



National Emergency Action Plan 2011 for Polio Eradication

**Federal Ministry of Health
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A) Executive summary

The continued transmission of poliovirus in Pakistan has become a national emergency. Pakistan now risks becoming the last remaining reservoir of endemic poliovirus transmission in the world, and the only remaining threat to achieving global polio eradication.

Poliovirus is continuing to cripple children in Pakistan because of the failure to reach all children with sufficient doses of vaccine. The reasons for this include inadequate Government oversight and ownership, access problems due to security particularly in the Federally Administered Tribal Areas (FATA), operational and planning challenges, and the failure to identify and include all high risk underserved population groups. In light of the situation and its national and global implications, ***the President of Pakistan has directed the immediate development of an emergency action plan for polio eradication in Pakistan. The current plan follows the Prime Minister's Plan launched in the beginning of 2009 that focused on the enhanced inter-sectoral collaboration.***

The Goal of the Emergency Action Plan is to interrupt transmission of poliovirus in Pakistan by the end of 2011.

This goal will be reached through achieving the following objectives:

- Achieving consistent government oversight, ownership, and accountability for polio programme performance at each administrative level in Pakistan. Ensuring consistent access to children in security compromised areas.
- Ensuring that all children are consistently immunized in the districts/agencies and populations that are at highest risk of sustaining transmission of poliovirus.

The new elements that this plan brings to eradicating polio from Pakistan are:

- Defining polio as a national emergency that must be urgently addressed, and ensuring that all arms of Government are engaged in eradicating polio
- Ensuring that District Coordination Officers (DCOs), Political Agents (PAs)/ Deputy Commissioners (DCs) take on direct oversight of polio eradication activities in districts, agencies, and towns
- Close coordination of the health and the revenue staff at the union council (UC) level for the campaign preparation and implementation ensuring that each vaccination team has a member accountable to the government
- Developing and sustaining oversight at district, province, and national level through responsible task forces and committees with wide representation of stakeholders

- Developing strategies and approaches to access children in security compromised areas through close cooperation between civil and military officials and through engagement of communities
- Concentrating efforts on the highest risk areas and populations and ensuring that all children in these areas are reached with polio vaccine every immunization round
- Closely monitoring the quality of programme performance to identify problems, and to design specific actions to address them

The Emergency Plan will be reviewed to ensuring the progress and taking remedial measures by the Prime Minister's Task Force for Polio Eradication every six months, Inter-provincial Ministerial Committee on Polio (IPCP) chaired by the Federal Minister for Health quarterly, every month by the Prime Minister's Monitoring Cell in the PM Secretariat (and subsequently in Secretariats of the Governor Khyber Pakhtunkhwa, Prime Minister AJK and all the Chief Ministers), Provincial Steering Committee chaired by the Chief Secretary (CS) every two months and DCOs monthly. Designated Focal Persons in the Prime Minister and Chief Minister (CM) Secretariats (senior official) will support and ensure coordination for the smooth implementation of the Plan. The Federal Minister for Health will review the progress once a month with the program staff and heads of technical partners and take corrective actions, as required.

According to the latest Financial Resource Requirements for the Global Polio Eradication Initiative (GPEI), planned activities for polio eradication in Pakistan for the period 2011-2012 will require US \$137.5 million. In addition to resources committed by the Government of Pakistan, international partners are requested to provide support to address any shortfalls in resource requirements. These requirements will be reviewed during the course of implementation of the emergency plan.

Pakistan has the ability to rapidly address the issues affecting the failure to reach all children with vaccine. With strong ownership/oversight and accountability by Government at all levels and the engagement of communities, all children can be reached and thousands saved from being permanently crippled or dying from polio.

B) Context

i. Rationale for the Emergency Plan

Pakistan has come a long way in its struggle to eradicate polio. In the early years of the 1990's the annual incidence of polio was estimated at more than 20,000 cases a year, but over the past 5 years an average of only 100 cases per year have been reported. The national polio eradication effort has made major strides in reaching children with immunization in all parts of the country over the past 15 years.

However, the tremendous progress towards the eradication of polio in Pakistan is threatened by stagnation. Children in key high risk areas are not receiving adequate numbers of doses of oral poliovirus vaccine (OPV) due to difficulties in access in areas affected by security problems (particularly in FATA and parts of Khyber Pakhtunkhwa) and managerial and implementation failures and lack of accountability in other districts. Recent floods have posed an additional challenge in terms of mass displacement of populations and damaged health infrastructure especially in the northern Sindh and southern Punjab. ***The failure to reach all children, especially in high risk areas, with sufficient doses of vaccine is leading to continued transmission of poliovirus in Pakistan.*** Pakistan has reported a total of 144 polio cases in 2010 so far, more cases than any year since 2000. ***Pakistan is now reporting more cases than the combined total cases of the other three endemic countries: Nigeria, India, and Afghanistan.***

The situation in Pakistan warrants urgent interventions to keep up with the pace of progress elsewhere. Both India and Nigeria have the potential to eradicate polio in the near future. ***This would leave Pakistan as the single largest threat to global polio eradication, and isolate the country in a world that wants to protect its citizens from the last remaining reservoir of wild poliovirus.***

Despite the challenges, Pakistan has the ability to rapidly address the issues affecting the failure to reach all children with vaccine. The history of polio eradication in Pakistan demonstrates that with strong ownership and oversight by the Government and the engagement of communities, all children can be reached and thousands saved from being permanently crippled or dying from polio.

In light of the expanding polio outbreak in the country and its national and global implications and the urgent need to address programme risks, the President of Pakistan directed the immediate development of an emergency plan for polio eradication in Pakistan that enables interruption of polio by the end of 2011.

ii. Epidemiology and risks of continued transmission

As noted above, Pakistan has reported 144 cases of polio in 2010, the highest number of cases since 2000. The epidemiological pattern is summarized below:

- Nearly three out of every four cases (69%) are from conflict affected parts of the FATA (74 cases) and associated areas of Khyber Pakhtunkhwa – KP (24 cases).
- Additional 27 cases have been reported from Sindh, 7 cases from Punjab, and 12 cases have been reported from Balochistan.
- The bulk of polio (more than 80% of cases) is from known persistent transmission and high risk districts in four major transmission zones: FATA and neighbouring districts of KP, north western Balochistan, central Pakistan (southern Punjab, northern Sindh, adjoining areas of Balochistan), and Karachi.
 - The major risks for continued transmission in FATA and KP are compromised access to children due to insecurity, and gaps in management and quality of campaign implementation.
 - In Balochistan, the main risks for polio transmission are sub-optimal quality of implementation and poor programme management. Extensive cross border population movement, pockets of insecurity and vaccination refusal are further compounding risk factors.
 - In Central Pakistan, the main risks are inconsistent quality of polio campaigns stemming from weak management and political interference. The poor law and order situation in certain pockets (KACHA areas) compromises access, as well.
 - Karachi, as one of the country's largest population hubs, hosts significant numbers of migrant, underserved and minority populations. Coupled with weak management and implementation of immunization campaigns, the city serves as a mixing bowl and amplifier of poliovirus associated with spread to the rest of the country.
- The risk of polio is closely associated with high risk population groups which include migrants, internally displaced people, and Afghan refugees.
- The effects of the recent flood pose potential risks on a number of fronts including damaged health infrastructure, increased pressures on

management, compromised water and sanitation and large displaced populations.

iii. The role of high risk districts, agencies, towns, and populations in maintaining poliovirus circulation

A limited number of high risk districts account for the bulk of poliovirus transmission in Pakistan, and are strongly implicated in the survival of poliovirus circulation. There are 15 districts that can be classified as persistently infected ('persistent transmission districts'). These districts are in close proximity to a further 18 districts that can be classified as very high risk; together they form the main poliovirus transmission zones in Pakistan. *In 2010, more than 50% of all polio cases have come from the 15 persistent transmission districts, and more than 80% of cases have come from the wider high risk zones.* It is therefore vitally important to ensure that all children in these high risk areas are reached with immunization during every campaign. List and map of the above 33 high risk districts is attached as Annexure 2.

In addition to the known differential in geographical risks, certain population groups have historically been at much higher risk both of suffering from polio, but also moving poliovirus from place to place within Pakistan and to neighbouring countries, Afghanistan in particular. Migrant and mobile populations are particularly important, but all minority or underserved groups are at higher risk, including nomads; agriculture, construction and other seasonal workers, internally displaced persons (IDPs) and Afghan refugees.

c) The National Emergency Action Plan 2011

i. GOAL

The goal of the Emergency Action Plan for Polio Eradication Initiative is:

- a) first to control the outbreaks of polio in conflict-affected FATA and associated areas of Khyber Pakhtunkwa, and in central Pakistan, by mid 2011; and
- b) through continuous programme improvements to stop wild poliovirus transmission throughout Pakistan by the end of 2011

In order to achieve this goal, three main objectives will need to be met.

ii. OBJECTIVES OF THE EMERGENCY PLAN

- a) Achieve consistent government oversight, ownership, and accountability of polio programme performance at each administrative level in Pakistan
- b) Ensure consistent access to children in security compromised areas especially in FATA and Khyber Pakhtunkwa
- c) Ensure highest quality polio vaccination in the high risk districts/ agencies and populations that suffer from persistent transmission of poliovirus or recurrent re-introductions of poliovirus

iii. STRATEGIES TO ACHIEVE THESE OBJECTIVES

PART 1: OVERSIGHT, OWNERSHIP AND ACCOUNTABILITY

The Polio Eradication Programme in Pakistan is a national programme and the responsibility for implementation rests with the Federal and Provincial Governments. *The intention of the following strategies is to establish appropriate oversight; and ownership and accountability is created within government structures to ensure that all children are reached and immunized.*

- **Ensuring the oversight of Civil Government at the district / agency / township level, and below**

The following steps will be taken in every district, agency and township:

- The DCO, DC, PA, or Town Municipal Officer (TMO) will immediately assume responsibility for ensuring that polio eradication activities are effectively carried out, and will work with the EDO (Health) / Agency Surgeon / Town Health Officer (THO) and representatives of other line departments to ensure that all eligible children in the district/agency/town (referred thereafter as district) are reached with immunization during campaigns.
- The DCO/DC/PA/TMO will chair the district Polio Eradication Committee or Task Force (referred thereafter as DPEC) for which the EDO (Health)/THO/Agency Surgeon (referred as EDO-H thereafter) is the secretariat. The DPEC will be responsible for reviewing a detailed range of indicators focusing on quality of work at the union council level. These include: a) the availability of micro plans for all Union Councils, prepared in consultation with local communities; b) selection and training of appropriate immunization teams and supervisors ensuring government accountable area in-

charges and one member in every vaccination; c) the deployment of human, financial, and other resources according to the micro plan; d) the engagement of line departments other than health in campaign operations; e) the identification of areas with missed children in previous campaigns (on the basis of post campaign assessment) and plans to ensure that all children in these areas are reached.

- Composition of the Polio Eradication Committees at district level should include members from the traditional/community, religious and political leadership as well as the administration, government line departments, Peoples Primary Health Care Initiative (PPHI) and health sector (both public and private). Public representatives may be invited in these meetings.
- In the lead up to campaigns, the DPEC, chaired by the DCO/PA/TMO, should meet no later than 2 weeks prior to the campaign to review plans and allocate resources.
- The DCO should nominate a representative of his choice for each Union Council (from outside of the health department) to support the work of the Health Department especially the UC Medical Officer, (health department or PPHI), especially in the planning and implementation of campaign activities. The EDO (Health) should designate a medical officer (MO) or other appropriate health representative in each UC who will be responsible for the quality of micro planning and campaign implementation.
- During each campaign, the DCO assisted by EDO-H should chair evening meetings at district level to review reports from monitoring in the field, identify issues, and take actions to address them.
- Following post-campaign evaluation and no later than 2 weeks following the campaign, the DPEC, chaired by the DCO / PA / DC / TMO, should meet to review the results, identify areas with sub-optimal performance and any issues impacting on the quality of the round, and take steps to address these issues prior to the next round.
- In designated high risk districts, the DPEC should meet monthly to review progress against the district specific plan (see the relevant section below).
- Detailed guidelines on the role of DCOs/PAs/Agency Surgeons/TMOs and of DPECs (Terms of References – TORs) are attached as Annexure (3d, 3e and 3f). These guidelines include

specific indicators that will be monitored at district level, to assess preparation for SIA rounds as well as implementation, [Annexure 4](#).

- The DCOs/DCs/PAs will accord developmental projects / community incentives on priority to the union councils having consistently high level of objectively verified performance in vaccination activities for at least six successive months.
- In the 33 high risk districts/agencies/towns the Plan will introduce a more intense monitoring of campaign planning and implementation assisted by the additional personnel (intensified human resource support).

- **Oversight at Provincial level**

- The Minister of Health will review progress against the Emergency Action Plan and District Specific Plans every month. A brief report, including request for any administrative actions, will be sent to the Chief Secretary.
- The Provincial Steering Committee or Task Force for Polio Eradication will meet every two months under the chairmanship of the Provincial Chief Minister/ Chief Secretary, with Secretary of Health as the secretariat. These meetings will review progress in the province against the Emergency Plan at district and sub-district level, and progress in preparing and implementing district specific plans in all high risk districts. Following each Provincial Steering Committee meeting, the Chief Secretary and Secretary of Health will brief the Chief Minister and Governor, the Minister of Health, and other provincial ministers on progress against the emergency plan. This briefing will be held in advance of the IPCP and National Task Force meeting (see below). TORs of the Provincial Steering Committee are attached as [Annexure 3c](#).

- **Oversight at National level - National Task Force and IPCP for Polio Eradication**

An executive order from the Government of Pakistan will be issued to make the senior administrative arms of the government at the provincial and district levels under leadership of the Chief Ministers and Governors, that is, Chief Secretary and DCOs/DCs/PAs/TMOs responsible and accountable for effective implementation of the National Emergency Action Plan 2011 and achieving the set goal and objectives.

- The IPCP will continue to meet every quarter as a forum for Ministers and senior Government officials to review progress against the

Emergency Plan, and in particular against the district specific plans in high risk districts. A report on implementation in high risk districts will be tabled prior to each meeting of the IPCP. TORs of the IPCP are attached as Annexure 3b.

- A National Task Force will be formed under the auspices of the Prime Minister. This Task Force will meet every six months to formally review progress under the Emergency Plan with a special focus on 33 high risk districts, and to take steps to address any issues identified. Key functions and composition for the National Task Force are attached as Annexure 3a.
- The purpose of the Task Force will be to review the overall progress on polio eradication nationwide through:
 - Reviewing epidemiological and programme implementation data
 - Reviewing the actions taken to implement the Emergency Plan
 - Examining the following indicators:
 - i. The number of polio cases;
 - ii. Progress in the implementation of district / agency / township specific plans in the highest risk areas
 - iii. The proportion of districts and union councils having a minimum evaluated coverage of 95%, verified by finger marking;
 - iv. The number of children accessed and vaccinated in conflict affected areas, and the number not vaccinated due to lack of access for vaccination teams as a result of security;
- On the basis of conclusions drawn from review of the situation, advice from members and advisors, the Task Force will prepare directives for actions to be taken as seen fit to overcome identified bottlenecks and/or obstacles.
- The Monitoring Cell in the PM Secretariat will serve as the secretariat for the Task Force which will review, compile and share updated data with Task Force members prior to its meetings.
- The first meeting of the Task Force will take place April 2011 and December 2011.

Coordination of the implementation of the emergency plan

- A senior official will be appointed in the Prime Minister and Chief Minister Secretariats as Polio Focal Point to coordinate implementation of the plan activities, including coordination between line departments at Federal level, and coordination with Provincial Governments.

The Technical Advisory Group (TAG) for Polio Eradication in Pakistan

The TAG will continue to be convened twice a year to provide detailed technical advice to the Government on polio eradication activities in Pakistan.

PART 2: ENSURING ACCESS IN AREAS OF INSECURITY

Special plans have been developed by the administrations in FATA and KP to address issues of access in areas of insecurity. Establishing and ensuring access to all children in the security compromised areas of the country through full implementation of these special plans will be critical to bring the current outbreak of polio under control and achieve interruption of poliovirus transmission in the country by the end-2011.

Key strategies for ensuring access in FATA and other insecure areas, as outlined in the special plans, will be:

- Developing a locally feasible and specific plan for each agency / FR areas in close coordination between the Political Agents/ DCs, the military command in each agency, Agency Surgeons, community leaders and partners. These detailed agency specific plans will include:
 - a survey of the level of insecurity with grading in every agency to guide agency specific plans
 - a regular process of grading the level of insecurity e.g. little or no insecurity zone to moderate, high and very high insecurity zones and mapping of these zones within the Agencies.
 - continuous analysis of the situation and flexibility of the programme with contingency plans to respond to emerging situations and opportunities
 - mapping of key influencers at all levels to get advice on locally appropriate strategies and engagement of all stakeholders involving different levels of civil society to de-politicize polio
 - recruiting teams from within the communities through close interaction with the local leadership in coordination with FATA civil administration in each agency
 - Civil and Military Coordination Committee in every agency/FR areas will meet regularly before and after every vaccination campaign, and facilitate accessing children in insecure areas
- Reaching out to all communities and stakeholders in the agencies through local religious, traditional and political leadership (Jirga) to ensure the widest access to all the children
- Using opportunistic strategies to reach children at every window of opportunity, and offering 'polio plus' in campaigns when accessing previously insecure areas

- Coordination and progress monitoring through mechanisms that have already been established under the chairmanship of the Governor and Chief Minister KP, the Chief Secretary, and the Additional Chief Secretary. These mechanisms will allow for monthly monitoring of progress and the identification of corrective actions.

PART 3: ENSURING THE HIGHEST QUALITY OF IMMUNIZATION ACTIVITIES PARTICULARLY IN HIGH RISK DISTRICTS AND HIGH RISK POPULATIONS

- **District / Agency / Township specific planning**

In early 2010 the national programme initiated a process of district-specific planning for the 15 districts, agencies, and towns known to be most persistently infected with poliovirus over the previous 5 years, with the objective of reaching all children with immunization during campaigns. District-specific planning appears to be improving the quality of activities in some key areas, including Karachi and northern Balochistan. Planning at this level engages the local administration and promotes cross-sectoral cooperation, and at the same time allows for the engagement of key community leaders and influencers.

- District specific planning will be expanded to include all designated high risk districts in the poliovirus transmission zones (Annexure 2). A planning workshop for the districts still requiring plans will be held in the first week of January 2011 to facilitate this process, which will build on experiences to date in the 15 persistent transmission districts. All plans will have a communications component to address increasing community demand for immunization. All high risk districts, agencies, and towns will have a district specific plan, endorsed by the DCO/DC/PA, prior to the planned NID round in the last week of January 2011.
- District specific plans for high risk districts should allow for a significant level of tactical flexibility in immunization campaigns, including Short Interval Additional Dose strategies, extended duration of immunization rounds, and opportunistic rounds particularly in security compromised areas.
- Progress against district specific plans will be reviewed monthly at the district (DPEC) and provincial level (Provincial Steering Committee); and quarterly at the national level. Each quarter

progress will be reported to the Inter Provincial Committee on Polio.

- The objective of district specific plans is to ensure improvement in coverage of children in high risk districts in each campaign, with coverage (verified by finger-marking and evaluated by the independent monitors) reaching at least 95% at district level and in each UC monitored by April 2011 and being maintained at that level for every round thereafter, as determined by independent monitoring.

- **Ensuring quality supplementary immunization activities**

The following quality imperatives related to preparations, implementation and monitoring of campaigns must be met to ensure high coverage and quality of polio SIAs:

- (a) Campaign preparation**

- Preparation of micro plans in each Union Council will be the responsibility of the union council level team comprising designated medical officer (health department and/or PPHI) and an officer designated by the DCO/PA/DC/TMO (district administration). The quality of the micro plans should be validated and endorsed at least 1 week before every campaign round by the DCO and EDO H.
- Selection of vaccination team members and their training should be the responsibility of the union council level team (Annexure 3f).
- Where LHWs are available, they must be members of local vaccination teams. In areas where LHWs are not available, as far as possible team members should be local government employees, preferably adult females. In FATA and in areas with specific ethnic/minority population settlements, team members should be selected from and acceptable to the local community and be of appropriate age.

- (b) Implementation**

- The quality of campaign implementation will be ensured by the DCO/DC/PA/TMO and EDOH. In addition to Health, key

line departments, particularly Education and Revenue, will be engaged to support and supervise implementation.

- District and UC funding will be released on time and the DPEC will monitor the receipt of entitlements by vaccinators and supervisors.

(c) Campaign Monitoring and Feedback

- Systematic and well planned independent monitoring using standard formats will be conducted in the preparatory, implementation and post-implementation phases of the campaign.
- Timely review and updating of micro plans will be monitored before each round. In high risk areas micro plans should be independently validated through field visits before every other round.
- The quality of training of vaccination team members will be monitored using a standard checklist. The performance of house-to-house teams and their supervisors will be closely monitored.
- In addition to the current process of post campaign monitoring, additional checks on monitoring quality will be performed including Lot Quality Assurance Sampling methodology and other innovative technologies, particularly in areas where monitoring data and epidemiological data are inconsistent.
- Partner agencies, in particular WHO and UNICEF, are requested to intensify their participation in the monitoring process, and to provide objective monitoring data at implementation level, district level, and province level, to enable district and provincial authorities to take corrective actions.

(d) Communication

- Based on local situation and objective evidence, relevant communication and social mobilization activities will be implemented to ensure acceptance and promote demand for vaccination in high-risk areas before each round. Detail can be seen at [Annex-5](#).

(e) Surveillance

- Provincial government will ensure that the designated District Surveillance Coordinators make all efforts to achieve the highest level of AFP surveillance and is made responsible to ensuring that all tehsils and districts have surveillance indicators meeting the Certification Standards.

(f) Applied Research

- Relevant applied research will be conducted to address operational issues to optimize the implementation of the Emergency Plan.

• Refining a comprehensive high risk populations strategy

Migrants, internally displaced persons, refugees and nomads are a particularly high risk group for polio because of their lower immunization levels and their important role in movement of poliovirus within the country and across the border in Afghanistan. Migrants groups comprise seasonal agricultural workers, migrants, shepherds (*Kochies, Pawindas, Bakarwals*), snake charmers, construction or brick-kiln workers, IDPs, Afghan Refugees, etc. Recognizing these risks, the national polio eradication program has developed a specific strategy to ensure immunization of children among these populations. The strategy aims at achieving at least 95% or above immunization coverage confirmed by finger marking through post campaign independent monitoring in specific mobile, migrant, and underserved population sites.

- The implementation of the national strategy to ensure immunization of these mobile groups should be prioritized in every district, but particularly in the high risk districts in the four poliovirus transmission zones.
- The key elements of this plan that must be implemented immediately include:
 - Mapping and listing of migrant communities and settlements and their inclusion in campaign micro plans;
 - Specially recruited and well trained vaccination teams that are acceptable to the local community, including members from the community.

- Special targeted communication and social mobilization strategies appropriate to the community.
- Enhanced supervision of teams covering mobile communities.
- Intensified post campaign coverage monitoring in these communities
- Enhanced transit point vaccination of children on the move through strengthened support of police and other relevant agencies.

Conclusion

Finishing polio eradication in Pakistan is vital not only for the health of the nation, but for the whole global community. This Emergency Plan is intended to rapidly and dramatically increase oversight and accountability in Government at all levels, and to ensure that all children will be reached with vaccine, no matter what geographical area of the country or what community they come from. The stimulus for this plan is from the highest levels for the nation's Government, and is recognition of the national responsibility to finish polio eradication so that the children of Pakistan, and of the world, can be free of the threat of polio forever.

Annexures attached

Acronyms and abbreviations

AFP	Acute Flaccid Paralysis
DCO	District Coordination Officer
DPEC	District Polio Eradication Committee
EDO	Executive District Officer
FATA	Federally Administered Tribal Areas
FR	Frontier Region
IDPs	Internally Displaced Persons
IPCP	Inter Provincial Committee on Polio Eradication
KP	Khyber Pakhtunkhwa
NID	National Immunization Days
PA	Political Agent
PPHI	Peoples Primary Healthcare Initiative
SAFRON	States and Frontier Regions
SIA	Supplementary Immunization Activities
TAG	Technical Advisory Group
TMO	Town Municipal Officer
UC	Union Council
UNICEF	United Nations Children Fund
US\$	United States Dollar
WHO	World Health Organization