NATIONAL EMERGENCY OPERATIONS CENTRE
ISLAMABAD, PAKISTAN

EXTENSION OF THE NATIONAL EMERGENCY ACTION PLAN FOR POLIO ERADICATION 2018/2019

CONTENTS

FIGURES

TABLES

ACRONYMS AND ABBREVIATIONS

ADC	Additional Deputy Commissioner
AFP	Acute flaccid paralysis
AoW	Area of work
APM	Accountability and performance management
BMGF	Bill & Melinda Gates Foundation
C4D	Communication for development
C4E	Communication for eradication
C4S	Communication for surveillance
CBV	Community-based vaccination
CDR	Comprehensive data review
CHW	Community health worker
COMNet	Communication Network
CO	Country office
CR	Case response
CSO	Civil Society Organizations
CTT	Communication task team
D&R	Detection and Response
DC	Deputy Commissioner
DHO	District Health Officer
DHCSO	District Health Communication Support Officer
DPEC	District Polio Eradication Committee
DPCR	District Polio Control Room
DSC	Data support centre
DSO	District Surveillance Officer
DSRC	District Surveillance Review Committee
DQA	Data quality assessment
DQSA	Data quality and system assessment
DSRC	District Surveillance Review Committee
EI	Essential immunization
eIFA	Electronic information for action
EOC	Emergency Operations Centre
EPI	Expanded programme on immunization
ER	Event response
ERM	Evening review meeting
ES+	Positive environmental sample
FLW	Frontline worker
FO	Field office
GHSS	Government higher secondary school
H2R	Hard to reach
HH	Household
HR&MP	High-risk and mobile populations
IDIMS	Integrated Disease Information Management System
IEC	Information, education, communication
IFA	Information for action
IMB	Independent Monitoring Board
IOR	Innovation and operational research
IPC	Interpersonal communication
IPV	Inactivated poliovirus vaccine
ISD	Integrated service delivery
KP	Khyber Pakhtunkhwa
KPI	Key performance indicator
LQAS	Lot quality assurance sampling
M&E	Monitoring and evaluation
MPQA	Microplan quality assessment
MT	Mobile team
NA	Not available
NEAP	National Emergency Action Plan
NEOC	National Emergency Operations Centre
NID	National Immunization Days
NNT	Neonatal tetanus
NSTOP	National Stop Transmission of Polio
NTF	National Task Force
ODK	Open data kit
OPV	Oral poliovirus vaccine
PDA	Programme data assistant
PEI	Polio Eradication Initiative
PEO	Polio Eradication Officer
PEOC	Provincial Emergency Operations Centre
PERMA	Pakistan Electronic Media Regulatory Authority
PID	Primary immunodeficiency disorder
PMI	Perception Management Initiative
PTF	Provincial Task Force
PTP	Permanent transit point
RADS	Risk Assessment and Decision Support
RRU	Rapid response unit
RSP	Religious support person
SE	Surveillance for Eradication
SETT	Surveillance for Eradication Task Team
SIA	Supplementary Immunization Activity
SMC	Still missed children
SMT	Special mobile teams
SNID	Subnational immunization days
SOP	Standard operating procedure
TAG	Technical Advisory Group
THO	Town Health Officer
TORs	Terms of reference
TT	Task team
TTSP	Temporary Tehsil Support Person
UC	Union Council
UCCO	Union Council Communication Officer
UCPO	Union Council Polio Officer
UNICEF	United Nations Children's Fund
UPEC	Union Council Polio Eradication Committee
VC	Video conference
VDPV	Vaccine-derived poliovirus
VPD	Vaccine-preventable disease
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WPV1	Wild poliovirus type 1

EXECUTIVE SUMMARY

Pakistan has come a long way in its struggle to eradicate polio. However, despite the recent progress in reducing the number of wild poliovirus type 1 (WPV1) cases to eight in 2017 and 12 in 2018, this year has seen a significant rise in the number of WPV1 cases and positive environmental samples has been reported this year.

One of the most intractable challenges faced by the programme has been refusals by parents and caregivers to immunize their children with the polio vaccine. Such refusals are often the product of "polio fatigue" – where communities that are deprived of many basic services i.e. health, nutrition, water and sanitation grow weary of repeated knocks at the door for polio activities. Added to this, the spread of misinformation and propaganda, fuelled by social media, has stirred up mistrust in the polio vaccine that has now materialized as real community resistance to vaccination. In addition to these external challenges, inconsistent and suboptimal suppementary immunization activity (SIA) campaign quality in some areas, massive population movements across the borders with Afghanistan and within the country, inadequate delivery of essential immunization services, amongst others, have contributed to the currently expanding epidemiology, where WPV1 cases have markedly increased when compared with 2018 year-to-date.

In light of these challenges, the Pakistan programme has revisited its strategy and put forward this Extension of the National Emergency Action Plan 2018/2019 (NEAP), which will carry the programme forward from July to December 2019. The Extension of the 2018/2019 NEAP allows the Pakistan programme to incorporate the goals outlined by the Global Polio Eradication Initiative (GPEI) in the Polio Endgame Strategy, 2019 – 2023, and to align with the Afghanistan programme for 2020/2021 planning, as coordination between the two countries is critical to interrupting polio both within and across the epidemiological block.

The Extension introduces a number of modifications, interventions, and innovations identified to respond to persistent challenges, unfolding epidemiological risks, and new strategic approaches.

Specifically, this Extension:

- Puts more emphasis on the following areas of work:
    - Communications, with dedicated task teams that will engage communities more effectively to increase vaccine acceptance as well as respond to external communication needs and crises; and
    - Synergy and additional activities, which will initiate new collaborations with the Expanded Programme on Immunization (EPI) and integrated services delivery (ISD), among other programmes or initiatives, so communities that are vulnerable for polio also receive other critical interventions that will improve their lives and positively impact their perception of the programme.
- Introduces a revised SIA campaign modality by spacing out SIA campaigns with at least a six-week buffer. The six-week interval may avert community fatigue with the polio programme, but more critically it will allow for activities to support community engagement, frontline worker (FLW) capacity, social mobilisation strategies, and overall campaign quality.
- Elevates the risk tier level for a handful of districts that either have continued transmission or are close to persistently infected districts or districts with programmatic gaps.
- Defines new case response and event response guidelines so the programme organises a focused and timely response to new WPV cases or positive environmental samples.
- Incorporates the latest guidelines for surveillance among high-risk and mobile populations and patients with primary immunodeficiency disorders.

- Streamlines data collection by prioritizing pre-campaign preparedness and retaining only one method of post-campaign evaluation: lot quality assurance sampling [LQAS] by third-party monitors. New mechanisms are also introduced to ensure the programme uses data effectively, reduces duplication, and maximizes the impact of programme resources.
- Builds upon the Accountability and Performance Management (APM) Framework to provide clearly defined and systematic mechanisms for the recognition of good performance and investigation, support, and sanctions for sub-optimal performance at all levels throughout the programme.

Across key priorities for the NEAP 2018/2019 Extension, the programme also organises a special task team with representation from all areas of work and all task teams, to encourage coordination, strengthen operations, and drive performance across all levels of the programme. This approach is put forward to close the remaining gaps and turn the tide toward polio eradication in Pakistan.

INTRODUCTION

The Pakistan Polio Eradication Initiative (PEI) is currently facing intensified challenges, as evidenced by an increase in wild poliovirus type 1 (WPV1) cases reported year-to-date for 2019 (41 cases as of 8 July 2019). Foremost among these challenges is increasing community resistance to vaccination that is attributable to parent and caregiver fatigue with supplementary immunization activities (SIAs), as well as the spread of misinformation about vaccines. In April 2019, propaganda against the polio programme in Peshawar resulted in a record number of refusals across Pakistan, particularly in districts of Khyber Pakhtunkhwa (KP).

In light of these and other ongoing challenges, it has become imperative that the programme revisit its current strategy and outline key priorities to ensure the programme moves successfully toward interrupting WPV1 transmission and eradicating polio in Pakistan.

This Extension outlines the programme's strategy for the period covering July to December 2019.

DISTRICT TIER CLASSIFICATION

A district-level tier classification informed the previous National Emergency Action Plan (NEAP) 2018/2019 by targeting programme activities to particular districts according to their risk for WPV1 circulation or ongoing transmission. The current challenges faced by the programme have not been due to misidentifying at-risk districts or failing to include them in SIAs; rather, the programme has encountered difficulties in reaching children with polio vaccines during SIAs due to poor campaign quality. Therefore, a formal reclassification based on historic data and risk assessment will not be included in this Extension but will be prioritized for the NEAP 2020/2021. Such a reclassification is also unwarranted as there are no subnational immunization days (SNIDs) planned for this six-month period, only national immunization days (NIDs) and case responses (CRs).

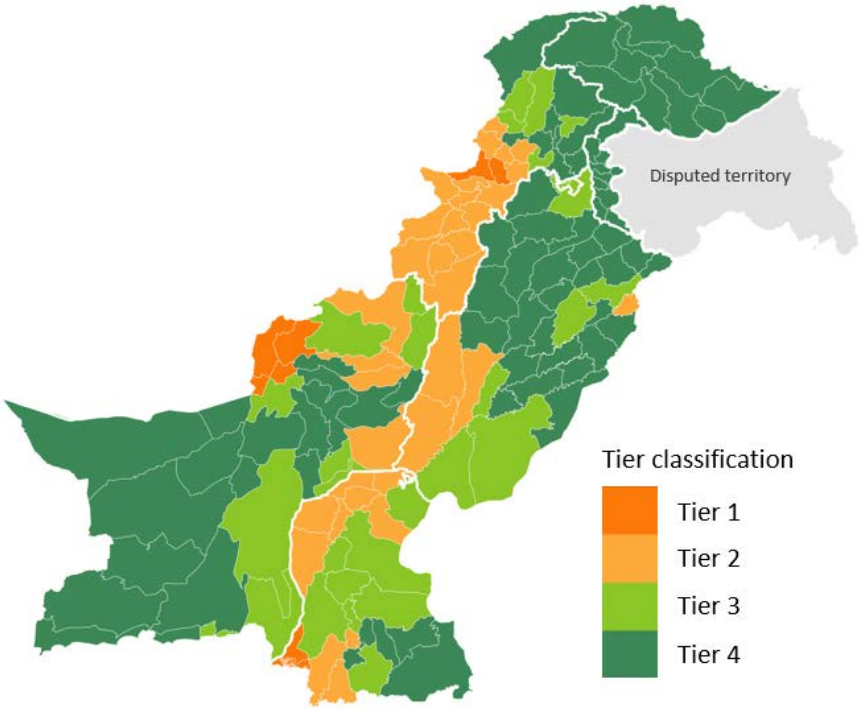
For the period of July to December 2019, given the currently expanding epidemiology, the tier classification of a few select districts will be raised due to continued transmission or proximity to persistently infected districts or districts with programmatic gaps (Table 1). This modification to the previous district tier classification will ensure increased programmatic focus on these districts over the next six months.

Table 1: Rationale for revised district tier classifications, July – December 2019

Province	District(s)	Previous Tier	Jul-Dec19 Tier	Rationale
KP	Kurram and Orakzai	3	2	Proximity to persistently infected districts and programmatic gaps
Punjab	Lahore	3	2	Continued poliovirus transmission
Balochistan	Mastung and Sohbatpur	4	3	Proximity to persistently infected districts and programmatic gaps
Sindh	Hyderabad	3	2	Continued poliovirus transmission and proximity to infected districts

In total, there are now 11 tier 1 districts, 34 tier 2 districts, 30 tier 3 districts and 77 tier 4 districts. The final tier classification for July – December 2019 is provided in Figure 1.

Figure 1: Final tier classification for Pakistan, July – December 2019

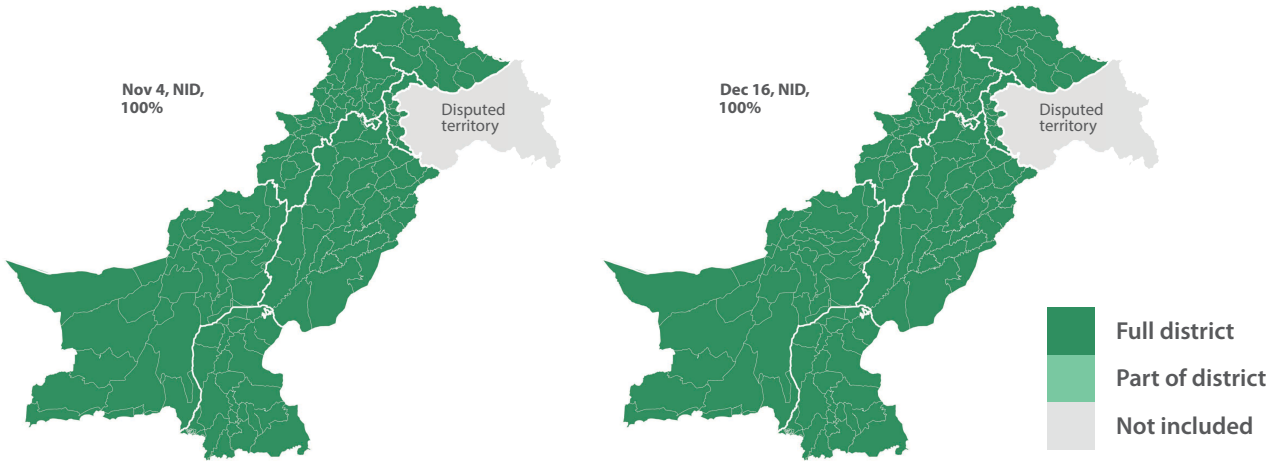


SIA CALENDAR

Given the increasing community resistance and challenges to adequately preparing for high-quality campaigns, SIAs planned for the July – December 2019 period will be conducted over at least a six-week interval, starting from first day of a campaign. This will address community and frontline worker (FLW) fatigue and ensure sufficient time for campaign preparation, implementation of activities to increase vaccine demand (such as social mobilisation and community engagement), and FLW capacity building and utilisation for supporting the Pakistan Expanded Programme on Immunization (EPI) and integrated services delivery (ISD). This new, comprehensive strategic approach to polio eradication will require time to implement and successfully integrate; therefore, the focus of programme activities in July through October will be on community engagement and training of FLWs and staff with EPI and ISD to ensure a solid foundation is developed before the next planned SIA in November.

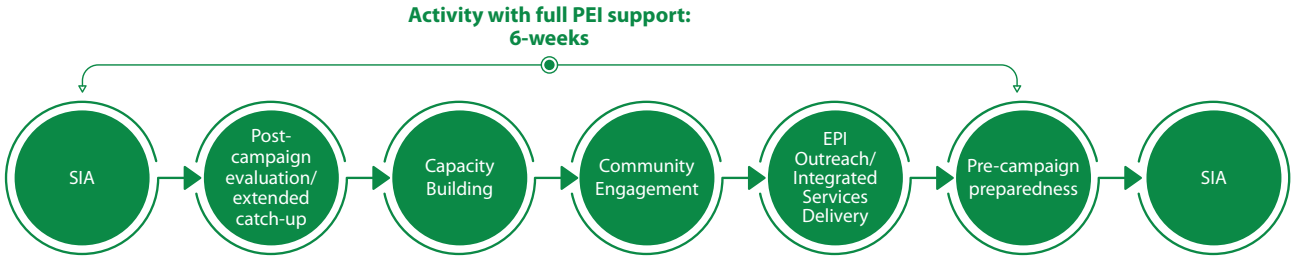
Also during this period, the programme will focus on high-quality oral poliovirus vaccine (OPV) SIAs targeting children <5 years of age. As such, there will be no additional SIA strategies (such as inactivated poliovirus vaccine [IPV] campaigns or expanded age OPV campaigns) for the remainder of 2019. This will ensure that the resources are devoted to reaching missed children with vaccine – *the primary challenge of the programme and the reason for continued WPV1 transmission across Pakistan.*

Figure 2: The SIAs plan for July – December 2019



The new six-week interval between SIAs will include comprehensive support to community engagement activities, EPI outreach, capacity building and integrated services delivery (e.g., water, sanitation and hygiene [WASH], nutrition and health). These activities will be ongoing throughout the interval by their respective units. In addition, at least one week will be dedicated each to capacity building, community engagement, and EPI outreach/ISD coordination where full PEI staff support will be provided as required (Figure 3). Capacity building activities will include both PEI- and EPI-related components.

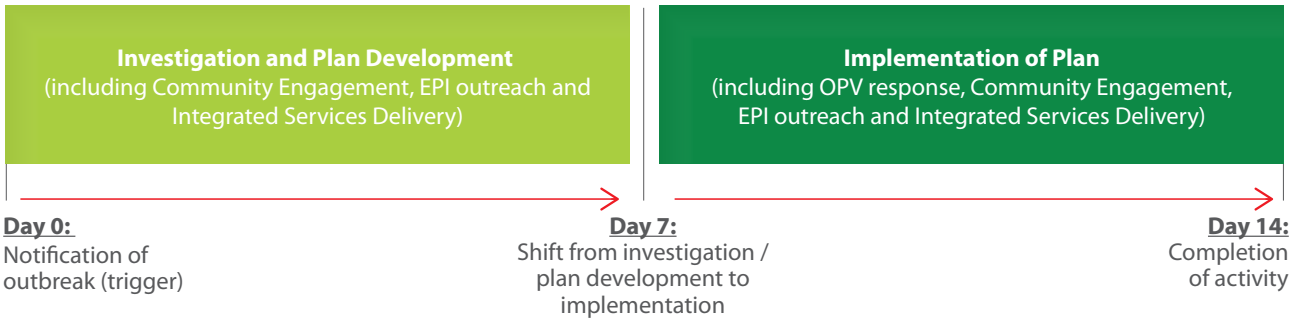
Figure 3: Activities with full PEI support during the six-week interval between SIAs



CASE RESPONSE AND EVENT RESPONSE

The case response (CR) and event response (ER) framework will include an initial focused mop-up activity to be completed within 14 days of an outbreak notification which triggers a response. The two-week timeline of mop-up activities will be divided and prioritized, whereby the first week will focus on investigating and developing a comprehensive and integrated plan (including community engagement, EPI outreach and additional service delivery) and the second week will be plan implementation (Figure 4).

Figure 4: Timeline of mop-up activity in response to WPV1



For the mop-up, a limited target should be considered with a focus on ensuring maximum quality in the epicentre of transmission. For larger outbreaks spanning multiple districts, the scope must reflect the scale of transmission and, consequently, a larger target population will be required. The initial focused mop-up activity will be followed by one to two rounds of CR/ER in six-week intervals or synchronised with the subsequent SIA. This strategy will reduce supplemental vaccination activities between SIAs and ensure the six-week interval can be maintained.

The triggers for mop-ups and CR/ER by tier are provided in Table 2. Where detection does not trigger response, the focus will be on investigation and enhanced preparation/support for the next SIA.

Table 2: Case response and event response guidelines

Isolation of WPV1	Tier 1	Tiers 2-4
1-2 ES+ (genetically linked) **OR** >1 ES+ in ≥1 site (NOT genetically linked)	Detection will NOT trigger response. Focus will be on investigation and enhanced preparation/support for next SIA.	
≥3 ES+ in 1 site (genetically linked) **OR** 1 ES+ in ≥2 sites (genetically linked)	Detection will NOT trigger response. Focus will be on investigation and enhanced preparation/support for next SIA.	Detection will trigger focused mop-up response in select UCs within 14-days. Subsequent ER in 6-weeks or synchronized with next SIA.
≥1 AFP case(s)	WPV1 case will trigger focused mop-up response in select UCs within 14-days. Subsequent CR in 6-weeks or synchronized with next SIA.	

AFP= acute flaccid paralysis; CR= case response; ER= event response; ES+= positive environmental sample; SIA= supplementary immunization activity; UC= Union Council; WPV1= wild poliovirus type 1

Moreover, there will be a synchronised CR planned for 23 September 2019. The geographic scope is yet to be defined based on the most current epidemiology prior to the response; however, the total population to be targeted will be 43-50 percent.

EMERGENCY OPERATIONS CENTRE STRUCTURE

The Pakistan polio programme has shifted to a more comprehensive and integrated approach, particularly through its collaboration with EPI and ISD, and therefore the Emergency Operations Centre (EOC) structure must likewise reflect current priorities. Due to the increased focus on communications and synergy with EPI and ISD activities, the functions of the EOC are now classified into the following six areas of work (AoWs).

1. Programme Operations
2. Risk Assessment and Decision Support (RADS)
3. Detection and Response (D&R)
4. Management
5. Communications
6. Synergy and additional activities

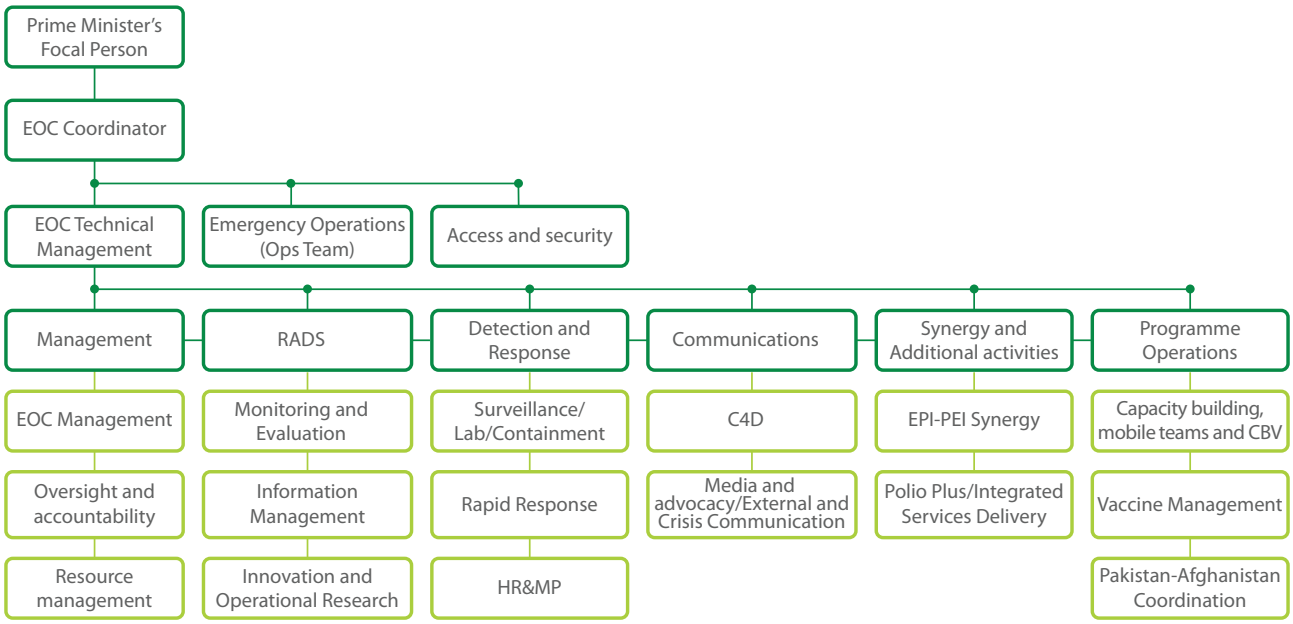
Within each AoW there are two to three task teams (TTs) for a total of 16 TTs (Table 3). Each TT will meet one to two times per month and outline a clear workplan with assigned responsibilities. Additionally, there will be one TT with two members from each AoW that will meet monthly to ensure close coordination between the various units. Finally, each AoW will have a video conference (VC) with provinces each month.

Table 3: Areas of work and task teams within the Pakistan Emergency Operations Centre

Area of Work	Task Team
Programme Ops	• Capacity building, mobile teams and CBV • Vaccine management • Pakistan-Afghanistan coordination
Risk Assessment and Decision Support (RADS)	• Monitoring and evaluation • Information management • Innovation and operational research
Detection and Response	• Surveillance / Lab / Containment • Rapid Response • HR&MP
Management	• EOC management • Oversight and accountability • Resource management
Communications	• C4D • Media and advocacy / external and crisis communications
Synergy and Additional activities	• EPI-PEI synergy • Polio plus / Integrated services delivery

EPI= Expanded programme on immunization; PEI= Polio Eradication Initiative

Figure 5: Functional structure of the Pakistan Emergency Operations Centre (EOC)



As a distinct unit that reports to the National EOC coordinator, Emergency Operations has defined priorities for the NEAP Extension period, which are summarized in Appendix B, Table B1.

1. Programme Operations

Programme Operations as an area of work includes three task teams that organise to address: capacity building, mobile teams and community-based vaccination (CBV); vaccine management; and Pakistan-Afghanistan coordination.

The overarching priority for the July – December 2019 NEAP Extension for Programme Operations will be to redefine the programme's SIA strategy, in particular the duration of vaccination activities, the amount of information collected by FLWs in CBV areas and capacity building. Changes to the SIA modality in terms of duration, data collection and capacity building are outlined in Table 4.

In CBV and special mobile team (SMT) areas SIAs will be carried out over five days, followed by two days of catch-up activities (5+2), whereas in mobile team (MT) areas, the SIA will be three days followed by one catch-up day (3+1). This approach ensures maximum coverage is achieved within one week of the start of SIAs. Although the current SIA strategy targets reaching children within the first seven days of an SIA campaign in both CBV and MT areas, this will be reviewed in January 2020 once the comprehensive strategy of community engagement, EPI outreach and additional services are fully integrated.

Furthermore, the programme's data strategy in CBV areas will be revised. The previous focus on collecting large amounts of data has limited the amount of time that FLWs can spend on proper area-specific communication activities. In light of this feedback from the frontlines, the data collection strategy will be refined for CBV areas to capture only key indicators to guide the programme.

Table 4. Changes to SIA modality

	Change to SIA modality
Duration of SIAs	• In CBV/SMT areas, SIAs will be carried out over 5 days, followed by 2 days of catch-up activities (5+2) • In MT areas, SIAs will be carried out over 3 days, followed by 1 day of catch-up activities (3+1) • Additional catch-up focusing on covering refusal and NA will take place until 14-days from start of SIA, with the target to reduce this to 7-days from Jan 2020.
Data collection	• In CBV areas, implementation of simple data collection, recording and reporting tools to capture key indicators (i.e. missed children recorded and covered with simple categorization of NA and refusals)
Capacity building	• Capacity building of first level supervisors on supportive supervision, communication/community engagement and use of data for planning at area level to tackle household access, increase acceptance in communities.

CBV= community-based vaccination; MT= mobile teams; NA= not available; SIAs= supplementary immunisation activities; SMT= special mobile teams

Finally, capacity building of supervisors will be strengthened to ensure FLWs are equipped to adequately address concerns. This will be critical as new data recording and reporting tools and an improved communications strategy are in development and will be finalized soon.

A complete list of key priorities by Programme Operations task teams for July – December 2019 are summarized in **Appendix A, Table A1.**

2. Risk Assessment and Decision Support

Risk Assessment and Decision Support (RADS) includes three task teams that oversee and support monitoring and evaluation (M&E), information management, and innovation and operational research.

The overarching priority for the July – December 2019 NEAP Extension for RADS is to address the amount of data being collected and its utilisation across the different levels of the Pakistan polio programme. As noted by recent reports of the Independent Monitoring Board (IMB) and Technical Advisory Group (TAG), the Pakistan programme must revisit its data strategy – namely, the type, amount and quality of data collected and how it is or should be

used to inform decision making at all levels. Independent monitoring and evaluation is critical to ensure the quality of data. Also essential is a process for reviewing the mechanisms by which data is collected in order to focus resources efficiently and reduce any duplication of efforts or other kinds of redundancies, as this oversight helps maximize the impact of programme resources.

The RADS unit is currently working on multiple strategies or initiatives to address concerns about the amount, utilisation and quality of data and mechanisms of collection, the details of which are outlined in Table 5 and Figure 6.

One strategic decision will address some of the underlying challenges in implementing high-quality SIAs. Starting with the NEAP Extension period, the programme will shift from post-campaign evaluation to pre-campaign preparedness and will retain only one method of post-campaign evaluation, lot quality assurance sampling (LQAS) by third-party monitors. This shift will further ensure a reduction in the number of knocks on doors, which is currently fuelling community resistance to vaccination. No LQAS will be conducted following CR/ER.

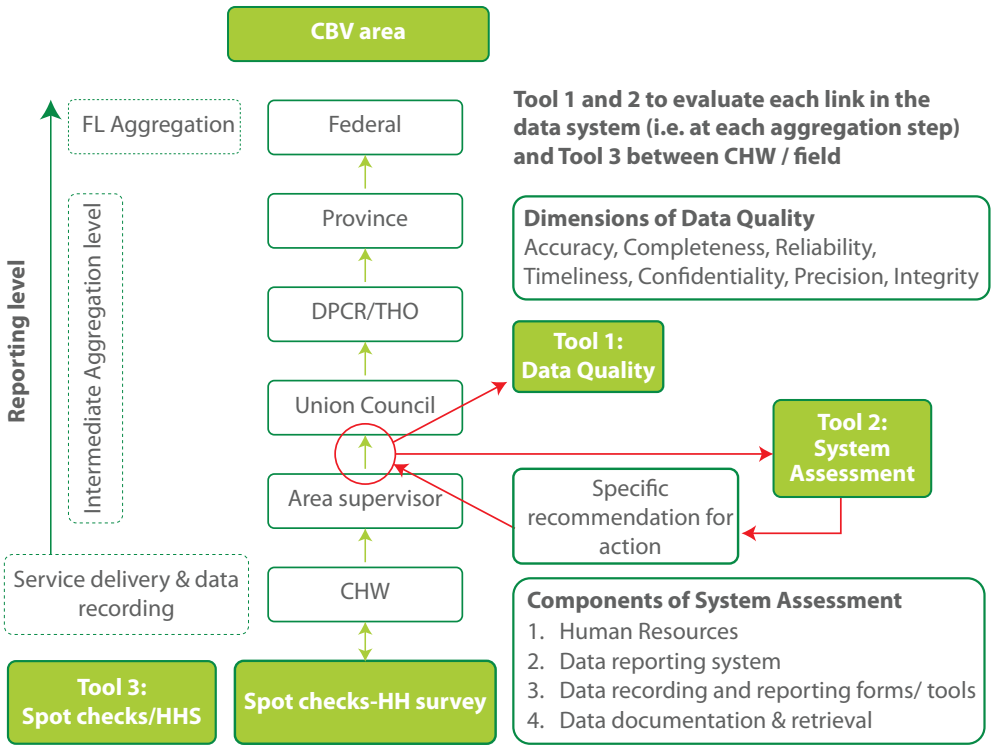
A complete list of key priorities by RADS task teams for July – December 2019 are summarized in **Appendix A, Table A2.**

Table 5: Strategies to address data concerns

Data concern	Strategy	Details of strategy
Amount	Comprehensive data review (CDR): Thorough review of all data collected within the programme to refine the data collection strategy and training	• Comprehensive review of all indicators across all tools for pre, intra and post campaign monitoring and development of framework outlining data collected at all levels and the responsibilities of data use, visualisation and management • For each data source, the following information is documented: 1) indicators collected; 2) description of indicators; 3) where it is found; 4) who uses it and how; 5) how and why it is reported; 6) what actions are taken; 7) has it been effective/useful in past 6-months; and 8) recommendations (keep as is, keep but modify, cut)
Utilization	Increasing data utilization through training and comprehensive analysis of key indicators from each campaign phase	• The CDR will be used to guide/inform targeted trainings by level to ensure people know what data is available, where they can access it, increasing capacity for use and understanding responsibility for use and reporting • The RADS unit will conduct comprehensive district-level analysis across retained indicators and tools for each stage of campaign and provide provinces with focused district-specific recommendations requiring follow-up with timelines for action
Quality	Data Quality and System Assessment (DQSA): Tools developed to evaluate the quality of data at all levels and identify gaps in the data management system	• Assess availability, completeness and accuracy of data at all levels (CHWs to DPCR/DSC) • Validate child-level information between registration book and household • Examine data management and reporting system to identify challenges to data quality • Results shared with Provincial EOCs for follow-up and action • To be conducted in CBV areas every 6-months
Mechanisms of collection	Review mechanisms by which data is collected to efficiently focus resources and reduce potential duplication of efforts	• Retaining only one method of post-campaign evaluation – LQAS by third-party monitors

CBV= community-based vaccination; CDR= comprehensive data review; CHW= community health worker; DPCR= District Polio Control Room; DSC= data support centre; DQSA= data quality and system assessment; EOC= Emergency Operations Centre; LQAS= lot quality assurance sampling; RADS= Risk Assessment and Decision Support

Figure 6: Overview of data quality and system assessment (DQSA) strategy



CBV= community-based vaccination; CDR= comprehensive data review; CHW= community health worker; DPCR= District Polio Control Room; HH= household; THO= Town Health Officer

3. Detection and Response

Detection and Response (D&R) includes three task teams that oversee field surveillance, laboratory, and containment teams, referred to collectively as Surveillance for Eradication; rapid response at the frontlines; and strategies for detecting poliovirus among high-risk and mobile populations (HR&MP).

The overarching priority of the July – December 2019 NEAP Extension for D&R will be to further enhance the quality of surveillance data and improve the depth of analysis to better drive the strategic direction of the programme. Other key priorities include ensuring timely and comprehensive investigations and integrated CR/ER strategies and improved use of programme data to assess impact of HR&MP related activities and strengthen operations preparedness to cover these groups.

A complete list of key priorities by D&R task teams for July – December 2019 are summarized in **Appendix A, Table A3,** including detailed CR/ER strategies. The key priorities for D&R outlined in NEAP 2018/2019 will be retained for this extension period.

4. Management

Management as an area of work contains three task teams: EOC management, programme oversight and accountability, and resource management.

The overarching priority of the July – December 2019 NEAP Extension for Management will be to address accountability and performance issues across all levels of the Pakistan polio programme. As a multi-disciplinary, multi-agency, and multi-level organisation, it is imperative for everyone across the programme to work consistently together as one team. Management supports this process by defining and upholding the accountability standards of individuals, teams, districts, provinces, the federal-provincial government and partners. To ensure

optimal functioning given such organisational complexity, Management provides a strong basis for oversight, measurement, evaluation, feedback and performance improvement. A critical part of driving accountability throughout the programme is also defining and communicating clear mechanisms for identifying good and bad performance with an associated system for recognition, rewards and sanctions (as required).

The Pakistan polio programme has implemented an Accountability and performance management (APM) Framework with the following components:

1. Systematic process of supervision, monitoring, evaluation and feedback for individuals, teams and the overall Pakistan PEI programme (summarised in Table 6), including:
    - Clear performance expectations
    - Supportive supervision
    - Transparent monitoring, evaluation and feedback

Table 6: Supervision, monitoring, evaluation and feedback mechanisms for the PEI programme

Level of monitoring	Clear performance expectations	Supportive supervision	Transparent monitoring, evaluation and feedback
Individuals	• TORs must be clear • Individual responsibilities, tasks and timelines should be clearly communicated • Tasks/timelines should be included in the NEAP Work Plan and/or the SIA Micro Plan	• Each individual must have a recognized Operational Supervisor of Team Lead for key tasks who provides guidance and support throughout the process of implementation and formal feedback on a regular basis	• Evaluation should be based on validated facts such as attendance, records of task completion against timelines agreed in NEAP Work Plans and formal supervisor assessments
Teams	• Team's deliverables, tasks and activities to be clearly outlined in NEAP Work Plans • KPIs and performance targets must be understood by the entire team and a mechanism must be in place to supervise, monitor and evaluated team performance	• Supervision of teams must be conducted at the level at which the team primarily works (e.g. DPCR managed and supervised by DHO who reports to DC)	• In addition to same-level supportive supervision, the monitoring of Team performance will be carried out at one level above (e.g. PEOC will monitor performance of DPCR through regular analysis of reported data, field visits by PEOC staff and formal review of each SIA with all districts)
Overall PEI Programme	• NEAP implementation will be continuously monitored and reviewed at all levels of the programme through the NEAP Work Plans, with KPIs being used as primary drivers of accountability and performance	• The coordination and oversight body at each level (e.g. UPEC, DPEC, PTF and NTF) must carry out regular reviews of programme performance at their respective levels (including assessing NEAP Work Plans, performance of Areas of Work, SIA implementation) • Formal quarterly NEAP Implementation Reviews must be conducted	• The deliberations and outcomes of meetings/reviews should be documented and shared widely • The quarterly NEAP Implementation Review findings must be reported to the governance and oversight bodies at Provincial, National and International (e.g. IMB, TAG) levels

DC= Deputy Commissioner; DHO= District Health Officer; DPCR= District Polio Control Room; DPEC= District Polio Eradication Committee; IMB= Independent Monitoring Board; KPI= key performance indicator; NEAP= National Emergency Action Plan; NTF= National Task Force; PEI= Polio Eradication Initiative; PEOC= Provincial Emergency Operations Centre; PTF= Provincial Task Force; SIA= supplementary immunization activity; TAG= Technical Advisory Group; TORs= Terms of reference; UPEC= Union Council Polio Eradication Committee

Because campaign quality is of central importance to the NEAP Extension, Management will also oversee the following expectations to ensure high-quality SIAs. Timings and duration of all UC- and district-level evening meetings during SIAs must be standardised. The duration will be between 1-1.5 hours, with the UC and district-level meetings to be completed by 5pm and 9pm, respectively. In order to ensure maximum utility of these meetings, the focus should be on highlighting key issues and outcomes and should be structured in an action-oriented manner. To achieve this, a one-page summary must be provided to the Deputy Commissioner (DC) by the National Stop Transmission of Polio (NSTOP) Officer or Polio Eradication Officer (PEO). Tehsil meetings should only take place if distance from the UC to a district exceeds a reasonable amount, as decided by the District Polio Control Room (DPCR).

2. Clearly defined and systematic mechanisms for the recognition of good performance and investigation, support and sanctions for suboptimal performance, including:
    - Good performance: Recognition, rewards and incentives for best performance, such as certificates of excellence and opportunities for further training, advancement and promotion.
    - Suboptimal performance: Investigation, support and sanctions for suboptimal performance, such as investigation and verification, coordination, intervention and resolution; sanction and separation as required.

The process of evaluation and action for good and poor performance is conducted by the APM Committee as outlined in Table 7.

Table 7: Level of competencies of the Accountability and Performance Management Committee

Level	APM Committee	Investigation, support and sanctions for poor performance	Recognition, rewards and incentives
1	UPEC Chairman, Principal GHSS, Revenue Staff and Partner's UC level staff	• Investigation and verification • Coordination • Intervention	
2	ADC, DDHO, Partners' district level staff (NSTOP, PEO, DHCSO, etc.)	• Intervention • Resolution • Sanction	• Specific notices of good performance • Issuance of certificates of excellence • Arrangement of ceremonies
3	Coordinator, Provincial EPI manager, Team leads of partner organizations (WHO, UNICEF, NSTOP, BMGF)	• Separation	• Opportunities for training, advancement and promotion • Bonuses

ADC= Additional Deputy Commissioner; APM= Accountability and performance management; BMGF= Bill & Melinda Gates Foundation; DHCSO= District Health Communication Support Officer; GHSS= government higher secondary school; NSTOP= National Stop Transmission of Polio; PEO= Polio Eradication Officer; UC= Union Council; UNICEF= United Nations Children's Fund; WHO=World Health Organization

5. Communications

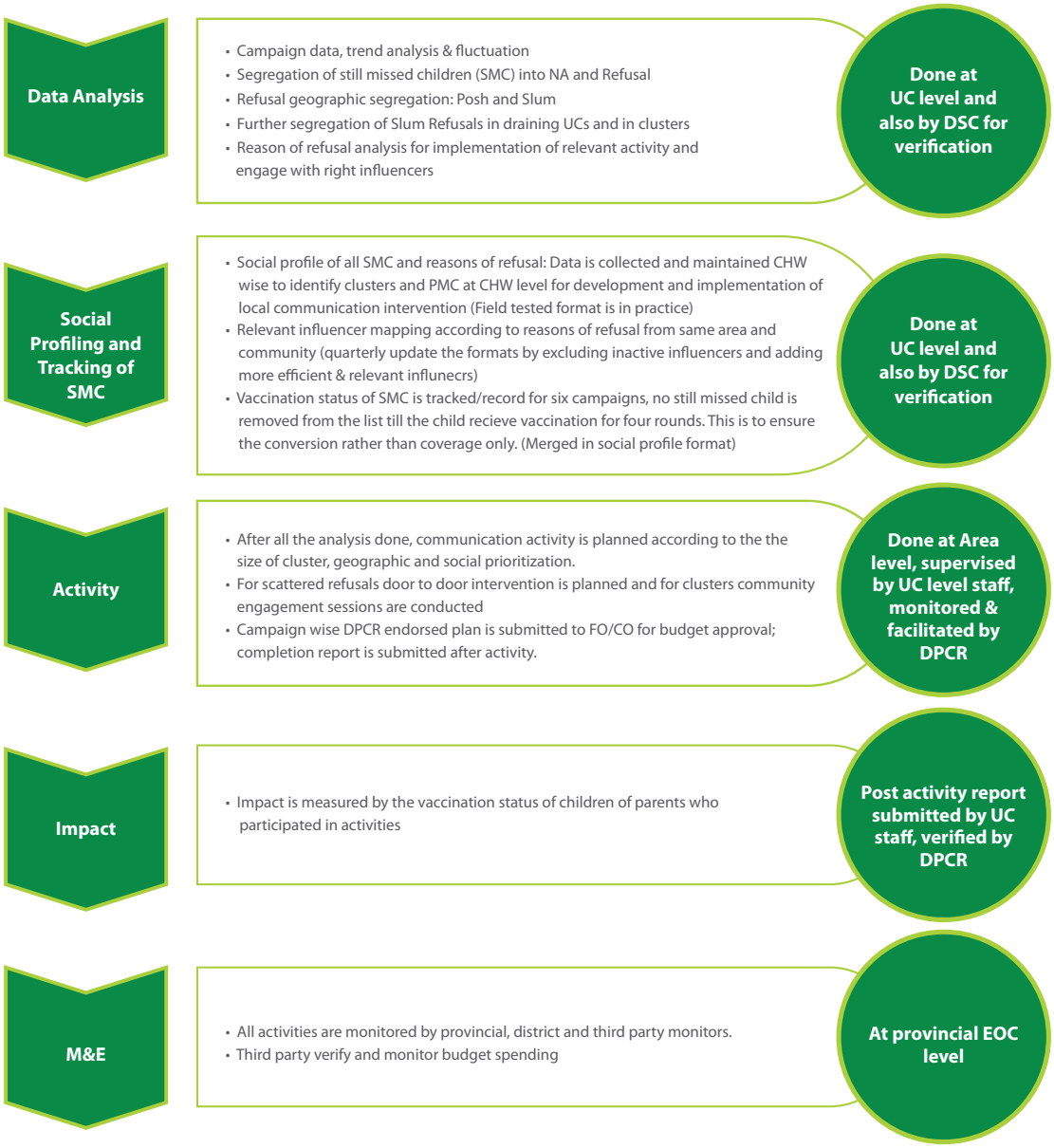
Communications is now a distinct AoW, given its importance for addressing challenges in the Pakistan polio programme. Communications has two task teams to provide strategic oversight and coordination for its efforts: communication for development (C4D) and a task team dedicated to media, advocacy, external communications and crisis communications. Despite its new distinction as a separate AoW, communications-related activities are still strongly integrated within Programme Operations strategies, and communications teams are still in close coordination with the Programme Operations AoW.

The overarching priority of the July – December 2019 NEAP Extension for Communications will be building trust in the polio programme on the part of communities at all levels and by all groups, especially those at highest risk of polio transmission. In support of this goal, Communications will fully engage communities and work to empower FLWs through increased capacity and motivation.

Key strategies for the NEAP Extension will target community fatigue and vaccination refusals. Reports of "polio fatigue" among communities that cite too many knocks on the door and the rapid spread of misinformation on social media have had negative impacts on vaccine acceptance amongst parents and caregivers. Moreover, trust in FLWs remains low in the highest-risk UCs largely due to concerns around the lack of technical knowledge to deliver safe vaccines and the appearance or hygiene and interpersonal skills of FLWs.

To transform perception of parents and caregivers, the community engagement process is data driven from inception to completion (see Figure 7). Initial plans are formulated at the provincial level and customized for each campaign to ensure the plan adequately reflects the current priorities or challenges, and the activities continue to have a productive impact on vaccine acceptability. All activities are planned at the area level and led at the UC level in coordination with DPCRs. Plans are then submitted to the Provincial Communication task team (CTT) at the PEOC. All activities are facilitated and closely monitored from the EOC and DPCR and followed by completion and impact report.

Figure 7: Community engagement process and responsibilities



CHW= community health worker; CO= country office; DPCR= District Polio Control Room; DSC= data support centre; FO= field office; NA= not available; PMC= persistently missed children; SMC= still missed children; UC= Union Council

In addition to implementing the above defined community engagement process, the programme will focus on the following key priorities over the next six months (Table 8):

1. Increase focus on building public trust in polio programme through managing public opinion (Perception Management Initiative [PMI]).
2. Advocate broader support for the polio programme and develop policies and actions in support of the polio programme through relevant sectors at all levels.
3. Foster social mobilisation and community engagement through community influencer support and media outreach.
4. Build caregiver and family knowledge, awareness and motivation in support of polio vaccination.
5. Strengthen crisis communication.
6. Synchronisation of and synergy for cross-border communication strategies to reach mobile populations and travellers crossing both countries' borders.
7. Improve FLW motivation and capacity building.
8. Implement compelling, context-specific content development and dissemination in support of all components of the C4D strategy.
9. Oversee and coordinate communication management structures.

Table 8: NEAP July – December 2019 Extension key priorities for Communications

Priority	Components of strategy
Perception Management Initiative (PMI)	• Partnerships and alliances with key stakeholders with capacity for mass public engagement and shaping of public opinion • High visibility sessions with key public opinion shapers • Dissemination of high quality content through various channels • Coordination Management Cell for PMI • Toll-free line for direction engagement with the public
Advocating for generating broader support for the polio programme	• Meetings with MoNHSR&C for integration and promoting polio vaccination through other health programmes • Meeting with Information Minister on key support (PEMRA) • Advocacy meetings and sessions with Pakistan Paediatric and Medical Associations • Orientation sessions with multi-party Parliamentarians forum for coalition support of programme • Engagement with top universities • Formation of high-level influencer platform at National and sub-National level
Fostering social mobilization and community engagement through influencers	• Influencer engagement, including: o Formation of key influencer alliances at national and district level o Mapping and orientation of district and UC level influencers o Community engagement (CE) sessions by key influencers o Mosque- and school-based activities o Engage community through media outputs and social media campaigns
Building caregiver knowledge, awareness and support of polio vaccination	• Parental/caregiver engagement through group sessions • Individual counselling sessions of refusal and persistently missed children parents by FLWs • Identification and mobilization of role model parents to mobilize other parents
Strengthen Crisis Communication	• Review and revise SOPs • Simulate possible situations and build possible plans around them • Develop a campaign cycle-wise crisis communication activity
Synchronization of and synergy for cross-border comms strategies	• Strengthen coordination and synchronize communication activities • Maintain regularity of communication with Afghanistan PEI • Mapping, forming and engaging influencers on both sides of border
Motivation and capacity building of FLWs	• Hiring top level motivational speakers to build morale of the FLWs • Development and roll-out of other motivational incentives • Capacity building FLWs, DHCSOs, UCCOs and RSPs • Development of an app for polio FLWs including key updates and IEC material
Content development and dissemination	• Evidence-based multimedia product developed in support of all C4E components • Evidence-based IEC developed
Coordination and communication management structures	• Strengthen National and Provincial Task Teams, DPCR and UPEC • Review of CBV, COMNet, CSOs, RSP and other communication cadres

CBV= community-based vaccination; CE= community engagement; COMNet= communications network; CSOs= civil society organisations; DHCSO= District Health Communication Support Officer; DPCR= District Polio Control Room; FLW= frontline worker; IEC= Information, education, communication; MOH= Ministry of Health; PEI= Polio Eradication Initiative; PEMRA= Pakistan Electronic Media Regulatory Authority; PMI= Perception Management Initiative; RSP= religious support person; SOPs= standard operating procedures; UCCO= Union Council Communication Officer; UPEC= Union Council Polio Eradication Committee

A complete list of key priorities by Communications task teams for July – December 2019 are summarized in **Appendix A, Table 4.**

6. Synergy and Additional Activities

Given the importance of collaboration between the Pakistan PEI, the Expanded Programme on Immunization (EPI) and integrated services delivery (ISD), including water, sanitation and hygiene [WASH], nutrition and health, Synergy has now become a distinct AoW. Synergy is comprised of two task teams focused on distinct sites of collaboration: immunization through PEI/EPI synergy and expanded services through Polio Plus/ISD synergy.

The overarching priority of the July – December 2019 NEAP Extension for Synergy will be better integration of EPI outreach and expanded delivery of additional services within the PEI programme.

A persistent challenge to eradication of WPV1 remains community resistance, particularly in the highest-risk districts. Some slow progress in addressing the systemic weaknesses of health infrastructure and EPI services in high-risk districts has indicated that community demand can be improved through the introduction of integrated services and EPI delivery in core reservoirs. Therefore, to increase acceptability of polio vaccination campaigns, the EOC will implement an integrated package of health, WASH and nutrition interventions in 52 selected UCs at high risk of polio transmission in the core reservoir areas (Table 9).

Table 9: Union Councils selected for integrated package of health, WASH and nutrition interventions

Province	District	Number of UCs	Target population <5 years
Balochistan	Killa Abdullah	6	31,961
	Quetta	9	78,975
KP	Peshawar	18	117,605
Sindh	Karachi Central	1	8,525
	Karachi East	8	183,953
	Karachi Malir	3	49,979
	Karachi West	7	166,543
Total		**52**	**637,541**

These integrated interventions will not only increase community acceptance of polio vaccination campaigns among parents and caregivers who may have previously refused immunization, but they will also reduce the transmissibility of poliovirus and the risk of seroconversion to the polio vaccine.

The focus of the ISD synergy will be on establishing collaboration and partnerships with partners, donors, local government authorities, private agencies and community-based or civil society organisations (CSO) that are actively involved in providing WASH, nutrition and health-related services to the communities (Table 10). The Health Minister will convene a Development Partners' Group Committee and create a technical working group to develop a comprehensive plan. Additionally, there will be national- and provincial-level focal points facilitating this collaboration, with support through ISD task team members.

Table 10: Integrated service delivery plan for WASH, nutrition and health components

Component	Outcome	Mechanism	Implementation
WASH	• Access to and use of safe drinking water and basic sanitation services and practice improved hygiene behaviors	• Sanitation and hygiene promotion • Access to clean drinking water supply • WASH in schools and health facilities	• Engage local authorities and private companies to: o Provide access to safe, clean water (e.g. extending existing water network, cleaning and disinfecting water storage tanks, providing ceramic water filters) o Remove solid waste, procure and supply waste bins and dispose of collected garbage safely o Extend and/or improve existing sewage lines o Undertake community and social mobilization for construction of latrines at household level • Communication for behavioral change o Safe disposal of household waste o Prevention of childhood illnesses (esp. diarrhea) through handwashing
Nutrition	• Provide nutrition services that are both curative and preventative among children <5 years of age • Promoting exclusive breastfeeding and health behaviors for pregnant and breastfeeding mothers	• Community based management of acute malnutrition (screening, identification and treatment) • Awareness for enhancing exclusive breastfeeding for first 6-months of life and mothers/ caretakers counselled on recommended maternal, infant and child nutrition, health and hygiene practices • Provision of Vitamin A supplementation for children 6-59 months • Increased capacity of health care providers and CHWs; strengthen the referral mechanism between houses and health facilities	• Door-to-door campaign to identify children severely acutely malnourished; enrolled in treatment programme • Capacity strengthening of staff at targeted health facilities
Health	• Provision of integrated health services to improve mother and child survival	• Improve routine immunization (RI) coverage through both fixed and outreach sites by training mobile vaccinators and provision of essential logistics (e.g. mobility and incentives) • Prevention and treatment of pneumonia and diarrhea in children <5 years of age • Maternal, antenatal, natal and post-natal care services provision	• Interventions will be carried out through fixed and outreach sites by use of existing health and nutrition departments and the CBV/CHW structure

CBV= community-based vaccination; EI= essential immunization; CHWs= community health workers; WASH= Water, sanitation and hygiene

Moreover, EPI strengthening, particularly in the core reservoirs, will be a priority for the Pakistan polio programme. There are many components of the current EPI-PEI synergy framework that require further decision making (e.g., synchronising outreach activities, microplans, data quality assessments, etc). Clearly refining the scope of support from PEI to EPI and vice versa will be imperative. A meeting will be held between EPI and PEI leadership at both national and provincial levels between July and December 2019 to refine the plan for PEI/EPI synergy and develop a formalized strategy for NEAP 2020/2021.

A complete list of key priorities by Synergy task teams for July – December 2019 are summarized in **Appendix A, Table A5.**

APPENDIX A. KEY PRIORITIES BY AREA OF WORK

For the National Emergency Operations Centre (NEOC) under the July – December 2019 NEAP Extension

Table A1. Priorities for Programme Operations task teams

Task team	Key priorities	Strategy implementation and monitoring
Capacity Building, Mobile Teams & Community-Based Vaccination	Implement training SOPs for staff in all provinces.	• Conduct Training of Master Trainers and DPCR members on training SOPs and ensure that DPCR members and Master Trainers identify training needs before conducting any training.
	Improve training through data analysis and feedback.	• Collect, collate and analyse training monitoring data; provide feedback to DPCRs for quality trainings of FLWs and their supervisors. • Link training monitoring data with EOC dashboard and build capacity of NEOC and PEOC staff on utilisation of this data and timely feedback to DPCRs.
	Orient DPCR members (together with DCs) on accountability framework for tier 1 & 2 districts.	• Train DPCR members from tiers 1 & 2 at the provincial level on the accountability framework. (Orientation of DCs together with DPCR members was strongly recommended by M&E task team.)
	Implement revamped tools in CBV areas.	• Data recording and reporting tools for CBV areas are under development; once finalized, all CBVs and their supervisors will be trained on updated tools.
	Train FLWs on improved communication strategy.	• C4D task team is developing an improved communication strategy for tier 1 & 2 districts. FLWs and their supervisors will be trained at the district/UC level after strategy is finalized.
	Implement induction training for newly recruited staff.	• Due to high turnover in programme staff, periodic trainings at provincial level will be conducted for new inductees.
	Build capacity of federal and provincial monitors on revised monitoring tools of microplan implementation.	• M&E task team is developing monitoring tools to assess the implementation status of microplans. Once these tools are finalized, training for federal and provincial monitors will be conducted.
	Review and possibly shorten campaign duration from seven to five days in CBV-supported districts of Quetta Block.	• Quetta Block is piloting the five-day campaign model in two UCs: Kharotabad 2 and 11 A (Pashtoonabad) in the June 2019 SIA. The Quetta Block Commissioner requested this review to allay security concerns and ensure adequate security provisions. • This five-day campaign model may be implemented in Khyber Pakhtunkhwa (KP) as well.

Task team	Key priorities	Strategy implementation and monitoring
Capacity Building, Mobile Teams & Community-Based Vaccination (continued)	Ensure low-visibility campaigns recommended for CBV areas.	• Decrease visibility in Peshawar and Quetta District (where clusters of refusals are already mapped) to address the increase in security incidents and overt/covert community resistance. • Campaign dates will not be announced through mass media; polio messaging on social media will be decreased.
	Address low motivation, low commitment and security concerns among CBV FLW.	• M&E task team to review and rationalise the intra-campaign work burden of CBV cadres and partner staff. • The data collection burden on CHWs is still too high. Efforts need to be taken to rationalise and reduce this load. This process of rationalisation should ensure data sharing and analysis is conducted on a need-to-know basis between levels. • This priority is based on feedback received from the FLWs.
	Conduct a national CBV review/assessment to guide the programme.	• NEOC CBV task team to lead the review. Timeline is proposed for August 2019. Outsourcing to external/ international consultants is recommended. • Pending NEOC Core Management team endorsement.
	Review of CBV strategy in posh areas of Karachi.	• Sindh team to review and suggest alternative strategy for posh areas. Karachi has a high number of still missed children in posh areas and is challenged by the ineffectiveness of non-local CBV workers.
	Strengthen supervision and monitoring of CBV in south KP districts through third-party field monitors.	• KP EOC to develop a strategy with support from RADS. • Review of cross-border HR&MP strategy – especially movement patterns to South KP/ Punjab – are critical in remote Bannu, Tank North and South Waziristan Agencies to ensure gaps are quickly identified and closed along the central cross-border transmission corridor.
	Strengthen CBV cadres' communication/IPC; strengthen supervisors' supervision and monitoring skills.	• Training TT to develop a strategy in consultation with C4D Team and provincial teams. • Performance management and accountability should be streamlined to reach the high-performance thresholds set in the NEAP.
	Implement performance improvement strategies from July to December 2019.	• Implement SOPs and monitor performance closely.
	Sensitize communities and CBV cadres on the risks of refusing OPV.	• Increase the risk perception of communities by focusing on children who have contracted polio in 2019. • Work with the Communications AoW to develop human interest videos to share on social media and distribute directly to CHWs for use during community engagement. The purpose of these videos is to show the potential repercussions of refusals, fake finger marking, or CHW dishonesty in record keeping.

Vaccine Management	Continue close collaboration with the Ops Team, review and update the target population to be used for vaccine forecasting for the remainder of 2019.	• Implementation/monitoring to be continued consistent with the previous NEAP cycle.
	Review and update forecasts for July – December 2019 in accordance with the extended NEAP and TAG recommended SIA schedule.	• Update OPV mapping based on the SIA schedule and other activities as finalized by NEOC Core Team. Financial implications to be highlighted to NEOC in case of increase in vaccine requirement.
	Ensure timely supply of vaccine to support NEAP Extension SIA schedule and all other activities.	• Timely procurement and arrival of vaccine at country level through coordination with supply division, finance and EPI. Timely distribution of vaccine to field well before all activities, as per vaccine management SOPs, while working in close collaboration with EPI at all levels.
	Continue training on vaccine management for all FLWs on a regular basis.	• Continue training of all field staff on curriculum recommended by Vaccine Management task team.
	Strengthen the vaccine management of HR&MPs, specifically at the district level.	• Coordinate with HR&MP task team to align recording, supervision/monitoring formats, training of staff on tools, data recording and reporting through IDIMS and synchronised with NEOC dashboard for regular reporting on vaccine utilisation and leftovers.
Pakistan-Afghanistan Coordination	Synchronisation of SIAs for July – December 2019.	• The Afghanistan programme has shared their SIA calendar with the Pakistan programme; RADS has developed a synchronised schedule for campaigns/responses. It will be finalized in the forthcoming meeting with the Afghanistan Programme Team, held June 26-27, 2019.
	Review and update all corridor plans (especially the Central Corridor Plan) based on recent epidemiology.	• At the time these corridor plans were developed, the Central Corridor was inactive in term of virus transmission; it is now the most active corridor. Other corridor tracker plans are also due for review. The plans will be updated at the June meeting, with additional follow up by regional teams held through video conference (VC) or teleconferences, as required.
	Review and enhance cross-border communication strategies.	• Engage the Communication team in upcoming meeting/ VCs and any follow-up interactions. Cross-border communication strategies are needed as people belong to same culture/tribes between and across both sides of the Afghanistan-Pakistan border. The Peshawar incident has effects on both sides so a joint communication review is needed for present PEI scenarios to support each other.
	Review and strengthen all age vaccination programme, particularly at Friendship Gate.	• The Pakistan and Afghanistan programme will work together to make vaccination at Friendship Gate compulsory (as it is in Torkham).

C4E= communications for eradication; CBV= community-based vaccination; CHW= community health worker; DC= Deputy Commissioner; DPCR= District Polio Eradication Committee; EOC= Emergency Operations Centre; FLW= frontline worker; IPC= interpersonal communication; HR&MP= High-risk and mobile populations; KP= Khyber Pakhtunkhwa; NEAP= National Emergency Action Plan; NEOC= National Emergency Operations Centre; OPV= oral poliovirus vaccine; PEOC= Provincial Emergency Operations Centre; RADS= Risk Assessment and Decision Support; SOPs= standard operating procedures; VC= video conference

Table A2. Priorities for Risk Assessment and Decision Support task teams

Task team	Key priorities	Strategy implementation and monitoring
Monitoring & Evaluation	Improve accountability.	• Implement provincial and district level scorecards to compare district performance, highlight performance gaps and take corrective action. District and provincial scorecards will be completed and shared monthly with relevant staff for follow up and corrective action. • At district and provincial level: Incorporate a systematic review of lessons learned at the district level via post-campaign reporting to strengthen campaign planning and implementation. M&E task team will develop report template and the protocol and schedule for submission.
	Improve data quality, dissemination and use.	• Implement data quality assessments (DQAs), which evaluate quality of data and data management system, in the remaining unassessed CBV areas. In addition, tools for mobile team areas will be developed. These DQAs will identify data-related issues and support the formulation of corrective action.
		• Train staff at UC level and above on the use of UC profiles in the dashboard to improve campaign planning and implementation.
		• Implement data analysis triangulation (campaign administration data, lot quality assurance sampling [LQAS], and surveillance data) and disseminate at provincial and district level to support informed decision making.
	Improve campaign planning and risk assessment.	• M&E team will develop an intra-campaign monitoring checklist for microplan implementation. The microplan quality assessment (MPQA) assesses quality of microplans ahead of campaigns. Because a strong microplan does not necessarily indicate strong performance in a given area, an implementation assessment determines whether planning is operationalised during campaigns.
		• Validate "still missed children" data, including silent refusals. M&E team will design an open data kit (ODK) tool and methodology for analysis, and train/disseminate at the provincial level.
		• Assess current data management and collection tools with a focus on "need to know", per recommendations from the Technical Advisory Group (TAG) and Independent Monitoring Board (IMB).
	Improve collaboration with provincial M&E task team ("one team" approach).	• Improve collaboration and communication among all M&E staff: - Update M&E task team standard operating procedures (SOPs). - Conduct monthly/bi-monthly video conferences with provincial M&E TTs. - Conduct quarterly meetings between national and provincial M&E TTs.
	Improve M&E capacity at the UC level.	• Design and implement an M&E training module for UC-level staff with M&E responsibilities who do not currently receive M&E training (e.g., programme data assistant, UC Polio Officer, UC Communication Officer, and temporary tehsil support person).

Task team	Key priorities	Strategy implementation and monitoring
Information Management	Improve systems (dashboard/IDIMS) and technology.	• Finalise and implement eIFA (to replace IFA) for real-time AFP/ environmental surveillance (ES). Link surveillance modules (and visualization) with Dashboard. This upgrade will enhance information utilisation among users.
		• Revamp NEOC dashboard to improve analytical features using business intelligence (BI) tools, enhanced user management and new modules. Information visualization for mobile users will be available in upgraded dashboard.
	Build capacity to analyse, interpret and use data.	• Implement provincial and district-level training on dashboard data use (new and current modules).
	Implement EOC Cloud system.	• The EOC Cloud (a central repository of all key programme documents to promote institutional knowledge and information sharing) was established during the 2018-2019 NEAP year. It has been successfully tested among small groups. Full implementation and access across all task teams, provinces, and partners by December 2019 is planned.
Innovation and Operational Research	Perform operational research to support informed decision making.	• Ongoing research will be finalized and published. • Finalize and disseminate proposal submission guidelines for programme staff and external applicants. • Assist other task teams with developing reports based on surveys and operational research.
	Promote institutional knowledge and information sharing.	• Integrate a polio research repository in the EOC Cloud. • Disseminate a database of current polio research being performed in Pakistan.
	Build capacity at the provincial level.	• Implement trainings for provincial-level research staff on research methodology and data analysis.

AFP= acute flaccid paralysis; CBV= community-based vaccination; DQAs= data quality assessments; eIFA= electronic information for action; EOC= Emergency Operations Centre; IDIMS= Integrated Disease Information Management System; IFA= information for action; IMB= Independent Monitoring Board; LQAS= lot quality assurance sampling; M&E= monitoring and evaluation; MPQA= microplan quality assessment; NEOC= National Emergency Operations Centre; ODK= open data kit; TAG= Technical Advisory Group; TT= task team; UC= Union Council

Table A3. Priorities for Detection and Response task teams

Task team	Key priorities	Strategy implementation and monitoring
Surveillance for Eradication	Strengthen surveillance infrastructure and workforce capacity.	• In addition to continued priorities from the 2018/2019 NEAP, the number and proportion of sanctioned positions will be tracked and recorded by province.
	Ensure "green is green" – that good surveillance indicators reflect a good surveillance system.	• In addition to continued priorities from the 2018/2019 NEAP, the following will be implemented: - Surveillance for eradication task team (SETT) will assess the surveillance review checklist and scoring sheet to ensure the process continues to drive performance of the surveillance system to the highest possible standard. - Follow-up reviews will be conducted until identified gaps are addressed and performance improves. • Extended support will be provided by the federal surveillance team in areas where surveillance performance is a concern, where requested by the PEOC, or where deemed necessary by the NEOC or the AoW lead.
	Reinforce surveillance oversight, guidance, and continuous improvement through self-evaluation, surveillance reviews, and granular data analysis.	• Oversee implementation of the NEAP Extension, July – December 2019. • Meet at least once per month at the national and provincial levels with minutes circulated to EOCs. (Meetings have been inconsistent at both levels, which has affected the ability to provide EOCs with timely guidance related to surveillance.) • Conduct a quarterly risk assessment. Jointly review the risk assessment to develop a list of districts-of-interest. • Conduct a quarterly audit of the progress made on the implementation of the NEAP workplan and review next quarter workplan and deliverables.
	Ensure the programme utilises the most current surveillance guidelines and SOPs by the end of 2019.	• Complete the process of updating the Pakistan AFP Surveillance Guide, as well as all protocols and SOPs derived from the guide, including: (a) community-based surveillance; (b) HR&MP surveillance; (c) H2R (hard-to-reach) areas surveillance; (d) polio serosurveys; (e) C4S - communication for surveillance.

Task team	Key priorities	Strategy implementation and monitoring
Surveillance for Eradication (continued)	Strengthen oversight and support of surveillance activities at the district and divisional levels.	• Conduct District Surveillance Review Committee (DSRC) meetings on a monthly basis, chaired by the DHO or equivalent. Share and discuss an update on surveillance indicators and progress on NEAP indicators. • Ensure that surveillance is a standing agenda item in all DPEC and UPEC meetings in every district. In the pre-campaign phase, DSO to provide a summary of AFP cases reported in the previous campaign, number investigated, and updates on case investigations. • In the pre-campaign phase, team training should include an orientation session on AFP case definition, reporting AFP cases identified in the intra-campaign period, and appropriate door marking to capture presence or absence of AFP cases in the household. • An update on number of AFP cases reported should be included in the evening review meeting (ERM) feedback during campaigns.
	Extend collaboration with EPI to vaccine-preventable diseases (VPD) surveillance.	• In addition to continued priorities from the 2018/2019 NEAP, the following activities will be implemented: - Ensure active visits where VPD surveillance report data is validated and tallied with zero reports. - Share essential immunization (EI) zero dose data of AFP surveillance data with EPI at district, provincial, and national level.
	Further incorporate primary immunodeficiency disorder (PID) surveillance into field activities, guidelines and reporting.	• Maintain PID surveillance system for child patients with PID in Lahore, Karachi, and Quetta. • Include PID surveillance system guidelines in the updated surveillance guidelines. • Include PID case analysis in the weekly surveillance analysis and bulletin.
	Enhance quality of data and improve depth of analysis.	• In addition to continued priorities from the 2018/2019 NEAP, an environmental surveillance module in IDIMS and a dashboard for ES data collected on ODK will be developed.
Rapid Response Unit	Standardize RRU structure, functions, and management across the country, including clear lines of reporting.	• Finalize the RRU SOPs and guidelines in consultation with provinces. Include the following key components: - Revised investigation and response triggers for national and provincial RRUs. - Investigation and response timelines and scope. - RRU structure at the national and provincial level with clear roles and responsibilities - RRU coordination and communication mechanisms. - Reporting and monitoring formats and templates. • Review and update ToRs and training materials as per revised RRU SOPs and guidelines.

Task team	Key priorities	Strategy implementation and monitoring
Rapid Response Unit (continued)	Respond to all poliovirus events as per the SOPs and within the stipulated timelines.	• RRU will respond within 24 hours to all WPV cases, VDPV cases, positive environmental samples (in sites that were negative in the preceding six months) and any other events as articulated in the SOPs. RRU will share a report with the national and provincial EOCs within seven days of the investigation. - All investigations will include a communication and social profile/ analysis component. - In consultation with DPCR, all investigation reports will include an action plan to address all gaps identified during the investigations. - In coordination with RADS, RRU will provide guidance on the scope of response based on the conducted risk assessment and various contextual factors, as identified in the investigation. - A monthly update will be provided to the PEOC and NEOC on RRU activities, progress on implementation of action plans, and quality of responses carried out. - The federal RRU TT will provide extended field support to address persistent gaps in locations identified by risk assessments, if directed by the NEOC Coordinator, or deemed necessary by the RRU TT/ AoW lead.
	Strengthen functions of National and Provincial RRU TTs.	• Establish multi-disciplinary, multi-organisational RRU TTs at the provincial level. • Review and revise RRU TT ToRs to ensure clarity on roles and expected outputs. • Meet every two weeks to strengthen coordination, quality of response, and follow up. • Notify members from all national and provincial stakeholders to meet at least every two weeks.
	Strengthen RRU response capacity	• Develop a staff roster of individuals trained on investigation and virus event response to provide surge capacity, where needed.
High-Risk & Mobile Populations	Strengthen vaccination of HR&MP children, including those in-transit.	• Ensure a clear, uniform understanding of the refined definition of HR&MP at the provincial, district, and field levels, including operational implications for staff. Update PEI training materials, orient HR&MP TTs and DPCRs, and develop follow-up action plans to integrate and monitor coverage of these populations during SIAs. • The updated definition delineates two components: - Mobile and migrant populations moving to and from core reservoirs and high-risk districts: o Economic and seasonal migrants o Guests visiting from outside the province, a core reservoir district, or Afghanistan (Afghan Guests) o Populations who move regularly/predictably, such as nomads, brick kiln workers, and agricultural migrant laborers - Vulnerable populations: o Peri-urban slum dwellers o Displaced populations (internally displaced within Pakistan, Afghan refugees, or returnees) o Populations who live along the border between Pakistan and Afghanistan, and along interprovincial boundaries o Minority populations o Beggars

Task team	Key priorities	Strategy implementation and monitoring
High-Risk & Mobile Populations (continued)	Strengthen vaccination of HR&MP children, including those in-transit.	• Strengthen the effectiveness of PTPs in vaccinating HR&MP children in-transit. By August 2019, ensure full implementation of the HR&MP operational shift (to ensure that all moving children are programmatically reported and referred to as Not Available (NAs), and guest children are vaccinated) in core reservoirs and other areas of concern, in coordination with Programme Operations and Communication teams.
		• In coordination with the Communication for Development (C4D) TT, develop customized material to sensitize HR&MP on polio vaccination, especially related to (a) major events and festivals; (b) communication aspects of the HR&MP operational shift; and (c) community engagement sessions with critical stakeholders. Complete by August 2019.
	Analyze effectiveness of HR&MP activities, and strengthen operational preparedness through improved use of programme data and assessments.	• Develop an electronic platform to consolidate all data routinely collected by the programme on HR&MP to facilitate regular analysis. • Develop a network of community influencers and resource persons to track movement of HR&MPs into core reservoir areas to identify movement patterns in order to strengthen operations. • Develop and distribute a quarterly HR&MP bulletin to provide critical information on HR&MP, and its movements to inform operations preparedness.
		• Conduct assessments to ensure detailed demographic information and vaccination status of HR&MP (as per updated definitions) are available to strengthen operational preparedness and coverage of these populations. • For the period July – December 2019, the following assessments have been prioritized: - Identification, mapping and vaccination assessments of minority populations (province/district). - Use of available secondary data and assessments to provide demographic information and vaccination coverage of populations living in peri-urban slums. - Assessments to better understand movement of guest children in core reservoir areas and other critical areas, including HR&MP movement across international borders.
	Strengthen cross-border (international and interprovincial) coordination and communication.	• Maintain close coordination at national and provincial levels for timely data sharing and tracking of HR&MP activities as outlined in corridor task trackers and continued implementation of all-age vaccination at major border crossings. • Hold quarterly inter-provincial coordination meetings with participation of national HR&MP TT.
	Strengthen oversight, monitoring and accountability of HR&MP activities at all levels.	• Update HR&MP strategy with a focus on developing a monitoring and accountability framework at the district and sub-district level to track progress of all HR&MP activities and ensure the structure is functional. DPCR must prioritize and lead HR&MP activities to ensure effective implementation and monitoring.

AFP= acute flaccid paralysis; AoW= area of work; C4E= communication for eradication; C4S= communication for surveillance; DPEC= District Polio Eradication Committee; DSO= District Surveillance Officer; DPCR= District Polio Control Room; DSRC= District Surveillance Review Committee; ERM= evening review meeting; ES= environmental surveillance; IDIMS= Integrated Disease Information Management System, H2R= hard to reach; HR&MP= high-risk and mobile population; NEAP= National Emergency Action Plan; NEOC= National Emergency Operations Centre; PEI= Polio Eradication Initiative; PEOC= Provincial Emergency Operations Centre; PID= primary immunodeficiency disorder; PTP= permanent transit point; ODK= open data kit; RI= routine immunization; RRU= rapid response unit; SETT= Surveillance for eradication task team; SOP= standard operating procedure; TORs= terms of reference; TT= task team; UPEC= Union Council Polio Eradication Committee; VDPV= vaccine-derived poliovirus; WPV= wild poliovirus

Note: Priorities for the Area-4 which is Management area of work (AoW) are already described in detail in the main NEAP Extension document

Table A4. Priorities for Communications task teams

Task team	Key priorities	Strategy implementation and monitoring
Media & Advocacy/ External Communications	Implement Perception Management Initiative (PMI).	Cultivate partnerships and alliances with key stakeholders (those with capacity for mass public engagement and shaping of public opinion): • Conduct high-visibility sessions with key public opinion shapers. • Disseminate high-quality content through various channels. • Establish a coordination management cell for PMI. • Establish a toll-free line for direct engagement with the public.
	Advocate for generating broader support for the polio programme via policies and actions by relevant sectors at all levels.	• Conduct meetings with MoNHSR&C (Health Minster, DG, Secretary) for integrating & promoting polio vaccination through other health programmes. • Conduct meeting(s) with Information Minster on key support (Pakistan Electronic Media Regulatory Authority - PEMRA) • Conduct advocacy sessions with Pakistan paediatric and Pakistan medical associations. • Hold orientation sessions with multi-party Parliamentarians Forum for coalition-building in support of the Programme. • Engage with top universities (e.g., Agha Khan, Quaid-e-Azam, Allama Iqbal, Punjab University) • Establish high-level influencer platform at national and sub-national level.
Communication for Development	Foster social mobilisation and community engagement through community/influencers' support and media outreach.	Influencer engagement: • Formation of key influencer alliances at national & district level. • Mapping & orientation of district- and UC-level influencers. • Community engagement sessions by key influencers. • Mosque-based activities (e.g., announcements and khutbas). • School-based activities and other information entertainment activities. • Engage community in favor of polio vaccination via compelling media outputs and social media campaigns.
	Build caregiver and family knowledge, awareness and motivation in support of polio vaccination.	• Parental/caregiver engagement through group sessions. • Individual counselling sessions of refusal and persistently missed children parents by FLWs/other. • Identification and mobilisation of role model parents to motivate other parents.
	Strengthen crisis communication.	• Review and revise SOPs (roles, responsibilities, focal persons, etc.) • Simulate possible situations and build possible plans around them. • Develop a campaign cycle-wise crisis communication activity.

Communication for Development (continued)	Oversee synchronisation of and synergy for cross-border communication strategies to reach mobile populations and travellers crossing both countries' borders.	• Maintaining regularity of communication with Afghanistan PEI to share/synchronise communication interventions to reach targeted populations. • Map and engage influencers for visibility and community engagement activities in both countries. • Disseminate high-quality content with the multi-media approach through various channels. • Synchronise communication activities during campaigns and special events by developing and disseminating specific contents. • Conduct quarterly cross-border meeting.
	Improve motivation and capacity-building of FLWs.	• Hire top-level motivational speakers to build FLW morale. • Develop and roll out other motivational incentives (medals, certificates, TV/other appearances). • Capacity-building for DHCSOs, UCCOs, and RSPs in communication management (planning, implementation, M&E). • Capacity-building in interpersonal communication (IPC) skills for FLWs. • Develop an app for polio FLWs including key updates and IEC material.
	Develop and disseminate compelling and context-specific content on C4E strategy.	• Develop evidence-based multi-media product. • Develop evidence-based information, education and communication (IEC).
	Coordinate & communicate within and across management structures	• Strengthen national and provincial task teams, DPCR and UPEC. • Review of CBV, COMNet, CSOs, RSP & other communication cadres.

CBV= community-based vaccination; C4E= communication for eradication; COMNet= communications network; DHCSO= District Health Communication Support Officer; DPCR= District Polio Control Room; FLW= frontline worker; IEC= Information, education, communication; MOH= Ministry of Health; PEMRA= Pakistan Electronic Media Regulatory Authority; PMI= Perception Management Initiative; RSP= religious support person; UC= Union Council; UCCO= Union Council Communication Officer; UPEC= Union Council Polio Eradication Committee

Table A5. Priorities for Synergy and additional activities task teams

Task team	Key priorities	Strategy implementation and monitoring
EPI-PEI Synergy	Enhance utilization of polio resources for other VPD surveillance.	• Strengthen community-based surveillance for VPD in tier 1 Districts (special focus on measles). • Incorporate operational case definition for measles and NNT in CBV training manuals. • Improve notification of suspected measles and NNT cases in tier 1 districts by CBV workforce and PEI staff.
	Enhance vaccination activities through improved coverage of birth doses.	• Improve coverage of "OPV birth dose" in tier 1 districts through CBV workforce. • Referral of all newborns for BCG /hepatitis B in tier 1 districts by CBV workforce and PEI staffs.
	Enhance management, oversight, and accountability by deepening the involvement of PEI management and oversight structures at all levels.	• All PEI management and oversight structures, particularly at the provincial level, to track and discuss EPI performance and activities, and ensure accountability for poor EPI performance. • Integrate PEI & EPI management and oversight structures, including name rebranding • (e.g., District Immunization Control Room/District Immunization Committee). • PEI staff at all levels should have time formally dedicated to EI activities; all UC-district, divisional- and provincial- level meetings should include time dedicated for strengthening EPI activities.

BCG= Bacille Calmette Guerin; CBV= community-based vaccination; EI= essential immunization; EPI= Expanded Programme on Immunization; NNT= neonatal tetanus; PEI= Polio Eradication Initiative; VPD= vaccine-preventable disease; UC= Union Council

APPENDIX B. EMERGENCY OPERATIONS UNIT

Table B1. Priorities for the Emergency Operations Unit

Unit	Key priorities	Strategy implementation and monitoring
Emergency Operations (Ops)	Follow-up with provinces on implementation of operational recommendations on pre-, intra-, and post-campaign phases to improve quality of campaign.	These recommendations are made by RADS and the NEOC core team based on MPQA, administrative data, third-party monitor and federal facilitator observations, as well as post-campaign assessments.
	Coordinate other task teams & facilitate their tasks/operations.	The Operations team facilitates implementation of other task teams' managerial and technical decisions, with the help of provincial EOCs.
	Facilitate campaign planning & implementation.	Based on epidemiology of virus, CR/ER & SNIDs plan varies. Ops team facilitates RADS & Operations AoW to finalize campaign planning with provincial EOCs, helps form vaccine and logistics plans, and monitors plan.
	Facilitate different synergy activities to previous and new stakeholders.	Examples of synergy activities facilitated by the Ops team include but are not limited to: (i) nutritional international for vitamin A; (ii) survey of Pakistan for mapping; (iii) EPI for measles.
	Enhance coordination with provincial control rooms and data teams through monthly video conferences and a joint workshop held before December 2019.	An in-person meeting will facilitate the Ops team's understanding of the specific nature and extent of problems data team staff face in compliance and follow up.

CR= case response; EOC= Emergency Operations Centre; ER= event response; MPQA= microplan quality assessment; NEOC= National Emergency Operations Centre; RADS= Risk Assessment and Decision Support; SNID= subnational immunization day