Peshawar-Khyber corridor and Karachi indicating continued vulnerability to re-importation from outside districts.

The estimated immunity levels needed to interrupt transmission is highest in these areas. Even within these zones, Karachi is a special case. Karachi as a whole needs to outperform every other part of the country to stop transmission and at the moment there is no evidence (data is not yet conclusive), the program has made substantial dent in the immunity gap in the last three months. Main reasons identified for sub-par performance were: 1) phased implementation of campaigns which doesn’t leave adequate time for preparations, 2) inadequate/inefficient security deployment, and 3) poor execution of operational plans.

In its most recent report, the International Monitoring Board praised Pakistan for improving the management and governance structures for the polio programme. However, it noted that the level of improvement is “not yet” enough to result in eradication by May 2016. Peak performance in every aspect of implementation is now a prerequisite to success. In all four special epidemiological zones, the data suggests campaign quality is below eradication-level threshold. Without substantial improvements in the quality of campaigns, we are unlikely to achieve our goals. Aggressive concerted efforts needed at all levels to ensure the program keeps its promise of polio-free Pakistan by May 2016.

Supplementary plan of action for Quarter 2

In order to attain peak performance in every area of work especially in the most important districts and UCs in the country, the NPMT put together a supplementary plan of action that should be implemented before the next review meeting in January 2015.

Area of Work 1: Management, coordination and oversight

1. Strengthen management structures and accountability at all levels
 - a. Develop and disseminate guidance note on refined management structures within the EOC network
 - b. Further clarify and assign partner specific roles at district and union council level and distribute a guidance note
 - c. Roll out the Accountability and Performance Management Framework after final review by provincial EOCs
 - d. Develop and implement a deployment plan for targeted additional human resources to strengthen performance of provincial EOCs, the Emergency Response Unit for Central Pakistan and the DPCRs within key epidemiological blocks
2. With special focus on tier 1 districts, enhance use of NEAP implementation tools at provincial and district level

- a. Each province to identify focal point to manage NEAP implementation and review process at provincial level
- b. Ensure the review of NEAP at district level before the Jan 2016 mid-term NEAP review
3. Identify scope and mechanism for financial resources needed for provincial contingency funds for operational response
 - a. PEOCs to develop requirements for contingency funds for detailed case investigation; case response, mop-up and review meetings.
 - b. NEOC and GPEI partners will work with government partners to find a mechanism for provision of EOCs to have a flexible operational budget

Area of Work 2: Supplementary immunization

1. Further improve SIA quality to achieve the required standard to interrupt transmission in Pakistan through a focus on operational preparedness for campaigns
 - a. Provinces to prepare an action plan with a focus on detailed microplanning; training; supportive supervision and retention of area-in-charges (AICs) and frontline workers (FLWs)
 - b. Operational preparedness roles at UC and DPCR level specified and linked to individual accountability (as specified in action 1b in Area of Work 1 above).
 - c. Provinces to review and submit CCPV expansion proposals to the national EOC and ensure these are targeted to security compromised tier 1 districts and HRUCs
2. Enhanced coordination mechanisms and updated operational plans for: Khyber-Peshawar- Nangarhar corridor, Quetta-Kandahar block, the Karachi Centrifuge, Central Pakistan, and the Islamabad – Rawalpindi emerging risk zone.
 - a. Karachi – implement the 4-point plan for performance strengthening outlined by the Sindh EOC. These are: 1) strengthening governance and oversight through the establishment and operationalization of a Karachi Task Force led by the Commissioner Karachi; 2) review and develop a fit-for-purpose integrated and realistic security assessment; 3) strengthen the functionality of Sindh EOC and the District Polio Control Rooms; 4) improve operational performance through the targeted expansion of CCPVs to more high risk Union Councils.
 - b. Khyber-Peshawar-Nangarhar – with technical support from the national EOC, update and roll-out jointly developed operational plan that aims at the delivery of eradication-level performance in all areas of work.
 - c. Quetta-Kandahar block – develop operational plan that re-evaluates the progress made and identifies additional measures that need to be taken to interrupt transmission. In this block, while the population is centred in and around the major cities of Quetta (Pakistan) and Kandahar (Afghanistan), quite a large fraction of the population is dispersed on the wide plains in Southern Afghanistan in what can be called Greater Kandahar. Eradication on either side of the border is only realistically achievable if progress is made towards eradication on both sides of the border. While the Balochistan team rightfully needs to focus on achieving peak performance



A lady health worker administers IPV to a child. Photo credit: Waseem Niaz/UNICEF

especially in the three key districts that constitute the Quetta block, closely aligning operational strategy with colleagues on the other side of the border will have a positive effect on eradication at home.

- d. Central Pakistan remains a major risk. The programme has already developed an operational plan for this region, however, implementation has lagged behind. Diligent implementation of the plan and further review of risk posed needed. A fortnightly coordination video/teleconference between the three EOCs should be established. The ERU should be strengthened further and the capacity of the Sindh EOC to respond to challenges emanating from this zone enhanced.
 - e. Islamabad and Rawalpindi are slowly beginning to move up the priority list in terms of possible emerging risk zones. There have been sub-optimal SIA implementation in many parts of these twin cities in the past few rounds. The program plans to formalize coordination mechanisms between the cities. The objective is planning at all levels is fully harmonized and quality of future SIAs improved.
3. Strengthen complementary SIA strategies
- a. High risk transit populations require special attention. This one area where substantial progress hasn't been made in the past quarter. In fact, the program has failed to speedily implement any of the decisions made during the NEAP work planning process. The program plans to completely review its operational plan in order to fully implement the revised high risk mobile populations' strategy.
 - b. The program will develop operational plan for IPV implementation plan in time for the February campaign. The program should also draft a brief for the utilization of IPV in SIAs beyond February 2016. There is strong evidence of improved seroconversion, increased intestinal immunity and decreased faecal excretion of virus among population groups receiving mixed dose of OPV and IPV. IPV vaccination is especially critical to eradication in the special epidemiological zones in need of higher than average population immunity threshold to interrupt transmission. In these zones where every one point gain in immunity could be the difference between eradication and low-incidence sustained transmission, the 3 – 9% of vaccinated children who do not seroconvert despite receiving repeated OPV doses become critical. Ensuring a high quality round of IPV among all populations (whether fully accessible, partially accessible, or inaccessible) living in the area is important.
 - c. Explore feasibility of permanent health camps in tier 1 agencies of FATA especially amongst pockets of populations not benefitting from CCPV or other strategies aimed at regularly vaccinating children



*A polio frontline worker in a far-flung area of Cholistan Desert, Punjab province making every effort to reach children who would otherwise be missed.
Photo credit: Waseem Niaz/UNICEF*

Area of Work 3: Surveillance

Improve surveillance quality to eradication level standards by

1. Rapidly implementing and reporting on progress on surveillance strengthening plans
2. Finalizing roll out of community surveillance plan for tier-1 districts by December 2015

Area of Work 4: Communications

Tightly focus on micro-application to targeted population targets

1. Mass media, religious and medical partnerships and community engagement networks more directly connected to the issues of concern raised by parents of missed children
2. Request PMDC for the inclusion of AFP surveillance and other PEI trainings, workshops and seminars into the CME recognized schedule
3. Develop communication packages and plan to incorporate and engage new Local Body representatives

Area of Work 5: Access and Security

Even though the access and security situation has improved substantially in the past year, the situation remains fragile in many areas. The programme must continue to explore avenues of decreasing the inaccessible children in inaccessible areas (Annex 7) and further improve the optimal utilization of available resources to ensure adequate security for all polio eradication activities. The programme should strengthen access and security in critical zones by:

1. Continuing work to reduce inaccessibility in FATA.
2. Re-assessing security requirements as part of the Karachi SIA quality improvement plan with the goal of ensuring a single-phased campaign is implemented starting January 2016.
3. Implement roll out of security incident management plan.

Area of Work 6: Information management, monitoring and evaluation

1. Improve footprint of high quality pre-campaign and post-campaign monitoring in zones of special epidemiological interest
 - a. Develop updated LQAS plan
 - b. Develop updated pre-campaign third-party monitoring plan
2. Improve capacity within provincial EOCs to effectively generate, manage and utilize available data to drive further program performance
 - a. Improved user interface within the EOC online portal that focuses on availability of correlated information for all geographic units
 - b. Improve feedback through all levels and ensure data and information is available to all who need to use it. Deploy data analysts/epidemiologists to provincial EOCs (refer to HR actions)
 - c. Quality of administrative data related to campaigns is a major concern for the program; increase government and partner accountability at UC, district and provincial levels
3. Enhance coordination in information management within the EOC network by operationalize the established National Data Management Working Group

Area of Work 7: PEI – EPI synergy

1. Focus activities on Tier 1 and Tier 2 districts with high number of zero-dose children
2. Organize training of task-team members at provincial EOCs and consider hiring of additional staff

Annexes

Annex 1 – The National Polio Management Team

1. Senator Ayesha Raza Farooq, Prime Ministers Focal Point, Chairperson
2. Dr Rana Muhammad Safdar, National Emergency Operations Centre Coordinator
3. Mr Shakeel Qadir Khan, Federally Administered Tribal Areas Emergency Operations Centre Coordinator
4. Mr Akbar Khan, Khyber Pakhtunkhwa Emergency Operations Centre Coordinator
5. Dr Munir Ahmed, Punjab Emergency Operations Centre/ Director Health EPI
6. Dr Usman Chachar, Sindh Emergency Operations Centre Coordinator
7. Dr Saif ur Rehman, Balochistan Emergency Operations Centre Coordinator

Annex 2 – Acute Flaccid Paralysis surveillance indicators (Tier 1)

Annex Table 1 – Non-polio Acute Flaccid Paralysis (AFP) indicators for Tier 1 districts, Pakistan, 2015. Non-polio AFP rate is per 100,000 children <15 years old.

Province	DISTRICT	Non Polio AFP rate	Adequate specimen %
Balochistan	Killa Abdullah	6.0	94
	Pishin	4.5	80
	Quetta	3.0	95
FATA	FR Bannu	83.2	88
	Khyber	7.7	82
	North Waziristan	4.6	80
	South Waziristan	5.0	69
Sindh	Baldia	3.1	82
	Gadap	9.2	71
Khyber Pakhtunkhwa	Bannu	7.7	88
	Peshawar	7.3	77
	Tank	10.2	78
Overall		6.7	81

Annex 3 – Acute Flaccid Paralysis surveillance indicators (Non-Tier 1)

Annex Table 2 – Non-polio Acute Flaccid Paralysis (AFP) indicators for non-Tier 1 districts, Balochistan, FATA and Islamabad, Pakistan, 2015. Non-polio AFP rate is per 100,000 children <15 years old.

Province	District	Non polio AFP rate	Adequate specimen %
Balochistan	Awaran	0.0	
	Barkhan	13.4	63
	Bolan	0.8	0
	Chaghai	7.5	100
	Dbugti	4.6	80
	Gwadur	2.8	100
	Harnai	2.2	100
	Jafarabad	2.9	100
	Jhalmagsi	3.2	100
	Kalat	1.0	100
	Kech	2.8	80
	Kharan	14.0	100
	Khuzdar	4.5	70
	Kohlu	5.9	100
	Ksaifulah	5.3	100
	Lasbela	4.5	75
	Loralai	3.9	100
	Mastung	3.9	67
	Musakhel	5.7	100
	Noshki	7.0	33
	Nsirabad	8.4	100
	Panjgour	1.6	100
	Sharani	7.4	67
	Sibi	12.2	80
	Washuk	9.8	100
	Zhob	12.4	93
Ziarat	5.8	67	
FATA	Bajour	18.6	80
	FR DI Khan	10.2	67
	FR Kohat	24.5	83
	FR Lakki	57.5	75
	FR Peshawar	5.4	100
	FR Tank	9.3	50
	Kurram	7.4	78
	Mohmand	12.5	82
	Orakzai	5.5	86
Islamabad	CDA	2.3	89
	ICT	8.7	83

Annex Table 3 – Non-polio Acute Flaccid Paralysis (AFP) indicators for non-Tier 1 districts, Punjab, Pakistan, 2015. Non-polio AFP rate is per 100,000 children <15 years old.

Province	District	Non polio AFP rate	Adequate specimen %
Punjab	Attock	8.3	91
	Bahawalpur	4.2	98
	Bahwlnagar	5.7	85
	Bhakkar	5.5	100
	Chakwal	6.6	95
	Chiniot	6.5	94
	Dgkhan	11.6	90
	Faisalabad	5.2	81
	Gujranwala	8.5	84
	Gujrat	8.7	90
	Hafizabad	9.9	86
	Jhang	5.2	90
	Jhelum	7.7	100
	Kasur	6.5	90
	Khanewal	5.5	88
	Khushab	3.9	100
	Lahore	4.2	90
	Layyah	8.9	98
	Lodhran	7.8	90
	Mbdin	12.1	90
	Mianwali	7.6	93
	Multan	5.6	85
	Muzfargarh	10.1	83
	Nankanasahib	7.6	87
	Narowal	6.3	85
	Okara	6.9	89
	Pakpatten	6.1	90
	Rajanpur	11.5	84
	Rawalpindi	5.9	85
	Rykhan	6.5	93
	Sahiwal	5.5	88
	Sargodha	4.6	94
	Sheikupura	7.3	90
	Sialkot	4.5	92
Ttsingh	6.9	91	
Vehari	4.6	89	

Annex Table 4 – Non-polio Acute Flaccid Paralysis (AFP) indicators for non-Tier 1 districts, Sindh, Pakistan, 2015.
Non-polio AFP rate is per 100,000 children <15 years old.

Province	District	Non polio AFP rate	Adequate specimen %
Sindh	Badin	8.3	100
	Dadu	8.1	100
	Ghotki	7.6	95
	Hyderabad	4.5	91
	Jacobabad	6.4	92
	Jamshoro	4.4	100
	Kambar	6.8	78
	Kashmore	8.7	83
	Khairpur	6.5	93
	Khibleqasim	4.3	70
	Khigiqbal	4.5	100
	Khigulberg	3.1	100
	Khijamsheed	1.9	100
	Khikamari	2.8	100
	Khikorangi	2.8	70
	Khilandhi	2.7	92
	Khilayari	2.3	100
	Khiliaqat	2.1	88
	Khimalir	3.4	100
	Khinnazim	3.2	78
	Khinorth	3.3	85
	Khiorangi	2.3	83
	Khisaddar	2.0	89
	Khishahfaisal	3.3	100
	Khisite	1.8	67
	Larkana	4.3	96
	Matiari	7.2	78
	Mirpurkhas	14.3	97
	Nferoz	4.2	82
	Sanghar	2.9	87
	Sbenazirabad	3.1	81
	Shikarpur	7.8	94
	Sujawal	0.0	
	Sukkur	4.5	88
T.allahyar	6.4	88	
Tharparkar	4.6	92	
Thatta	18.3	95	
Tmkhan	12.6	100	
Umerkot	7.5	97	

Annex Table 5 – Non-polio Acute Flaccid Paralysis (AFP) indicators for non-Tier 1 districts, Khyber Pakhtunkhwa, Pakistan, 2015. Non-polio AFP rate is per 100,000 children <15 years old.

Province	District	Non polio AFP rate	Adequate specimen %
Khyber Pakhtunkhwa	Abotabad	6.9	88
	Batagram	7.9	100
	Bunir	15.0	94
	Charsada	10.6	86
	Chitral	7.6	100
	Dikhan	6.8	92
	Dirlower	7.0	88
	Dirupper	5.8	91
	Hangu	6.3	93
	Haripur	6.2	93
	Karak	10.2	79
	Kohat	8.9	88
	Kohistan	2.9	67
	Lakkimrwt	16.2	81
	Malakand	13.1	92
	Mansehra	5.5	94
	Mardan	11.2	93
	Nowshera	7.1	74
	Shangla	4.6	92
	Swabi	9.6	86
Swat	5.4	78	
Torghar	7.0	88	

Annex 4 – Cross-border Coordination Meetings with Afghanistan

Annex Table 6 – Cross-border meetings between polio eradicators in Balochistan province, Pakistan and Southern Region, Afghanistan, June – November 2015

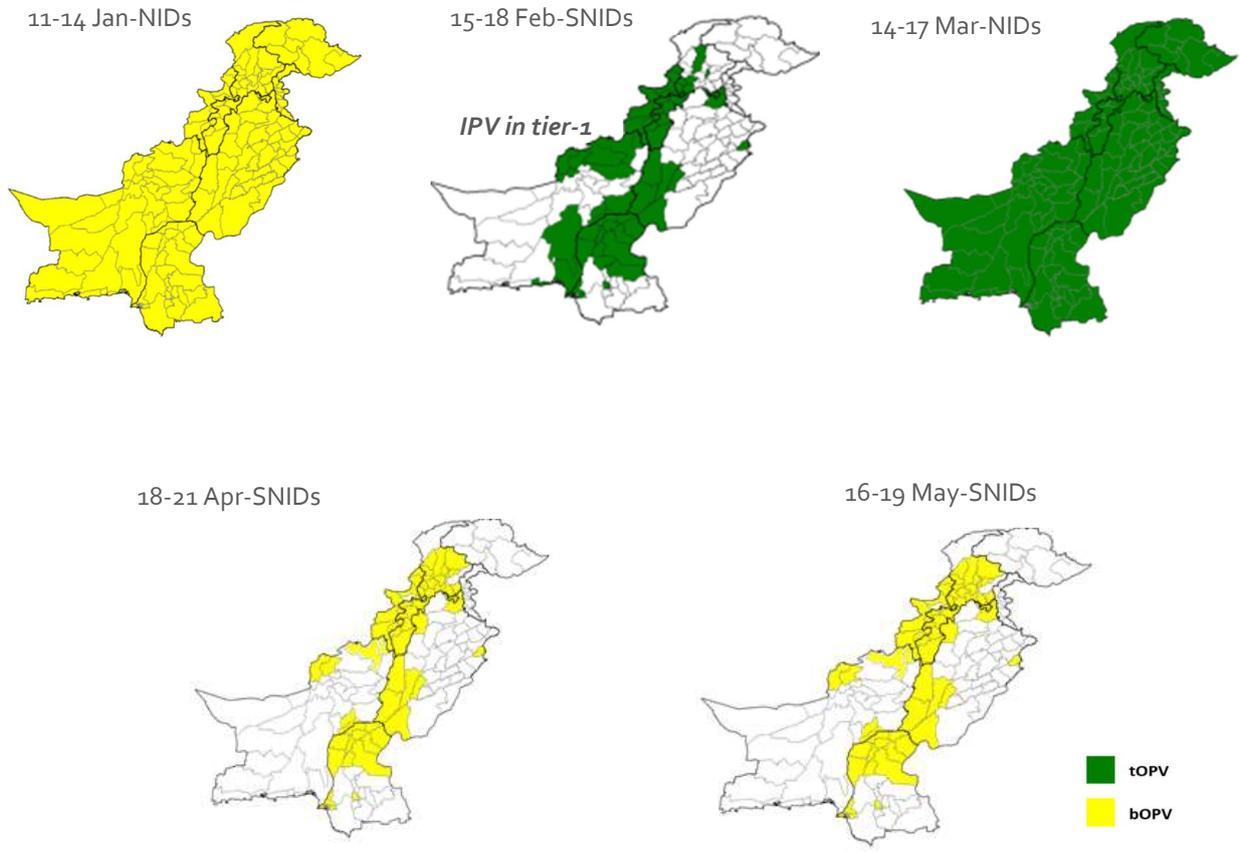
No.	Date	Type of communication
1	11 June	Tele-conference
2	25 th June	Tele-conference
3	30 th June	Face to Face; Zero Point Pak Afghan Friend Ship Gate
4	9 th July	Tele-conference
5	23 July	Tele-conference
6	13 August	Tele-conference
7	10 sept	Face to Face; Zero Point Pak Afghan Friend Ship Gate
8	17 Sept	Tele-conference
9	1 st Oct	Tele-conference
10	15 th Oct	Tele-conference
11	29 th Oct	Tele-conference
12	4 th Nov	Face to Face; Zero Point Pak Afghan Friend Ship Gate
13	19 th Nov	Tele-conference
14	26 th Nov	Tele-conference

Annex Table 7 – Cross-border meetings between polio eradicators in FATA and Khyber Pakhtunkhwa, Pakistan and Eastern and South Eastern Regions, Afghanistan, June – November 2015

Sr. No.	Dates	Type of Communication
1	6 th July, 2015	Video Conference
2	24 th August, 2014	Video Conference
3	10 th September, 2015	Face to Face; FATA EOC
4	Last week of October, 2015	Face to Face; at Turkham

Annex 5 – Revised Supplementary Immunization Calendar

Annex Figure 2 – The Supplementary Immunizations Calendar for Pakistan, January – May 2016



Annex 6 – Agenda of review meeting

Annex Table 8 – Agenda of the National Polio Management Team Meeting held on 18th November 2015 at the National Emergency Operations Centre, Islamabad, Pakistan to review the implementation of NEAP

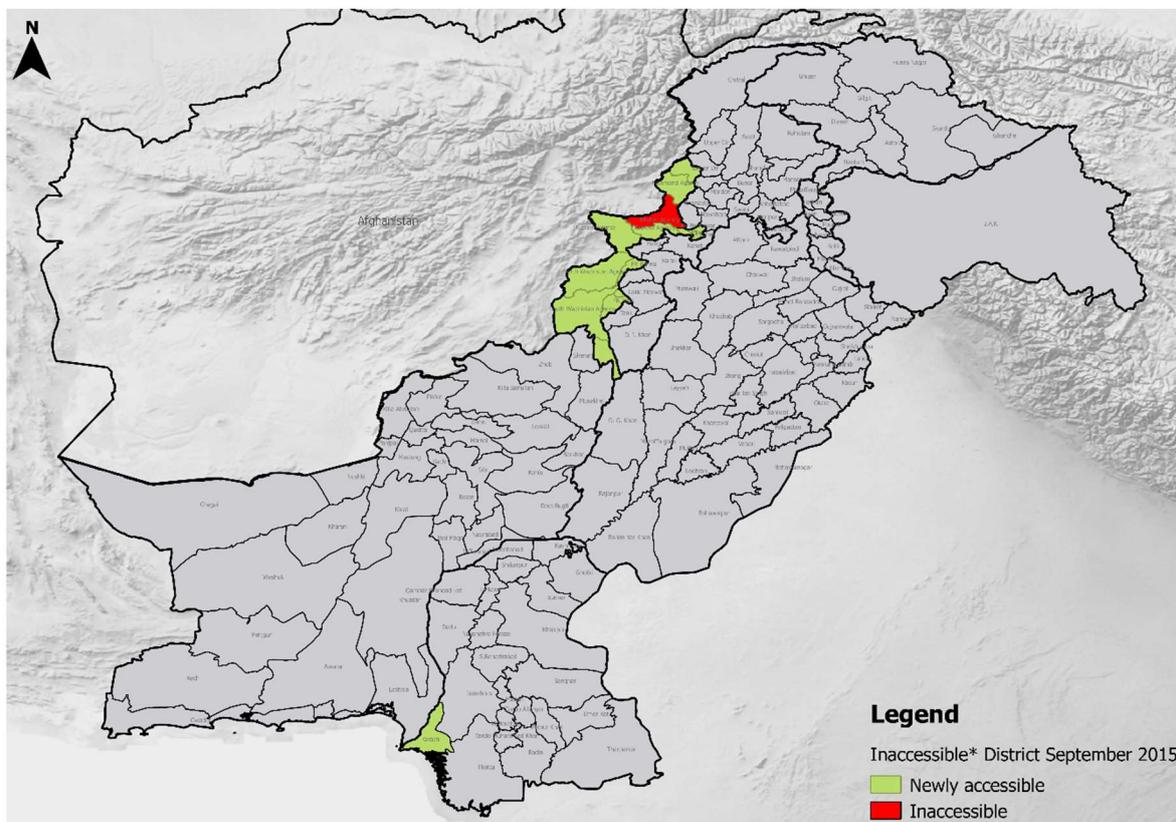
Time	Agenda item	Materials required	Presenter/Moderator
9.00 – 9.15 AM	Welcome remarks and expected meeting outcomes	None	Sen Ayesha Farooq, PM Focal Point for Polio Eradication
9.15 – 9.30 AM	Review of the implementation of the NEAP <ul style="list-style-type: none"> Overview of implementation of NEAP work plan at National EOC (7 pillars) Progress and challenges 	<i>Max 10 Slides;</i> <i>NEOC NEAP Workplan</i>	Dr. Rana Safdar National EOC Coordinator
9.30 – 9.45 AM	Discussion of matters arising from National presentation		Sen Ayesha Farooq, PM Focal Point for Polio Eradication
9.45 – 10.00 AM	Balochistan: Review of Implementation of NEAP <ul style="list-style-type: none"> Overview of implementation of NEAP work plan at Provincial Level (7 pillars) Progress and challenges 	<i>Max 10 Slides;</i> <i>Balochistan NEAP Workplan</i>	EOC Coordinator
10.00 – 10.15 AM	Discussion of matters arising from Balochistan presentation <i>Suggested discussion points</i> <ul style="list-style-type: none"> Progress made and challenges faced in Quetta block Outcome of cross-border coordination with Loy Kandahar provinces in Southern Afghanistan 		Dr. Rana Safdar National EOC Coordinator
10.15 – 10.30 AM	TEA BREAK		
10.30 – 10.45 AM	KP: Review of Implementation of NEAP <ul style="list-style-type: none"> Overview of implementation of NEAP work plan at Provincial Level (7 pillars) Progress and challenges 	<i>Max 10 Slides;</i> <i>KP NEAP Workplan</i>	EOC Coordinator
10.45 – 11.00 AM	Discussion of matters arising from KP presentation <i>Suggested discussion points</i> <ul style="list-style-type: none"> Progress made in Peshawar and other Tier 1 districts Coordination with FATA on the Khyber-Peshawar transmission corridor 		Dr. Rana Safdar National EOC Coordinator

11.15 – 11.30 PM	FATA: Review of Implementation of NEAP <ul style="list-style-type: none"> • Overview of implementation of NEAP work plan at Provincial Level (7 pillars) • Progress and challenges 	<i>Max 10 Slides; FATA NEAP Workplan</i>	EOC Coordinator
11.30 – 11.45 AM	Discussion of matters arising from FATA presentation <i>Suggested discussion points</i> <ul style="list-style-type: none"> • Coordination with KP on the Khyber-Peshawar transmission corridor • Coordination with Loy Nangarhar provinces in Eastern Afghanistan 		Dr. Rana Safdar National EOC Coordinator
11.45 – 12.00 PM	Sindh: Review of Implementation of NEAP <ul style="list-style-type: none"> • Overview of implementation of NEAP work plan at Provincial Level (7 pillars) • Progress and challenges 	<i>Max 10 Slides, Sindh NEAP Workplan</i>	EOC Coordinator
12.00 – 12.15 AM	Discussion of matters arising from Sindh presentation <i>Suggested discussion points</i> <ul style="list-style-type: none"> • Quality SIAs in Karachi in preceding three rounds • Risk of sustained low-incidence transmission in Karachi during the low season and potential strategies of overcoming current obstacles to achieving high population immunity • AFP and environmental surveillance 		Dr. Rana Safdar National EOC Coordinator
12.15 – 12.30 PM	Punjab: Review of Implementation of NEAP <ul style="list-style-type: none"> • Overview of implementation of NEAP work plan at Provincial Level (7 pillars) • Progress and challenges 	<i>Max 10 Slides; Punjab NEAP Workplan</i>	EOC Coordinator
12.30 – 12.45 AM	Discussion of matters arising from Punjab presentation <i>Suggested discussion points</i> <ul style="list-style-type: none"> • Residual risk in Rawalpindi, Lahore, DG Khan, and Southern Punjab/Central Pakistan • Lessons learnt from the Chakwal experience and the environmental surveillance review 		Dr. Rana Safdar National EOC Coordinator
12.45 – 2.00 PM	Lunch break		

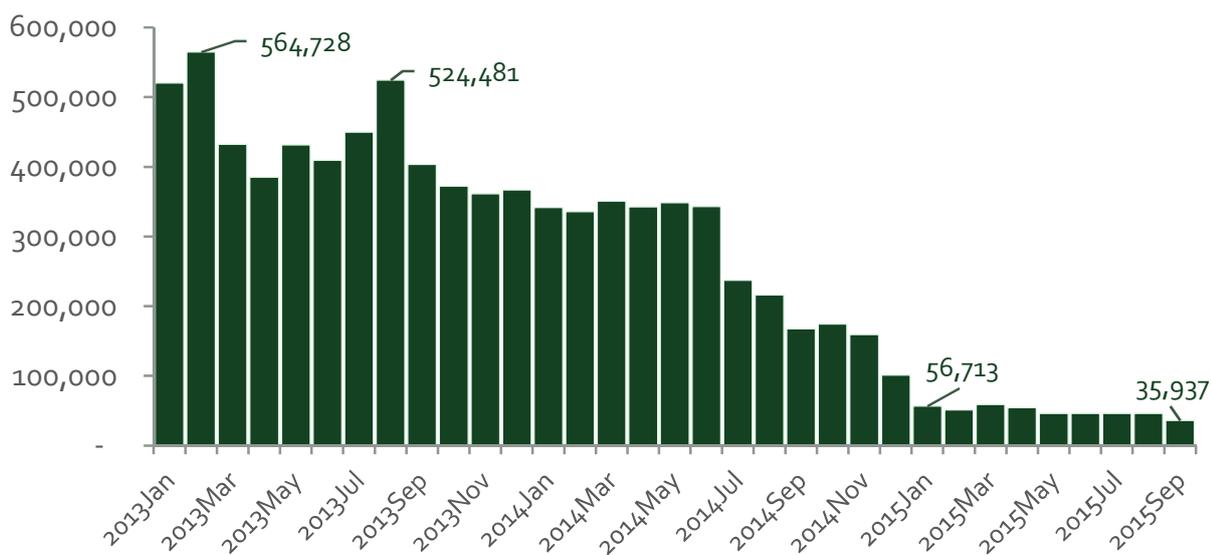
2.00 – 5.00 PM	Special panel discussion sessions <i>Setting the scene: For these sessions, the moderator is expected to prepare and present a maximum 7 slides to kick start the panel discussion</i>		
2.00 – 3.00 PM	Special session I Khyber-Peshawar corridor, Quetta block, Karachi centrifuge, and Central Pakistan: What will it take to eradicate the virus from these last sanctuaries	<i>Max 7 slides</i>	Moderators: Zubair Wadood and Mike Ryan
3.00 – 4.00 PM	Special session II Achieving high quality supplementary immunizations: right tactics? Adequate planning?	<i>Max 7 slides</i>	Moderators: Aidan O’Leary and Abdi Mahamud
4.00 – 4.20 PM	Tea Break		
4.20 – 5.00 PM	Special session III Implementing the Accountability Framework and Performance Management	<i>Max 7 slides</i>	Moderators: Carl Tinstman and Altaf Bosan
5.00 – 5.20 PM	Conclusions and recommendations of the NEAP review		Dr. Rana Safdar National EOC Coordinator
5.20 – 5.30 PM	Closing remarks		Sen Ayesha/Dr Rana

Annex 6 – Inaccessible population, Pakistan, November 2015

Annex Figure 2 – Map of Pakistan showing areas still having pockets of inaccessible children (red) and areas made fully accessible in the past 2 years.



Annex Table 9 – Estimated number of children living in inaccessible areas, Pakistan, 2013 – 2015





صحت محافظ



National Emergency Operations Centre, Islamabad, Pakistan