CORE GROUP POLIO PROJECT

FY13 Annual Program Report

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EXECUTIVE SUMMARY

In October of 2012 the CORE Group Polio Project (CGPP) received funding from the USAID Global Bureau intended to continue the polio eradication activities begun under the earlier USAID-funded CGPP project. The CGPP grant provides funding of up to US$38 million for five years, ending in September 2017.

In 2013, the CORE Group Polio Project (CGPP) completed thirteen years of polio eradication work in Angola, Ethiopia, and India, celebrating more than two years with no new cases of Wild Polio Virus (WPV) in India and Angola, while Ethiopia suffered a re-importation of six wild polio virus One cases as a result of the large ongoing outbreak in Somalia and the Horn of Africa. The project has also been laying the foundation for new project activities in Nigeria, one of the three remaining polio endemic countries. While the project has continued to build on their successes, the outbreak in the Horn of Africa and the ongoing transmission in northern Nigeria have presented major challenges in 2013. In Angola, Ethiopia and India, the CGPP has contributed to polio eradication by supporting strong Supplementary Immunization Activities (SIAs), enhanced routine immunization, AFP surveillance, partner coordination, and the use of good data. With significant outbreaks in the Horn of Africa and Syria, 2013 has been a tough year for global polio eradication. While progress toward eradication was extremely promising in Afghanistan and the total number of cases decreased significantly in Nigeria, continued circulation of wild polio virus in Pakistan, major security concerns in Northern Nigeria, and the outbreaks in Somalia, Kenya, Syria, Ethiopia, and the Cameroon, demonstrate the continued risk of wide spread polio circulation until the virus in eradicated.

Eradication progress in CGPP countries has remained strong with no new cases in India or Angola and a strong response effort underway in Ethiopia. CGPP is also in the process in launching project activities in Northern Nigeria and the Horn of Africa to contribute to these critical areas. A review of the data demonstrates that the CGPP in India has made notable and steady progress on project objectives, achieving high quality NIDs, building effective partnerships between agencies, and raising routine immunization rates. GGPP Angola has developed strong partnerships, contributed to high quality NIDS and community AFP surveillance but continues to struggle with low routine immunization rates and a troubling decrease in AFP surveillance numbers. CGPP Ethiopia has demonstrated leadership in NIDS, AFP surveillance, partner coordination, border protection and by all accounts mounted a strong and successful outbreak response which appears to have halted the spread of wild polio virus in Ethiopia well within the targeted six months of onset. Many of these accomplishments have also been documented in independent evaluations, journal articles, and presentations.

In all three countries, the CGPP partners have successfully implemented the secretariat model to coordinate and promote civil society engagement in polio eradication, while simultaneously injecting a crucial community- level component through the coordinated activities of thousands of community health workers. These two components, encompassing both the national policy level and the grass roots community level, are a unique and critical contribution to polio eradication not generally covered by either the MOH or the spearheading partners.

The global polio eradication initiative has come a long way, posting significant gains in recent years despite this year's setbacks. The GGPP has contributed to those gains and thanks to a new USAID grant for FY2013 to FY 2017, CGPP is in position to capitalize on lessons learned to cross the finish line to polio eradication in the last few remaining reservoirs of wild polio virus.

List of Acronyms and Abbreviations

ADP	Area Development Program
ADRA	Adventist Development and Relief Agency
AFP	Acute flaccid paralysis
ANM	Auxiliary nurse midwife
BCC	Behavior change communications
CARE	Cooperative for Assistance and Relief Everywhere, Inc.
CBO	Community-based organization
CBS	Community-based (AFP) surveillance
CF	Child Fund
CGPP	CORE Group Polio Project
CMC	Community Mobilization Coordinator
CORE	Collaboration and Resources for Child, Maternal and Community Health
CORE PEI	CORE Group Polio Eradication Initiative (1999-2007)
CRS	Catholic Relief Services
DPT	Diphtheria, pertussis, tetanus vaccine (DPT3 refers to the 3rd dose)
FCHV	Female Community Health Volunteer
GAPS	Geographic assessment of planning and services
HQ	Headquarters
HMIS	Health management information system
HRA	High-risk area
ICC	Inter-agency Coordinating Committee (for Polio Eradication)
IEAG	India Expert Advisory Group
IR	Intermediate Result
IRC	International Rescue Committee
LEAP	Learning through evaluation with accountability and planning
LQAS	Lot quality assurance sampling
M&E	Monitoring and evaluation
MNT	Maternal/neonatal tetanus
MOH	Ministry of Health
MTE	Mid-term evaluation
NGO	Non-governmental organization
NID	National Immunization Day
NPAFP	Non-polio acute flaccid paralysis
NPEV	Non-polio enterovirus
NPSP	National Polio Surveillance Project
NS	National Secretariat
OPV	Oral polio vaccine
OPV-Zero	Oral polio vaccine – 1st dose, provided to newborns within 15 days of birth
PCI	Project Concern International
PEI	Polio Eradication Initiative
PPCC	Polio Partners Coordinating Committee
PVO	Private voluntary organization
RED	Reaching Every District
RI	Routine immunization
SC	Save the Children Federation
SD	Secretariat Director

SIA	Supplemental Immunization Activity (includes NIDs, SNIDs and “mop-up” campaigns)
SMNet	Social Mobilization Network
SNID	Sub-national Immunization Day
SMO	Surveillance Medical Officer
TAG	Technical Advisory Group
TCG	Technical Consultative Group
TFI	Task Force on Immunization
UNICEF	United Nations Children’s Fund
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization
WPV	Wild Poliovirus
WV	World Vision
WV-US	World Vision United States

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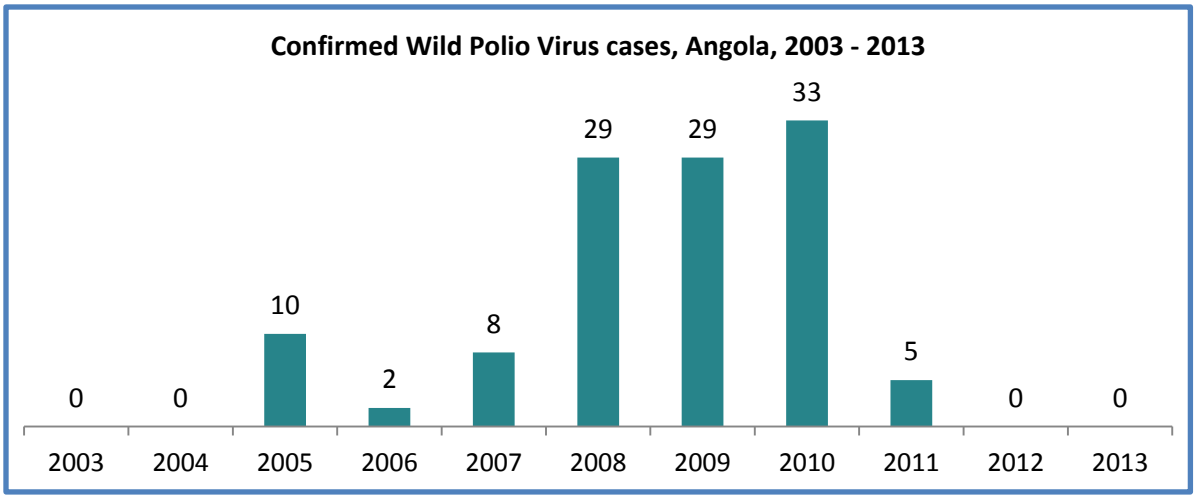
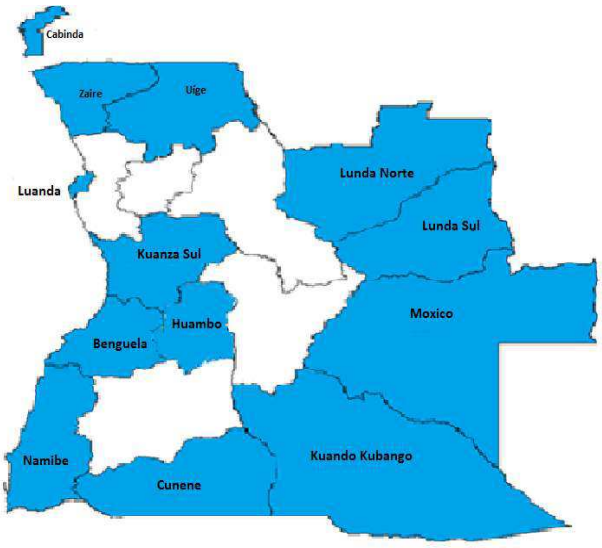
CGPP Angola

When the CORE Group Polio Project was initiated in Angola in 2000, the country was experiencing a major WPV outbreak with over 1,000 cases, primarily concentrated in the capital city of Luanda. Intensive efforts by the MOH, WHO, UNICEF, Rotary, the GGPP and others, interupted the ciruculation of wild polio viurs in 2001. Angola remained polio free until 2005, when a wild polio virus strain from India was reimported due to poor routine immunization. Following the re-establishment of WPV in Angola, Angola also exported wild polio virus to the DRC and the Congo. Through the combined efforts of the MOH, spearheading partners, CGPP, and donors, Angola interupted the circulation of WPV again in July 2011 and has now completed more than two years with no new cases of WPV. Although this is a major accomplishment, the continued presence of WPV in other parts of Africa coupled with persistent challenges to the quality of routine immunization, SIAs, and surveillance present a strong case for continued interventions in Angola.



CGPP-Angola is currently working in 40 high-risk districts in 12 provinces reaching 9,422,824 children under the age of fifteen each year. CGPP-Angola continues to mobilize community volunteers, support the implementation of high-quality vaccination campaigns and identify cases of acute flaccid paralysis (AFP). This year, the project focused on several key areas including: 1) active case detection targeting



community leaders and urban health facilities, 2) support to strengthen SIAs, 3) campaign monitoring, and 4) local level advocacy meetings to more effectively mobilize leaders at district (*municipio*) and sub-distrcit (*communa*) levels.

Provinces in which the CGPP implements activities

Objective 1: Build effective partnerships between agencies

CGPP-Angola has established a strong working relationship with the MOH and spearheading partners in Angola, playing an important role in the national ICC meetings and working closely with the MOH, UNICEF, CDC, Rotary, and WHO to plan, implement and monitor all aspects of polio eradication in Angola. The CGPP partner NGOs meet on a monthly basis to coordinate and discuss strategies to strengthen polio eradication activities. These monthly meetings also provide the CGPP Secretariat an opportunity to communicate decisions, policies, and guidelines established by the ICC, MOH, and the Global Polio Eradication Initiative. In a similar fashion the presence of the Secretariat Director on the ICC and the Technical Working Group gives the NGOs and civil society a voice at the national decision making level among the MOH and spearheading partners. In qualitative interviews conducted as a part of the final project evaluation, it was clear that the MOH and spearheading partners have a great deal of respect for the contributions of the CGPP and the secretariat.

The current project coordinates the participation of four international NGOs; Africare, CRS, World Vission, and the Salvation Army, and three local NGOs; CARITAS, ASSODER, and TWAYOVOKO. To better coordinate and plan activities and build the capacity of project staff, CGPP Angola held two partner forums in 2013 which included the polio management staff and senior leadership of all of the partner NGOs. These meetings provided an opportunity for project staff from different NGOs working in varied regions to learn from, interact with and share best practices with their counterparts throghout the country.

Objective 2: Strengthen routine immunization systems

Based on data from a 30 cluster baseline, mid-term and a final evaluation survey, OPV3 coverage rates in project areas based on card only were 32% in 2008, 40% in 2010 and 37% in 2012. OPV3 coverage by card plus mother recall actually declined from 59% at mid-term in 2010 to 49% at Final Evaluation in July 2012. Ministry of Health (MOH) administrative data shows a decrease in routine OPV3 coverage rates nationally from 86% in 2012 to 75% in 2013. Various logistical challenges such as stock outs, poor administrative support to outreach vaccination teams, and vacancies in vaccination staff have all contributed to less than ideal access to vaccination services in many parts of the country.

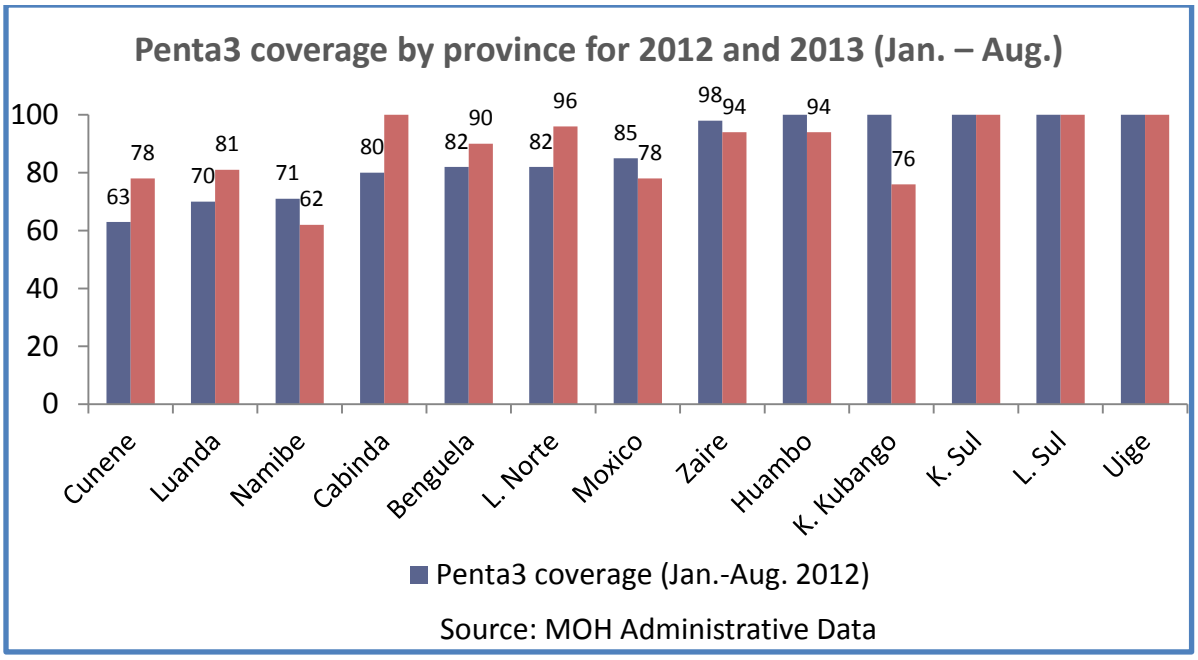
There is clearly a pressing need to prioritize this pillar of polio eradication in order to reduce the country's reliance on SIAs and protect the country from potential importations. In 2013 the project continued to build the capacity of vaccination staff through technical training in vaccination techniques and cold chain management and on the job supervision. Responses on the 30 cluster survey identified various access related issues as important factors in the low immunization coverage. Mothers responded that they did not know where or when to go for immunizations, the vaccination site was too far, there was no vaccine at the vaccination site, and that the vaccination teams did not come to their village or area. Discussions with health administrators have countered that mothers were too busy working to bring their children for immunizations and that families did not prioritize preventative services such as immunization. Based on these responses, the project has engaged both the health workers and the communities in creative ways such as outreach campaigns and social mobilization to increase vaccination coverage. Stock outs of up to three months are also contributing to less than favorable coverage rates

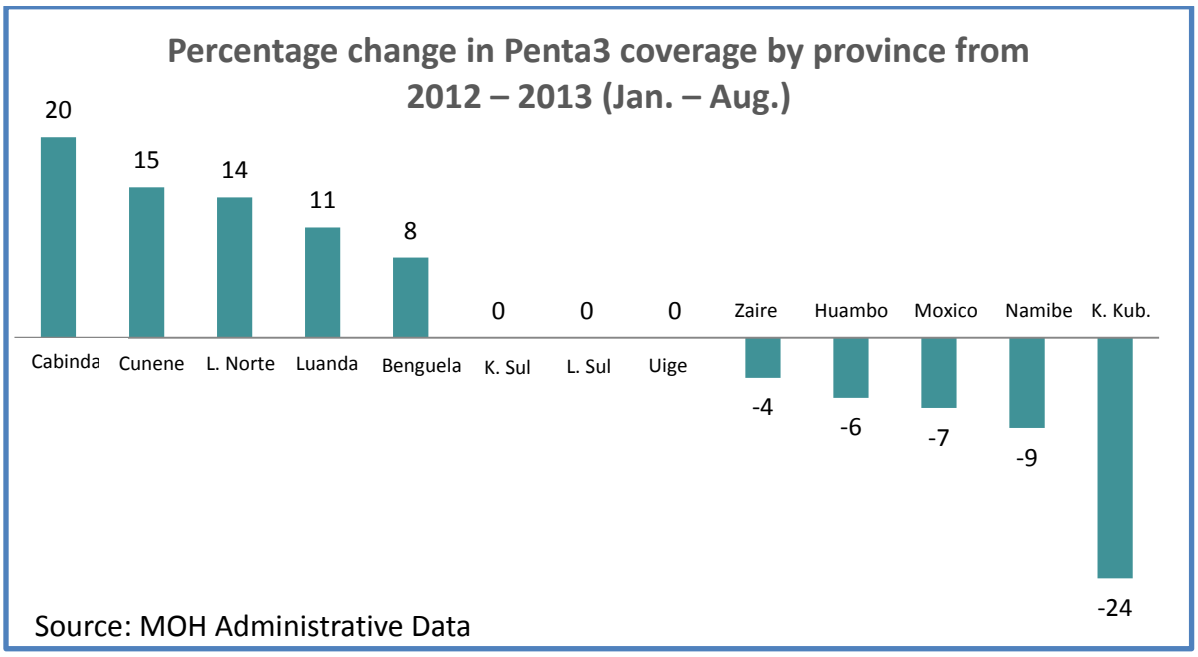
One of the ways in which the project is working to increase routine immunization is through the use of vaccination registries maintained by community health workers (CHWs). This strategy requires the CHWs to visit households under their supervision and record the vaccination status of all children under five. By tracking the individual vaccination status of these children, the CHWs are able to identify which children need to go for follow up vaccinations and to verify their compliance. Anecdotally, the project partners and volunteers are convinced that this strategy has increased vaccination coverage in project areas, although there is no concrete data thus far to confirm this. The CGPP has 2700 trained CHWs covering approximately 25 to 50 households each in 40 districts of twelve provinces.

Volunteers and health staff trained in FY13

Province	# volunteers	# volunteers trained in FY13	# health staff trained in FY13	# of trainings in FY13
Benguela	490	490	92	10
Cabinda	60	60	20	2
Cunene	100	100	0	5
Huambo	80	80	1	3
K. Kubango	220	220	0	7
K. Sul	350	324	6	11
Luanda	450	450	248	23
L. Norte	100	100	0	2
L. Sul	240	240	49	4
Moxico	150	150	58	2
Namibe	100	100	203	16
Uige	190	190	99	11
Zaire	170	170	171	28
TOTAL	2,700	2,674	947	124

Post-war demographic shifts have significantly increased population in the large urban areas of Luanda and Benguela without necessarily providing the increased capacity to meet the health needs of these populations. Government officials estimate that the population of Luanda may have doubled or tripled since the end of the war in 2002. Demographically, this means that the majority of unvaccinated children are concentrated in a small number of high-risk areas. In response to this, the project has increased its focus on the dense urban populations of Luanda and Benguela but these dense population centers are expensive and difficult to access due to traffic congestion.


Penta3 coverage by province for 2012 and 2013 (Jan. – Aug.)
100
80
60
40
20
0
63
78
70
81
71
62
80
82
90
82
96
85
78
98
94
94
76
Cunene
Luanda
Namibe
Cabinda
Benguela
L. Norte
Moxico
Zaire
Huambo
K. Kubango
K. Sul
L. Sul
Uige
Penta3 coverage (Jan.-Aug. 2012)
Source: MOH Administrative Data


Percentage change in Penta3 coverage by province from 2012 – 2013 (Jan. – Aug.)
20
15
14
11
8
0
0
0
-4
-6
-7
-9
-24
Cabinda
Cunene
L. Norte
Luanda
Benguela
K. Sul
L. Sul
Uige
Zaire
Huambo
Moxico
Namibe
K. Kub.
Source: MOH Administrative Data

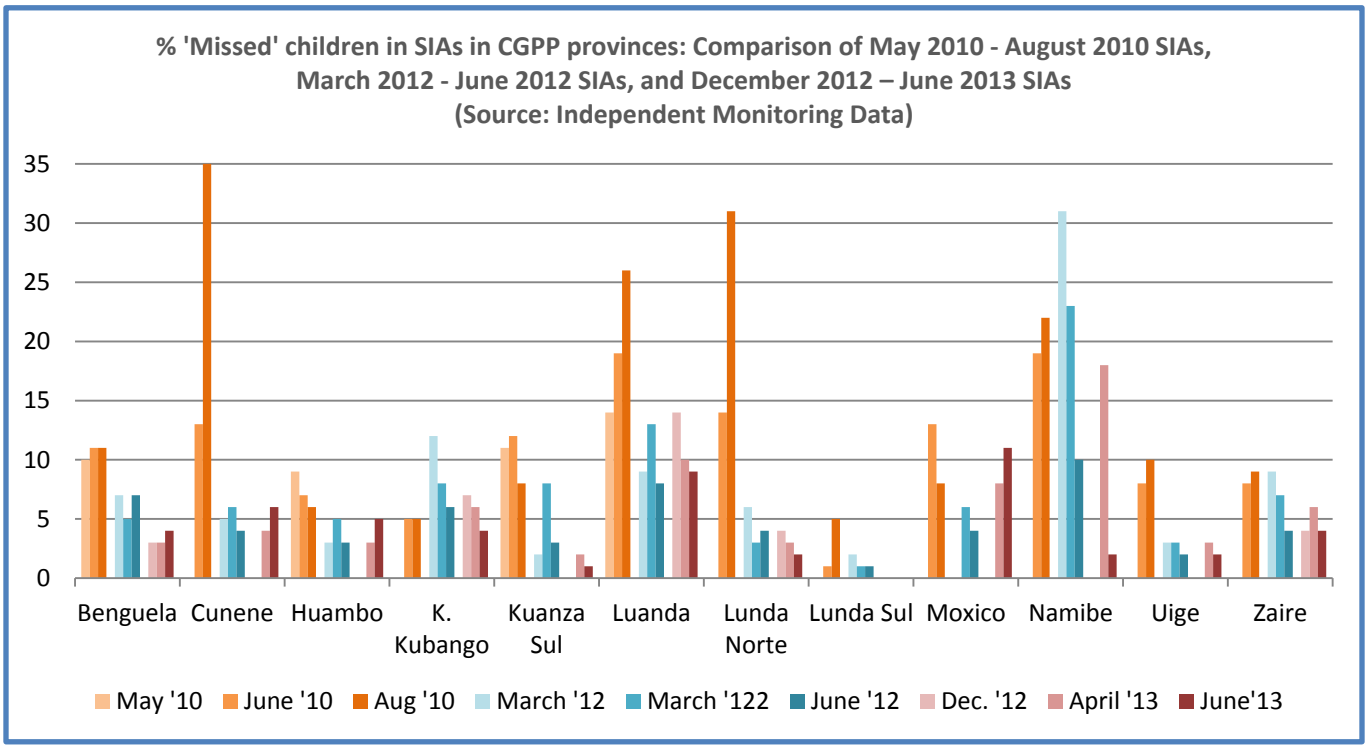
Unvaccinated children in project municipalities, 2010 and 2013

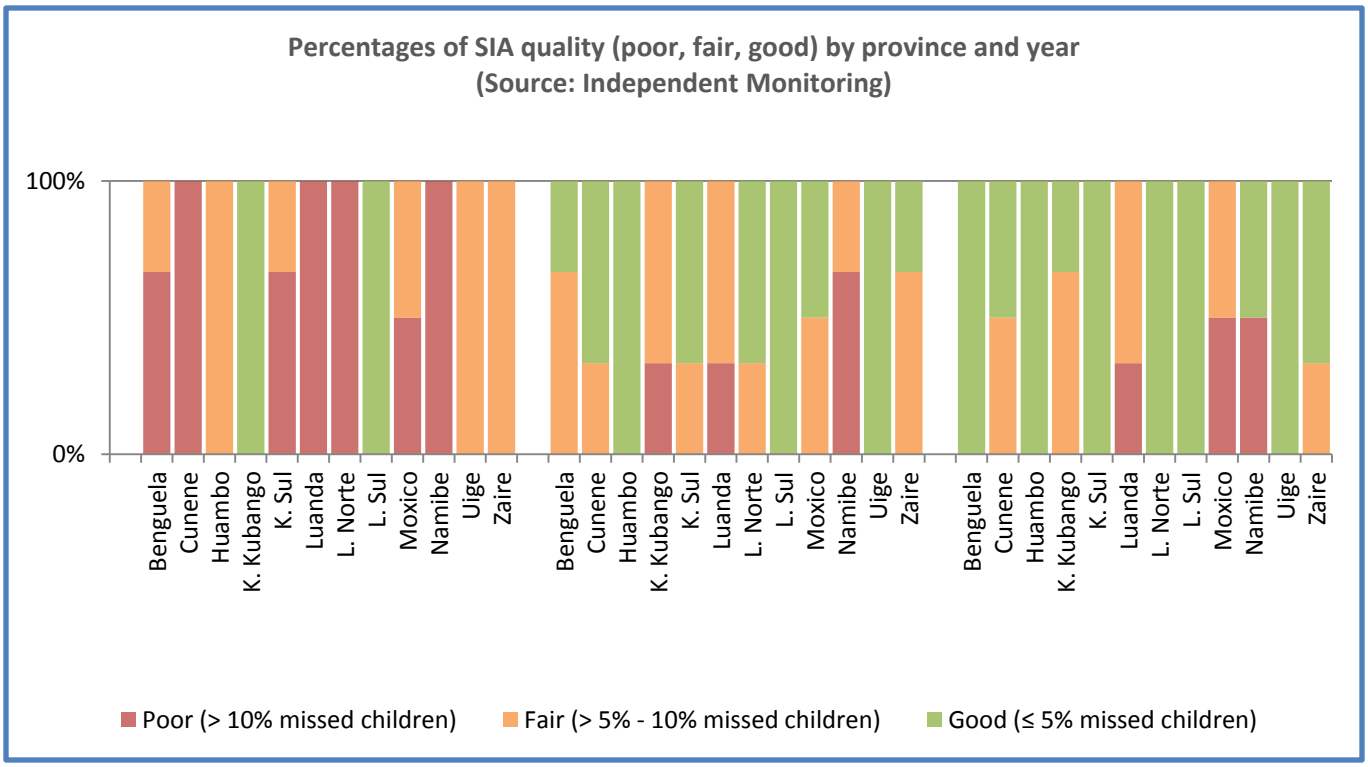
	# of project municipalities included on list of 7 municipalities with the most unvaccinated children	# project municipalities, included on 2010 list of 7 municipalities with the most unvaccinated children, with fewer unvaccinated children in 2013	# of project municipalities included on list of 22 municipalities with the most unvaccinated children
2010	7	NA	9
2013	3	6	6

Objective 3: Support supplemental polio immunization activities

As the following charts demonstrate, 95% of parents reported that their under five children were vaccinated in the most recent NID, up from 91% at baseline and 93% at mid-term. These results were corroborated by the independent campaign monitoring data from the last NID which showed similar results. The CGPP has contributed a great deal of effort to both the implementation of the campaigns as well as the implementation and supervision of independent campaign monitoring using Angolan military personnel trained, transported, and supervised by CGPP staff. Each of the CGPP partner NGOs provide transportation, training, social mobilization, supervision, and planning support to the annual NIDs and SNIDs ensuring high quality implementation. In light of the low routine immunization coverage, maintaining high coverage through SIAs is critically important in order to maintain an adequate protection against re-importation of the wild polio virus.

The quality of the independent monitoring data has been recognized by both the MOH and the spearheading partners and has now replaced the less reliable administrative data as the preferred method of evaluating and strengthening SIA performance. Based on the independent monitoring data, approximately 2.36 % of houses were missed during NIDS in 2013. In an effort to improve vaccination as well as other health services, the MOH appointed new Provincial Health Directors in Luanda and Benguela and the National EPI office sent national support staff out to the provinces with the greatest number of missed children. This year for the first time CGPP used smart phones using the MagPi system to collect and record campaign monitoring data.


% 'Missed' children in SIAs in CGPP provinces: Comparison of May 2010 - August 2010 SIAs, March 2012 - June 2012 SIAs, and December 2012 – June 2013 SIAs (Source: Independent Monitoring Data)
35
30
25
20
15
10
5
0
Benguela
Cunene
Huambo
K. Kubango
Kuanza Sul
Luanda
Lunda Norte
Lunda Sul
Moxico
Namibe
Uige
Zaire
May '10
June '10
Aug '10
March '12
March '122
June '12
Dec. '12
April '13
June'13


Percentages of SIA quality (poor, fair, good) by province and year (Source: Independent Monitoring)
100%
0%
Benguela
Cunene
Huambo
K. Kubango
K. Sul
Luanda
L. Norte
L. Sul
Moxico
Namibe
Uige
Zaire
Poor (> 10% missed children)
Fair (> 5% - 10% missed children)
Good (≤ 5% missed children)

Objective 4: Support efforts to strengthen AFP surveillance

The CGPP contributed to Non polio AFP rates of above 2 per 100,000 in children under the age of 15 and Stool adequacy rates above 80% in the majority of project areas. CGPP partner staff have worked hard to improve AFP surveillance by supporting active case surveillance in coordination with the WHO and MOH surveillance personnel, providing transportation to surveillance officers, and visiting health facilities according to a calendar based on the level of priority. Additionally, CGPP partners use their extensive network of 2700 Community Health Workers (CHWs) to promote community level case detection to ensure that no cases are missed and to identify cases earlier. In 2013 the project distributed bicycles to all of the CHWs to motivate and enable them to conduct community based active case detection. Community based case detection is particularly important since some cases have previously been identified late due to community reliance on traditional healers outside the official health system. Now that Angola, has been polio free for more than two years, the project will need to continue to maintain a high level of vigilance to ensure that any new importation is rapidly detected and stopped through a mop-up response.

AFP Cases Detected by CGPP Community Health Workers

Province	2010	2011	2012	2013
Huambo	0	4	0	1
K.Kubango	0	3	2	5
K.Sul	4	3	5	5
Luanda	6	10	15	0
Moxico	0	2	0	0
Lunda Sul	0	0	0	0
Zaire	0	1	0	0
Namibe	0	1	0	2
Cunene	0	0	0	0
Uige	0	4	0	0
Benguela	8	6	2	0
Lunda Norte	0	1	0	0
Total	18	35	24	13

AFP Surveillance Performance By province, 2010 – 2013 (Source: WHO Weekly polio updates)

Province	Oct. 15, 2010 – Oct. 14, 2011		Oct. 21, 2011 – Oct. 20, 2012		Oct. 21, 2012 – Oct. 21, 2013	
	NP AFP Rate	Adequacy Rate	NP AFP Rate	Adequacy Rate	NP AFP Rate	Adequacy Rate
Benguela	2.7	92%	2.0	80%	3.0	93%
Cabinda	2.3	62%	3.4	100%	3.2	100%
Cunene	2.0	75%	1.7	100%	1.7	100%
Huambo	2.3	100%	2.1	94%	3.0	84%
K. Kubango	7.0	95%	3.8	89%	2.6	100%
K. Sul	1.4	89%	3.0	88%	3.2	95%
Luanda	1.9	77%	2.6	81%	2.2	86%
L. Norte	4.0	100%	4.9	88%	5.9	90%
L. Sul	5.5	100%	4.6	88%	1.7	100%
Moxico	2.3	91%	2.2	100%	1.5	100%
Namibe	6.0	100%	11.5	100%	6.7	100%
Uige	3.7	70%	4.3	87%	3.1	76%
Zaire	6.0	88%	2.3	100%	3.5	100%

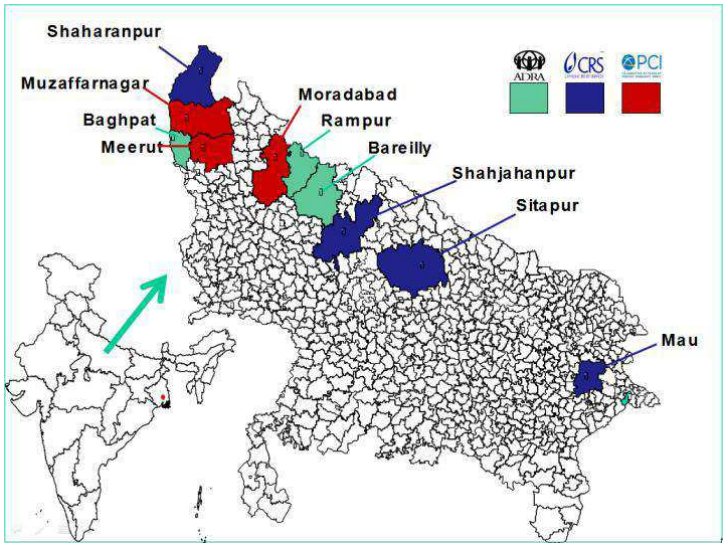
Objective 5: Support timely documentation and use of information

As mentioned in the section on support to SIAs, one of the primary ways in which CGPP has promoted timely documentation and use of information is their oversight of independent campaign monitoring. During campaign implementation, the independent monitors, trained and supervised by CGPP staff, conduct monitoring surveys which are tallied on a daily basis and used in end of the day review discussions to tailor the plans for the following day. In this fashion, the data is used to improve the current campaign as it is taking place. Naturally, the post-campaign monitoring data are also used to evaluate and improve the following campaigns.

As members of the national EPI technical team, the CGPP participated in the preparation of 12 MOH international presentations. CGPP made three presentations to the ICC on independent campaign monitoring, one presentation to the Governor of Luanda, four presentations at cross border meetings, and one presentation on the CGPP Angola program at the CGPP multi-country meeting in India.

CGPP India

India is nearing the three year anniversary of the last case of wild polio virus in January 2011. This hard won accomplishment was achieved through the contributions of numerous partners including the MOH, spearheading partners, donors, the government, and the CGPP. Despite extremely high population density and poor sanitation, India succeeded in stopping the transmission of WPV in the most difficult areas through perseverance and dedication to achieve remarkably high rates of SIA coverage and strong AFP surveillance. Long expected to be the final polio endemic country in the world, India is now seen as a model of how to stop polio transmission in difficult areas.



CGPP India continues to work through a cadre of 1300 community mobilization coordinators (CMCs) in 58 blocks of 12 Districts of Uttar Pradesh (U.P.) As a founding member of the social mobilization network (SM Net), along with UNICEF, CGPP volunteers ensure high quality social mobilization promoting maximum campaign participation and routine immunization coverage. The CGPP India project is implemented by three international partner agencies, ADRA, CRS and PCI, and ten local NGOs. The CGPP India program has also been a model and source of ideas and inspiration for polio eradication work in Pakistan, Afghanistan and Africa.

Objective 1: Build Effective Partnerships between agencies

The CGPP secretariat, established in 2000, facilitates implementation of the CORE polio eradication program and coordinates activities at the national level, ensuring that the CORE PVOs in India function as a working coalition for the polio eradication initiative rather than as individual entities. It maintains full communications with PVO partners, providing them with regular polio and other program updates as well as surveillance data from MOH, WHO and UNICEF; fosters effective working relationships with and linkages between USAID, NPSP, MOH, WHO/SEARO, UNICEF, Rotary and other stakeholders; facilitates proposal preparation, training, implementation and evaluation; represents the coalition at the national and sub-regional levels and promotes coalition and collaboration among the PVO partners especially in the four hot districts to foster innovations, best practices and capacity building.

Organizations and NGOs in India consortium

PVO Partner	NGO Partner	Work Districts
ADRA (Adventist Development and Relief Agency)	Innovative Approach for Social Development Society (IASDS)	Baghpat
	Malik Social Welfare Society Rampur (MSWS)	Rampur
	ADRA (direct implementation)	Bareilly
PCI	Society for All Round Development (SARD)	Meerut
	Adarsh Seva Samiti (ASS)	Moradabad
	Jan Kalyan Samiti (JKS)	Muzaffarnagar & Shamli
	Mahila Jagriti Sewa Samiti (MJSS)	Moradabad & Sambhal
CRS (Catholic Relief Services)	Meerut Seva Samaj	Saharanpur
	Sarathi Development Foundation	Shahjahanpur & Sitapur
	Jeevan Jyoti Community Center	Sitapur
	Diocese of Varanasi Social Welfare Society	Mau

CGPP India and Unicef are founding members of the Social Mobilization Network (GoI, UNICEF, WHO NPSP, Rotary) which engages community level mobilizers working in high risk areas of Uttar Pradesh (U.P.). CGPP is also a member of the routine immunization working group (GoI, UNICEF, WHO NPSP, MCHIP, PATH, etc) at the national level and participates in most polio-related meetings with partners like WHO, UNICEF, etc. Every quarter the secretariat participates in the UP Polio Partners meeting at Lucknow, which is attended by the GoUP, UNICEF, WHO, Rotary and MCHIP. India has no ICC for polio eradication. The Secretariat Director of the CGPP in India is also a member of the Oversight Advisory Group of GAVI CSO constituency.

In February 2013, fifteen participants from CGPP programs in Angola, Ethiopia, S. Sudan and US HQ gathered for the first time at Gurgaon, India to exchange ideas and strategies across countries and regions. The group participated in the unveiling of the *Polio Chowk* in Moradabad and observed NID activities in Moradabad and Rampur districts. They also interacted with field staff and senior officials from CGPP

Partners, UNICEF , WHO-NPSP and the government. Some of the highlights and observations by the participants were the importace of seamless partnership among all partners and the government, ownership and accountablity by each stakeholder, high quality microplans, rigorous review and monitoring and strong involvement of community and influencers.

The India Secretariat Director participated in the Annual Regional Conference on Immunization and the African Regional ICC in Tanzania in December 2012 and shared the India polio eradication experience at a workshop in Nigeria in May 2013. The India Deputy Director shared best practices from the CGPP with the Afghanistan Polio Program team in Kabul in June 2013 and the India social mobilization officer participated in the Leadership in Health and Strategic Communication workshop at Johns Hopkins University in June 2013. The India Secretariat Director also represents NGO interests on the GAVI NGO steering committee.

ADRA India, in association with the local health department and an NGO, Bharat Bikash Parishad, created good will and raised the profile of polio eradication by conducting four camps in Baghpat and Rampur districts where more than 400 tricycles, wheelchairs, calipers, shoes, etc were distributed to physically challenged children.

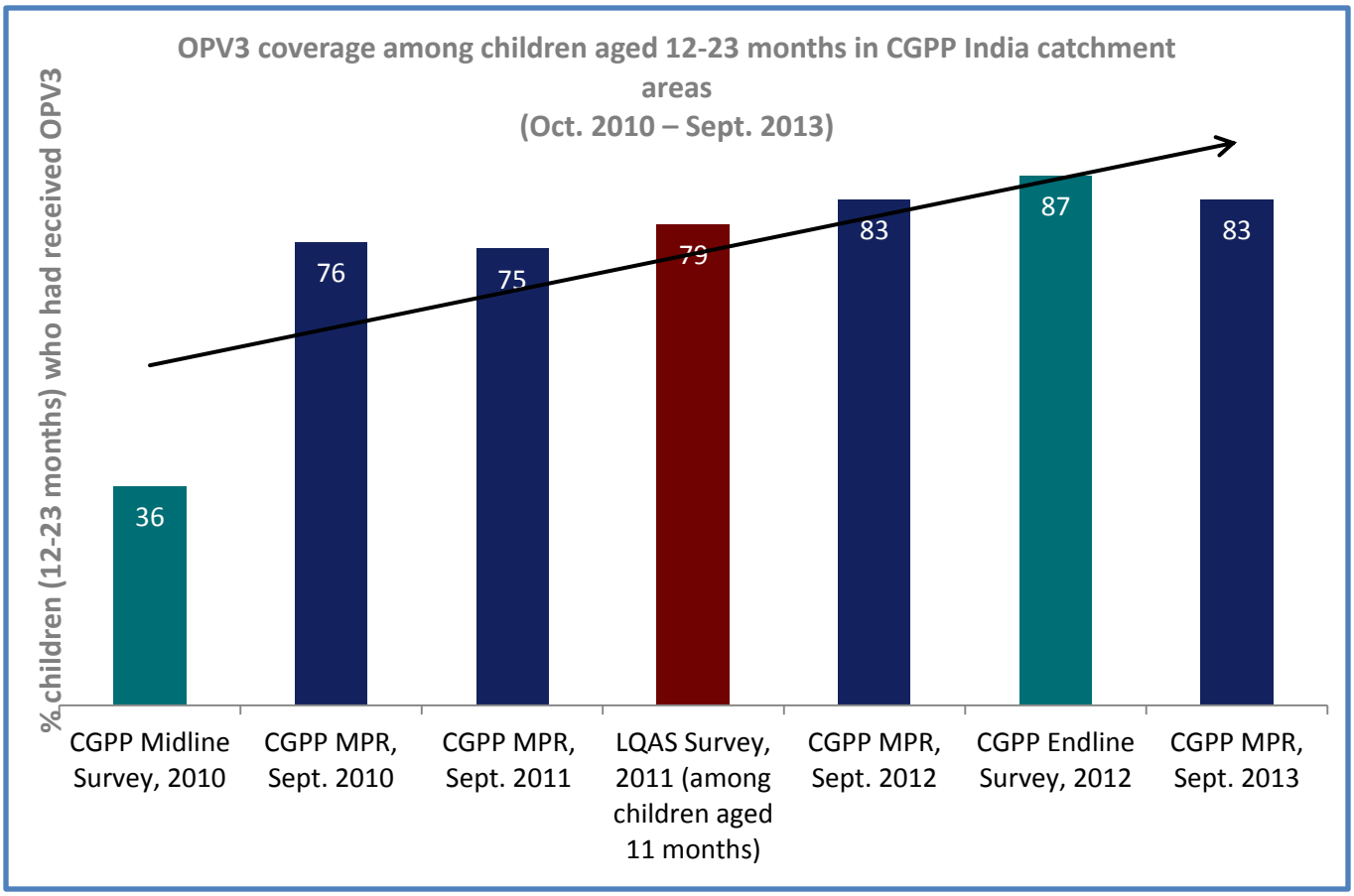
Membership and activities in Committees and organizations focusing on immunization and polio eradication (ICC, SM-NET, etc.)

- **SM Net (Social Mobilization Network in U.P):** The SM Net consists of UNICEF, CORE and Rotary and came into existence in 2003 with the aim of working together in the high risk areas of UP. Community mobilizers from the same communities are allocated households to ensure that all children under the age of 5 years are covered both for polio and RI. The field staff structure, activities (IPC with mothers, mass awareness shows, meetings with influencers, religious leaders, etc), honorariums, reporting, etc are uniform throughout the network.
- **Social Mobilization Working Group:** All partner agencies working in social mobilization (CGPP, GoI, WHO NPSP, UNICEF, Rotary) meet at least 4-5 times a year to review the field situation and interact with each other.
- **Routine Immunization Working Group:** This group of partners involved in Routine Immunization range from the government to WHO, UNICEF, CGPP, etc. and meet at least twice or thrice a year. The Polio model is being used for microplanning , etc of RI.
- **India Expert Advisory Group:** This is a group of national and international experts who meet at least twice a year to give recommendations for the polio program. The meetings are chaired by the government.
- **UP Polio Partners meeting:** The GoUP, UNICEF, CGPP, Rotary and NPSP U.P meet at least three times a year in U.P to review data, get partner updates and re-strategize if necessary.
- **District core group meetings:** All partners meet at least once a month at the district level to sort out local issues and keep each other updated.

- **District Task Force meetings:** These meetings are held just before the SIA to check preparedness and are chaired by the District Magistrate. Vaccination coverage or gaps (both administrative and operational) of previous rounds are reviewed and strategies modified if required. The Task Force comprises all the partners from the government to WHO NPSP, CGPP, UNICEF, Rotary, NGOs, etc.
- **Evening feedback meetings during S/NIDs**: These are organized every evening during SIAs at CMO offices to review the coverage, gaps by health department or special problems and all partners participate. Thus the situation is corrected before the next day.

Objective 2: Strengthen routine immunization systems

Through a continuous focus on immunization promotion by Community Mobilization Coordinators (CMCs), the CGPP has steadily raised routine immunization coverage rates in project areas. The 1,283 CGPP CMCs each cover approximately 500 households covering a total of 474,520 households in 2013 and maintain detailed vaccination registries for all of the under five children in the households, thereby tracking and promoting routine immunization in their communities. OPV3 coverage for children 12 to 23 months in project areas increased from 67% at final evaluation in 2012 to 83% in 2013

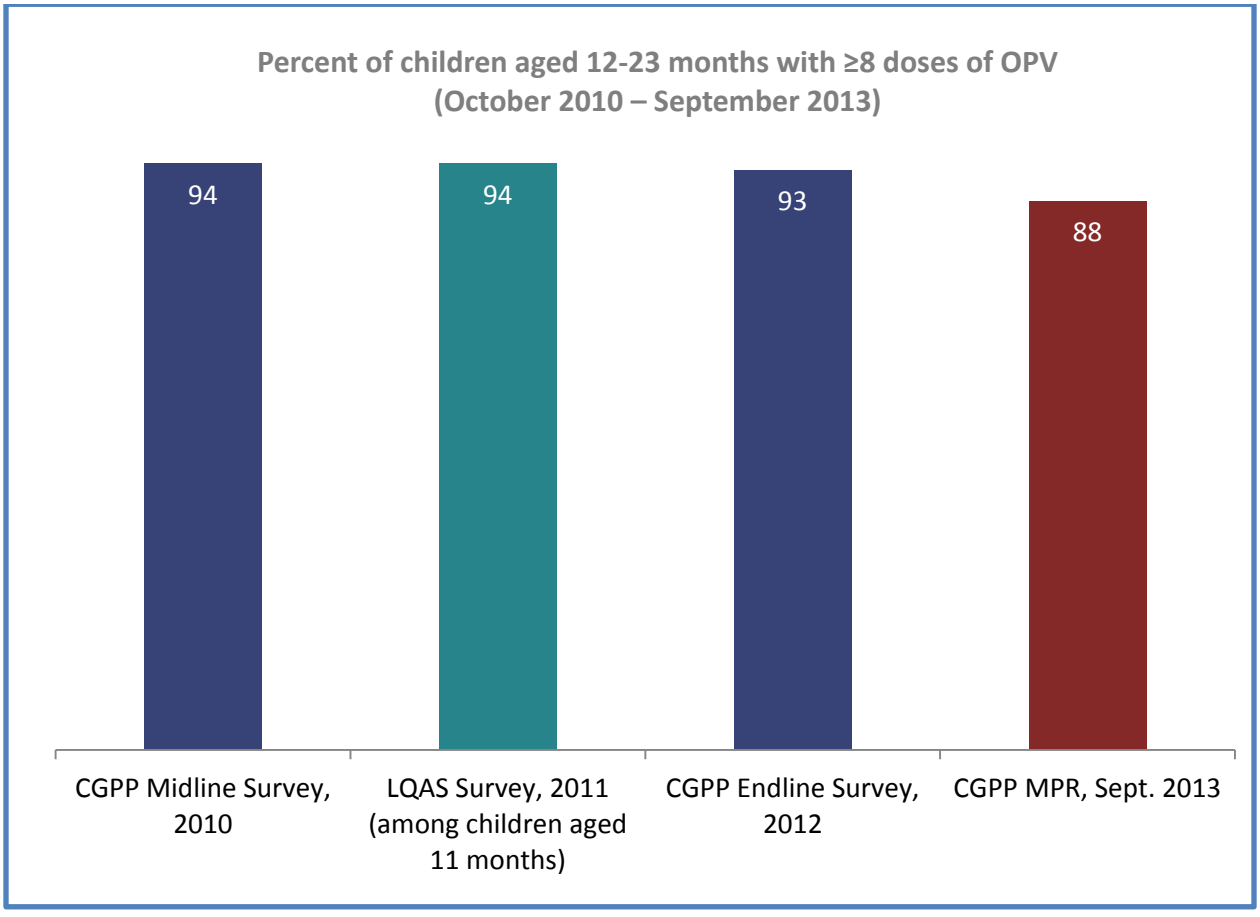


CGPP India is a member of the national and U.P. State level **RI Task Force** that meets quarterly to discuss vaccine supply, human resource issues, adverse events following immunization (AEFI), and other challenges. At the district level, CGPP DMCs continue to assist in the **development of RI Micro plans as well as monitoring of RI** sessions. The BMCs (Block Mobilization Coordinators) and CMCs also ensure that all eligible children in their work areas reach the sessions by sending out **RI invitation slips (**Printed slips given out to mothers of eligible children a few days before the planned RI session as a reminder to bring them. The location and time of the session site are also printed). This practice has now been adopted by the government of U.P. in some places.

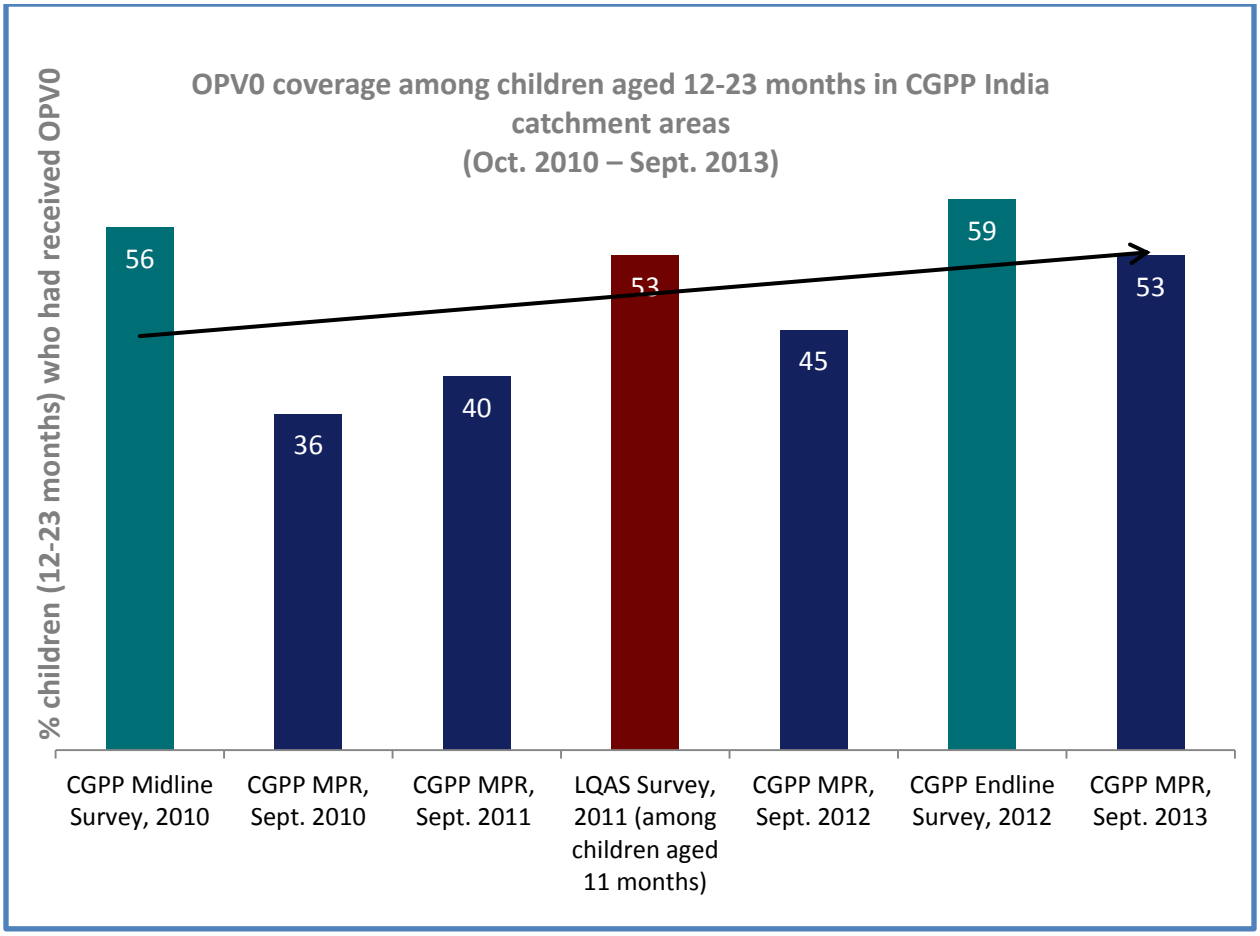
Special routine immunization drives are also held as catch up rounds wherever there is very low RI coverage. Here, auxiliary nurse midwives (ANMs) from other blocks are brought (through the government system) to the worst performing block for catch up rounds. CMCs prepare lists of these children and are responsible for bringing them to the session site. For example, in Moradabad, 39 sessions were held in a single day and 2,732 children were vaccinated.

CORE field staff participated in special immunization weeks and a measles campaign by mobilizing the community as well as in the development of micro plans for high risk group areas i.e. mobile populations, etc. Due lists of eligible children were developed and shared with the health department. Mobilization activities included IPC and mother meetings.

On average 88% of children 12 to 23 months in project areas had received 8 doses of OPV



OPV 0 or birth dose increased from 51% in 2012 to 59% in 2013 but remains low due to the cultural practice of giving birth in the home and not allowing women to go outside the home in the first weeks of a new birth.



CGPP partner NGOs have engaged in various polio plus activities designed to promote polio eradication and demonstrate that the program does more than just provide vaccine. Partner NGOs mobilized district officials to conduct special sanitation drives in the newly formed district of Sambhal through a detailed plan of action. The VHSNC (Village Health, Sanitation and Nutrition Committee) members, village development officers, village head (*pradhan*) and sweepers were sensitized on the importance of such a drive and also the responsibilities of each. Community mobilizers simultaneously sensitized the community through group meetings on cleanliness, open defecation and waste disposal. Additionally, all field staff were trained on the use of ORS and Zinc in diarrhea management. They were also asked to report on the availability of both at their village and block levels.

Project area districts	# IPC visits		Number of group meetings								No. of health camps		Number of coordination meetings*		# of Govt. RI sessions monitored by CGPP team	
			Mothers/ Adolescent girls meetings		Fathers/ Adolescent boys meetings		Influencers/ Religious leaders meetings		Total							
	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done
Baghpat	93812	89250	1549	1541	165	154	1199	1186	2913	2881	35	35	826	801	648	536
Bareilly	109635	105406	1315	1298	267	240	819	781	2401	2319	22	20	231	203	648	689
Rampur	56307	52326	1924	1748	24	23	84	73	2032	1844	46	29	409	378	432	482
Mau	23907	23950	2182	2160	409	409	813	800	3404	3369	28	24	122	120	288	520
Saharanpur	38583	35253	1931	1805	289	243	859	784	3079	2832	44	26	133	112	432	391
Shahjahanpur	39319	38849	2408	2375	277	274	877	815	3562	3464	31	28	222	207	432	532
Sitapur	39617	36940	2787	2618	590	529	983	983	4360	4130	55	41	198	174	432	510
Meerut	47743	45723	2286	2236	8	8	167	167	2461	2411	23	23	267	259	576	742
Moradabad	115829	105528	2093	1913	4	4	677	581	2774	2498	27	25	317	234	936	1032
Muzaffarnagar	85397	80097	3023	2876	86	81	217	209	3326	3166	36	34	163	154	864	1067
Sambhal	122156	101528	2008	1955	0	0	492	417	2500	2372	34	24	285	208	936	738
Shamli	20394	19076	915	888	0	0	58	58	973	946	12	11	51	46	216	241
CGPP India (12 districts)	**792699**	**733926**	**24421**	**23413**	**2119**	**1965**	**7245**	**6854**	**33785**	**32232**	**393**	**320**	**3224**	**2896**	**6840**	**7480**

* Number of coordination meetings with frontline govt. workers of health and ICDS department (ASHAs & ANMs)

Objective 3: Support supplemental polio immunization activities

CGPP India implements a variety of social mobilization activities between the SIA rounds which range from one-to-one contact to large group contacts. *Anticipating refusals due to negative fatwas and development issues, CGPP field staff try to use appropriate strategies & quality mobilization activities such as interface meetings, and community meetings in sensitive areas prior to the SIAs.*

In January 2013, 50,000 handbills with negative messages were distributed in a major religious congregation in Bareilly district and later, in the entire state. As a precautionary step, CORE ADRA team responded by contacting religious leaders immediately and sensitized them in case of mass refusals. In addition, CMCs used positive appeal booklets during IPC sessions and group meetings. Video shows with positive polio appeals were shown in sensitive areas. SM net partners met the person who distributed the handbills and tried to convince him to support a counter positive appeal but he strongly opposed the OPV campaign.

The impact of negative propaganda was limited in the January 2013 SIA but many refusals were seen in the February SIA. However, with planned mobilization activities at the end of the round, refusals were minimized to 0.02%. In Non CMC areas, however, 106 families refused polio vaccination. Responding to a request by the medical officer in charge, the BMC, Mr. Wasif Ali who has great expertise and reputation, was able to mobilize the entire community including the local imam of the mosque. This resulted in acceptance of OPV by all the 106 refusal families.

In between the polio rounds, the main activity performed by the CMCs is interpersonal communication (IPC) and counseling for the target families. The main objective is to quell misconceptions and fears by disseminating facts and information about polio and routine immunization, how polio spreads, its prevention and the need for them to immunize their children.

On the day of the polio round **'*Bulawa Tolies'* (children's calling groups) of** selected children with leadership skills chosen from primary schools in the village are formed into groups of 8-10 who go house to house, urging the mothers to bring their children to the polio booths. Each CMC has one group per polio booth. As an incentive, the children are given biscuits, pencils, etc. The schools also encourage these children by recognizing their contribution at special functions and school assemblies. Involving children in the program helps to create awareness and a spirit of volunteerism. Children of the communities are also used in rallies in which they move around in villages with banners and posters displaying messages about polio eradication and shouting slogans on vaccinating. **Rooster rallies** were conducted in the 14 high-risk blocks to discourage open defaecation and promote the use of household sanitary toilets. Children shout out "cock a doodle do *(Kuckru-ku)'* and hold up pictorial placards for message dissemination.

Another initiative carried out by CMCs is the initiation of polio classes that are being held for primary and middle school children. These are awareness generation classes and focus on the involvement of children in eradicating polio from their village. A 'child to parent' approach is adopted during the classes where children are encouraged to translate their learning into action. **Fun Classes *(Masti Ki Kaksha)*** were also held in schools using entertainment formats like coloring books, games – all leading to discussions on polio, immunization, hand washing and sanitation issues. These classes were also held with the help of class teachers.

Project partners held numerous small group meetings with 5-10 individuals representing various stakeholders who have a common agenda and objective. The meetings included needs assessment, information dissemination and the identification of solutions or actions to be taken. These meetings were held with school teachers**,** who help to inform, motivate and organize school children for involvement in the pulse polio and routine immunization programs through polio classes, rallies, etc.

Monthly meetings were also held with mothers to ensure that they have an opportunity to ask questions and discuss the advantages of vaccinating their children against polio and other childhood diseases. The "positive communication" is applied to convince and motivate mothers who have misconceptions or are resistant to the idea of immunizing their child. Various games and materials are used to stimulate discussions.

Meetings were held with influencers in the village, who can influence parents to get their children vaccinated. The aim of involving influencers is to assist the CMCs to allay fears of families who are reluctant to vaccinate their children for various reasons such as illness, age, fear of sickness, impotency or general ignorance. Influencers such as community leaders, religious leaders, ration dealers, shopkeepers, etc. help build the momentum of positive perceptions, attitudes and behaviors before every pulse polio round and routine immunization session.

Interface meetings are conducted prior to the polio round and the invitees include influencers of the village, religious leaders, *Pradhan* (elected head of village), ration dealers, vaccination team supervisors, NPSP representatives and block level staff of CGPP. Resistant families in the village are identified and attendees take ownership to talk to them and persuade them to get their children immunized at the next round. Strategies for conducting the polio rounds and door-to-door campaigns are also shared. It is viewed as an excellent example of experience sharing and problem solving by the community as well as the field staff. It also brings a sense of ownership in the community members.

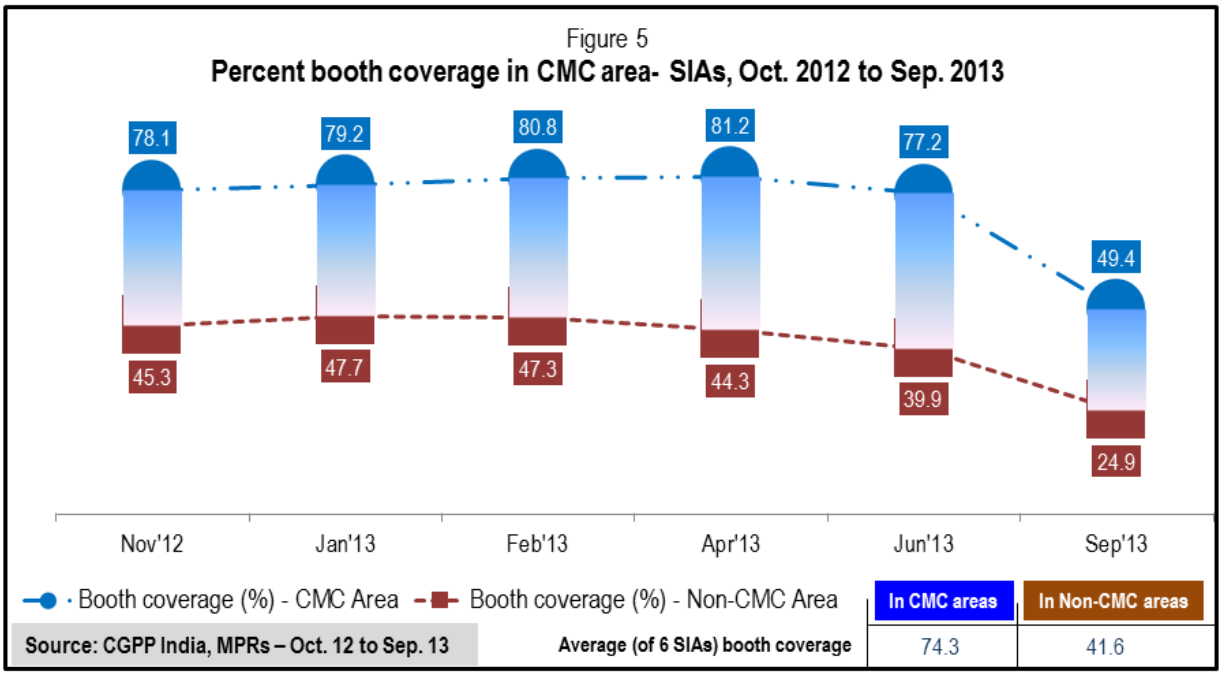
- **Mosque announcements -** Imam/Maulana/Maulvis(*Religious leaders in a mosque*) are approached for making announcements of the date of the polio round at congregations through loudspeakers.

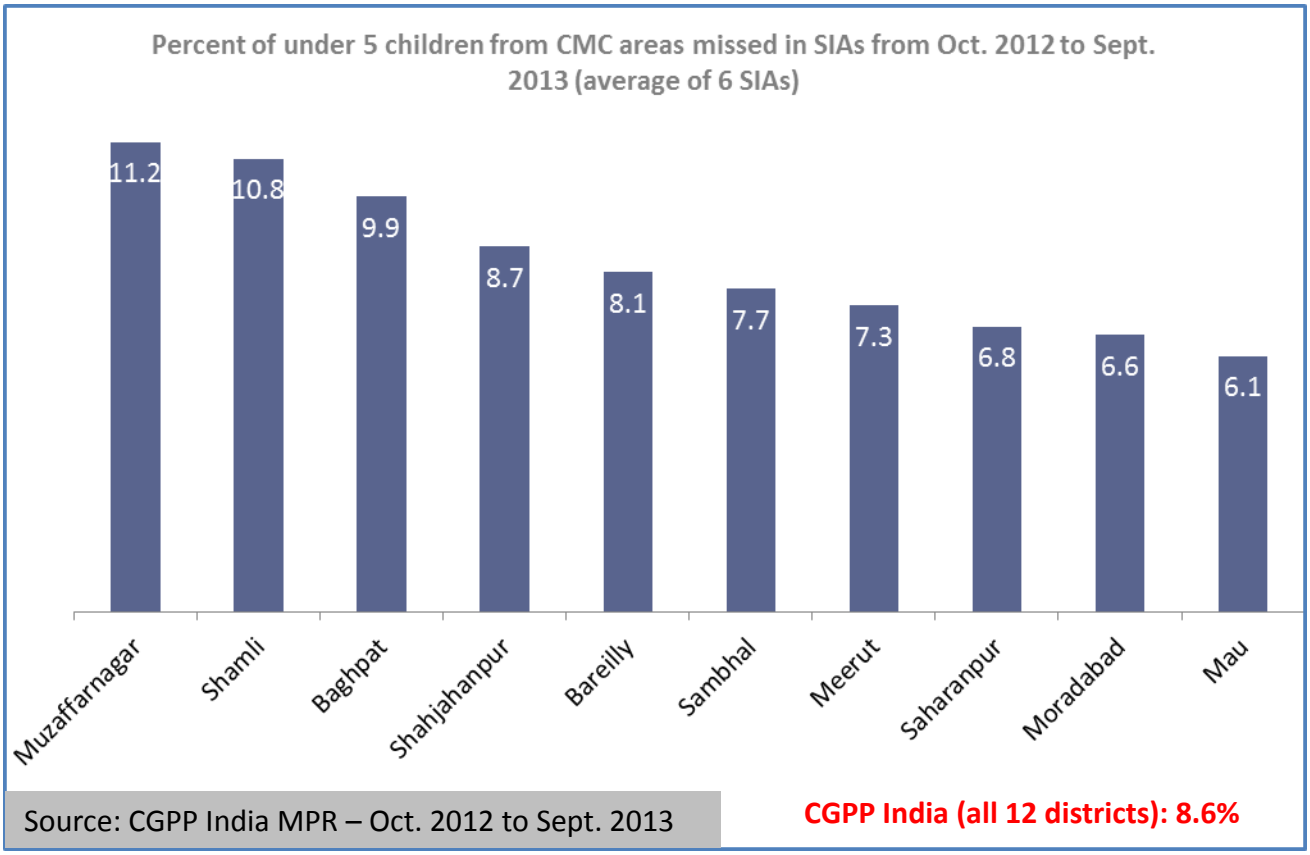
- **Emergency Planning & Response**

a. **CGPP withdrew from West Bengal** after working for two years in the emergency response to the only poliovirus in the country in 2011 at the request of NPSP and UNICEF. CORE Master Trainers from UP trained mobilisers in the districts of Howrah and Burdwan and supervisory support was also given in selected wards of Howrah.

b. A **desktop simulation exercise** was conducted in March 2013 so that CGPP would be prepared for strengthening an emergency response to a wild virus case occurring in any part of the country that had communication challenges. A Rapid Response Team was trained to assess and strategize, define joint polio response priorities, decide upon activities for the response within first 72 hours of an emergency, apply the coordination structures and identify gaps in simulated emergency response as learning for real time preparedness.

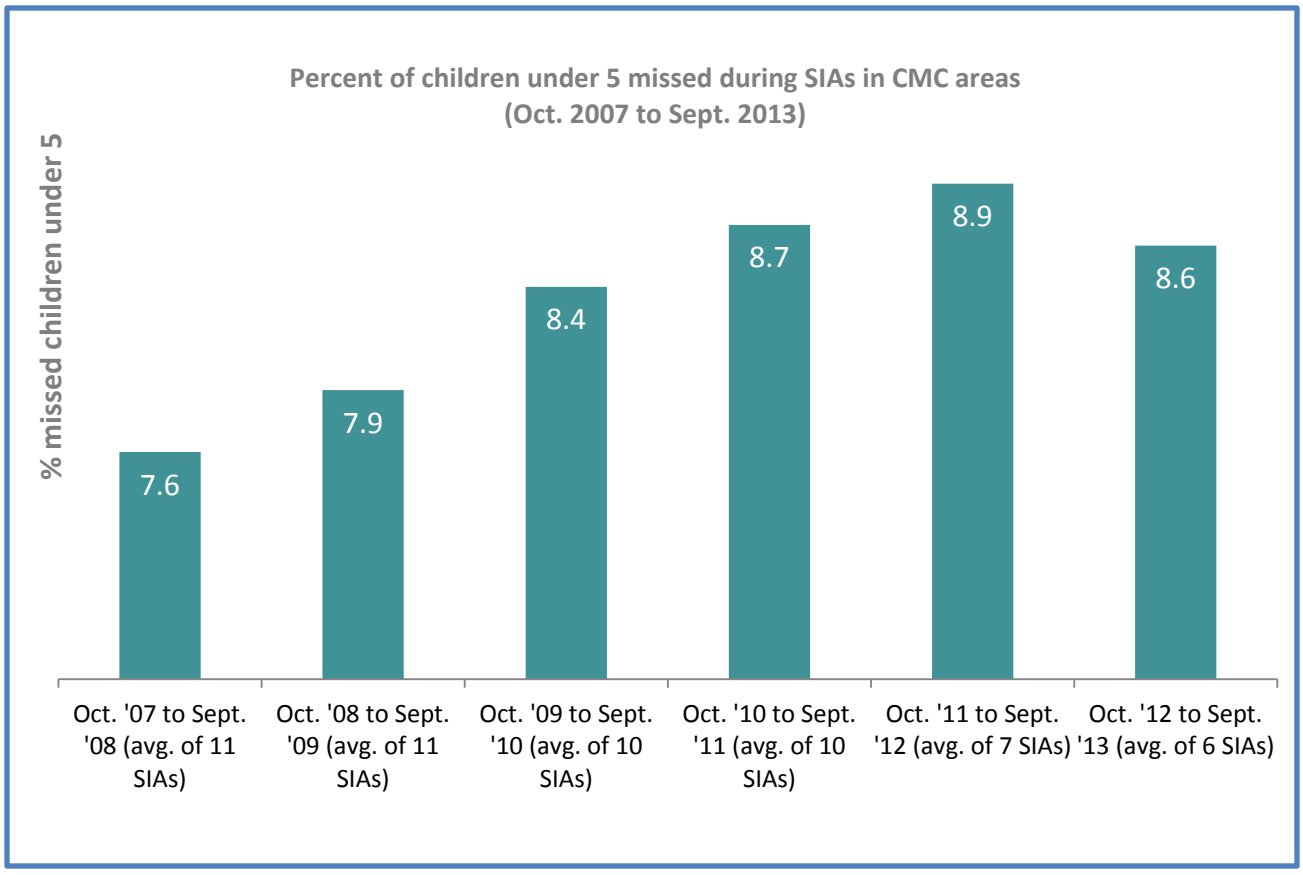
Details of SIA campaigns in catchment area (CMC area) of CGPP India, October 2007 – September 2013

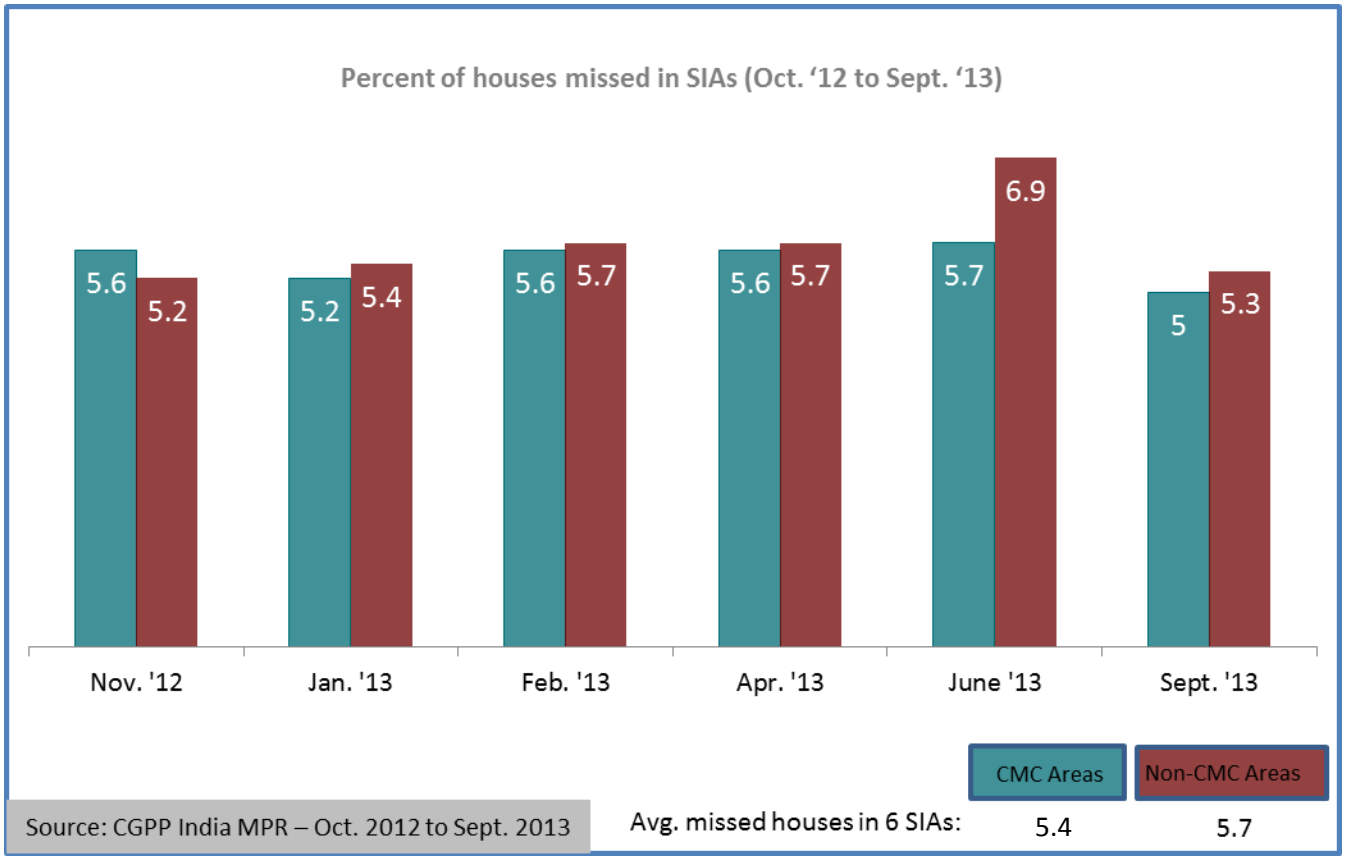


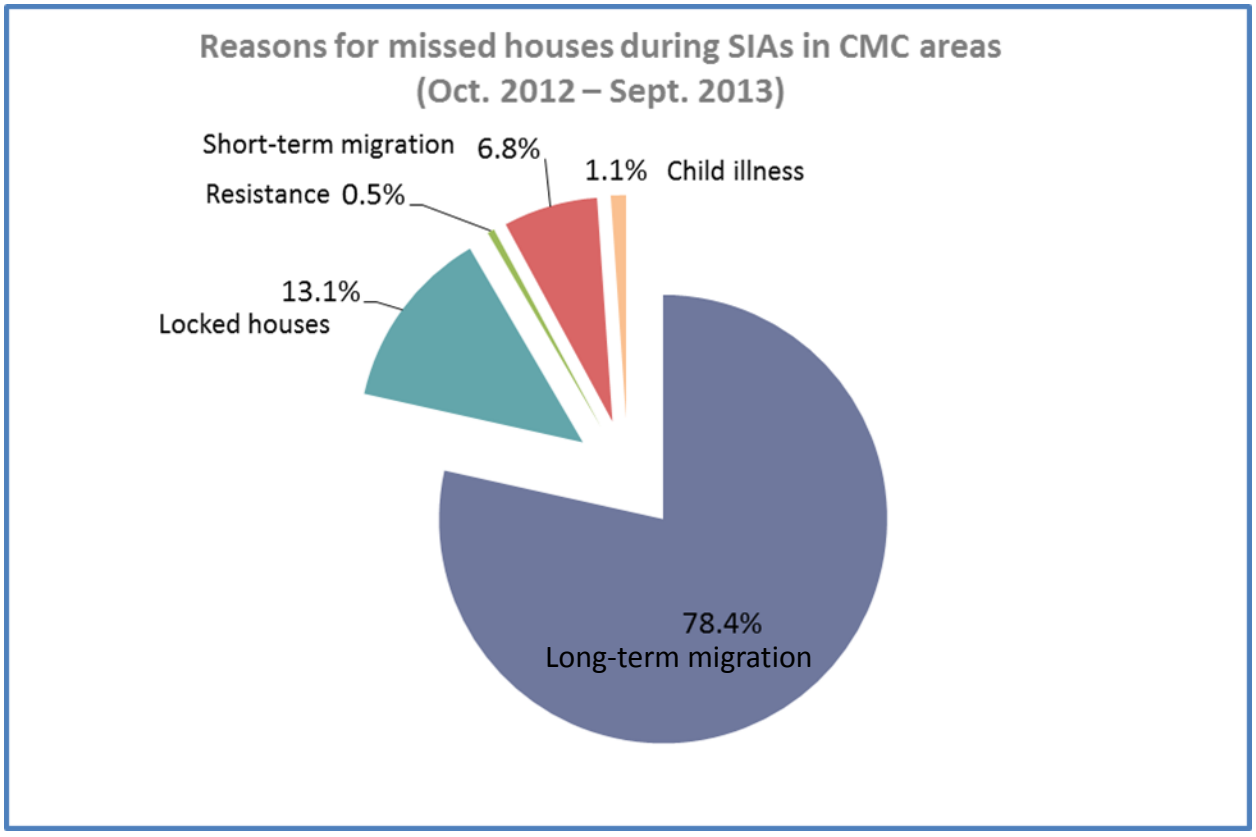


Source: CGPP India MPR – Oct. 2012 to Sept. 2013

CGPP India (all 12 districts): 8.6%




Percent of houses missed in SIAs (Oct. '12 to Sept. '13)
5.6
5.2
5.2
5.4
5.6
5.7
5.6
5.7
5.7
6.9
5
5.3
Nov. '12
Jan. '13
Feb. '13
Apr. '13
June '13
Sept. '13
CMC Areas
Non-CMC Areas
Source: CGPP India MPR – Oct. 2012 to Sept. 2013
Avg. missed houses in 6 SIAs:
5.4
5.7


Reasons for missed houses during SIAs in CMC areas
(Oct. 2012 – Sept. 2013)
Short-term migration 6.8%
1.1% Child illness
Resistance 0.5%
13.1%
Locked houses
78.4%
Long-term migration

- **Numbers of social mobilizers or community volunteers trained (MPR data)**

No.	Training	Participants	Dates	No. of batches	No. of participants		
					Male	Female	Total
1	Rapid response team (RRT) training	Selected DMCs, DUCs and BMCs	12 - 13 Mar.2013	1	19	2	21
2	Training on data analysis and data validation	All DMCs, MIS Coordinators and SRCs	13 - 15 Mar.2013	1	18	6	24
3	Training of new CMCs	All new CMCs	18 Mar.- 23 Apr. 2013	10	6	187	193
4	Training of master trainers	Selected DMCs, DUCs and BMCs	22 - 26 July 2013	1	24	3	27
5	Training for interventions & activities of FY14	All SRCs, DMCs, DUCs, MIS Coordinators, BMCs	16 - 24 Aug.2013	4	72	24	96
6	Training for interventions & activities of FY14	All CMCs	12 Aug.- 12 Sep. 2013	52	77	1204	1281
Total				**69**	**216**	**1426**	**1642**

CGPP India executes specific activities for high risk groups (Include nomads, construction laborers, brick kiln workers, etc.) High risk group sites are identified and details of families and children recorded and then social mobilization activities for SIA and RI are conducted.

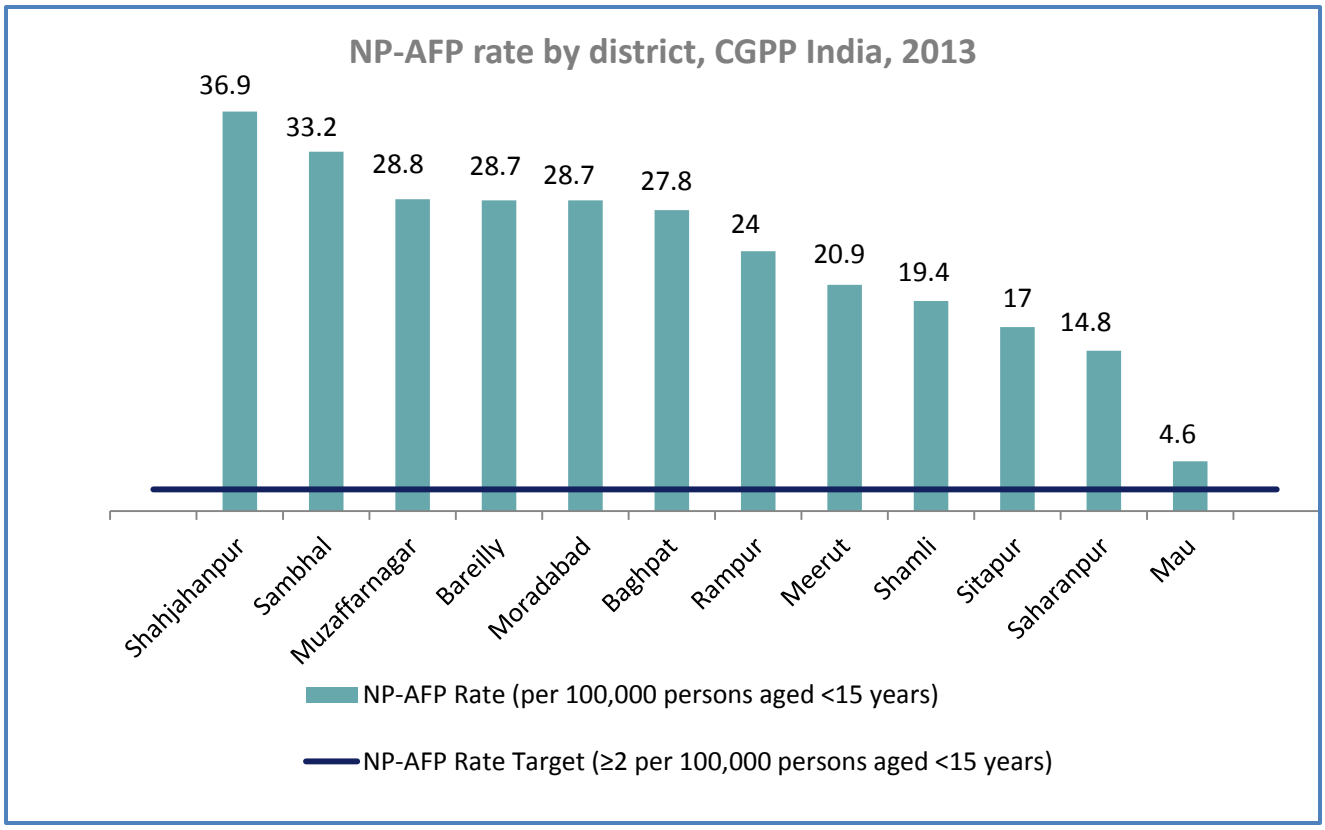
Details of high risk groups sites - September 2013

Number of informers giving information about high risk groups	1,105
Number of high risk group sites identified in the catchment area	1,254
Total number of families in the identified high risk group sites	3,999
Total number of under five children in the identified high risk group sites	4,055

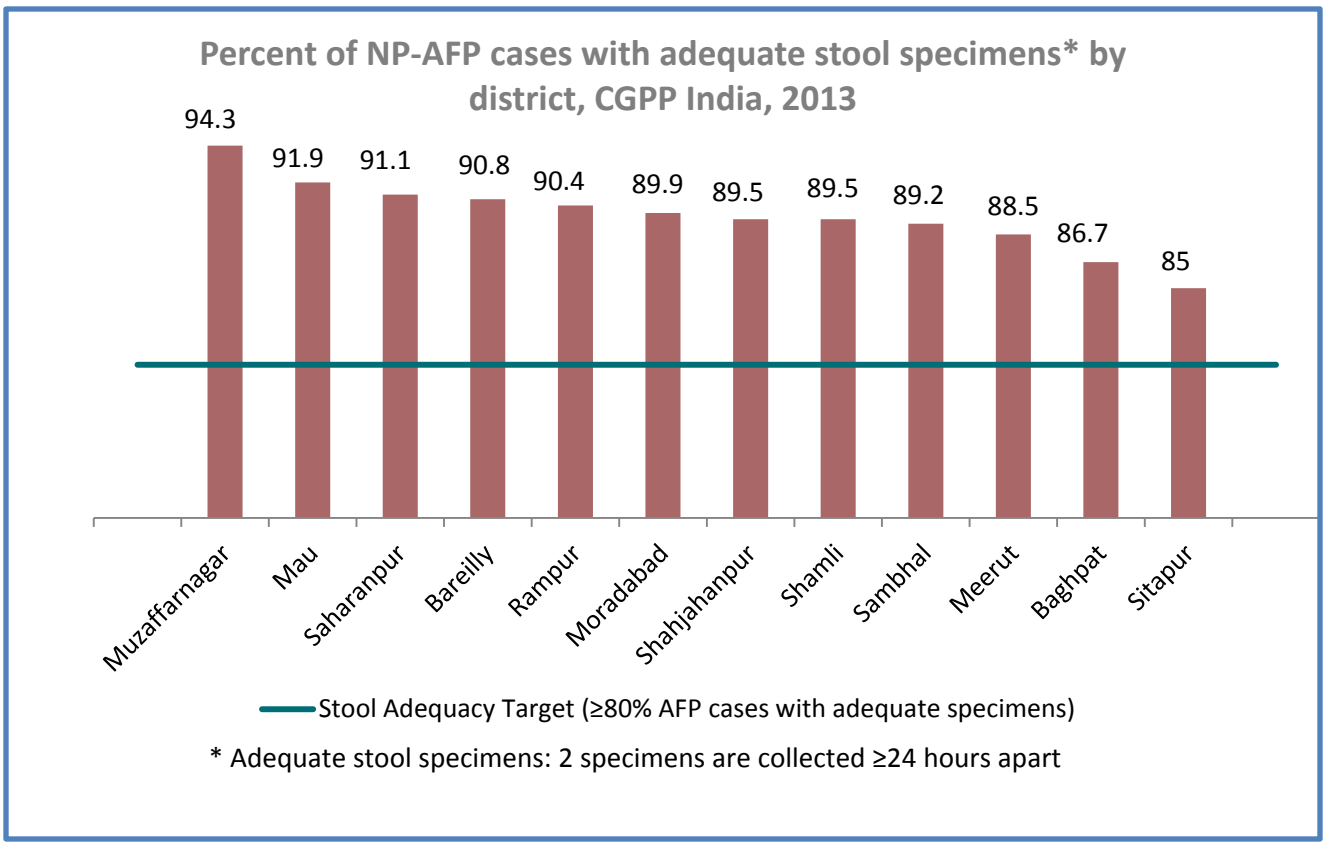
Objective 4: Support efforts to strengthen AFP surveillance

Although the CGPP project is not directly engaged in AFP surveillance, their work with CMCs promotes AFP surveillance and the high non-polio AFP rates in project areas reliably demonstrates the absence of WPV cases.

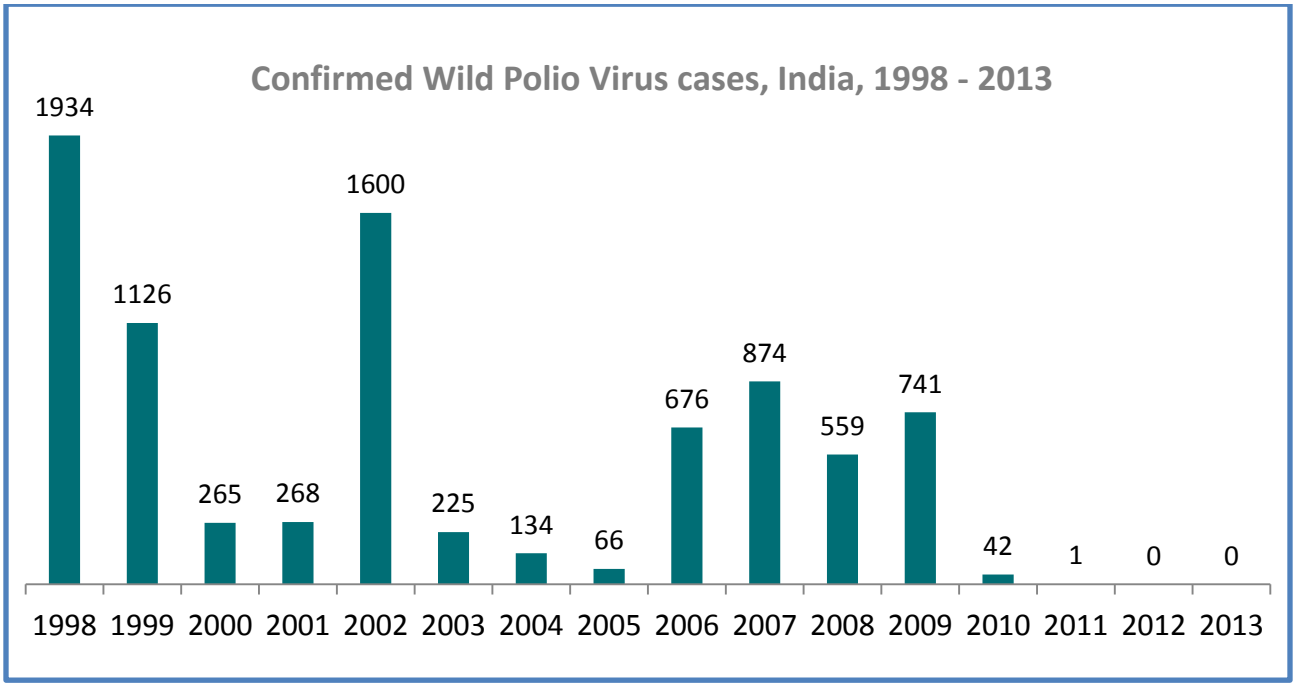
- **Non-polio AFP rate per 100,000 children under 15 year of age population in CGPP program areas compared to target NP-AFP rate over 5 years.**



- **Percent of stool samples collected in a timely manner, according to WHO/MOH guidelines (compared to national target)**



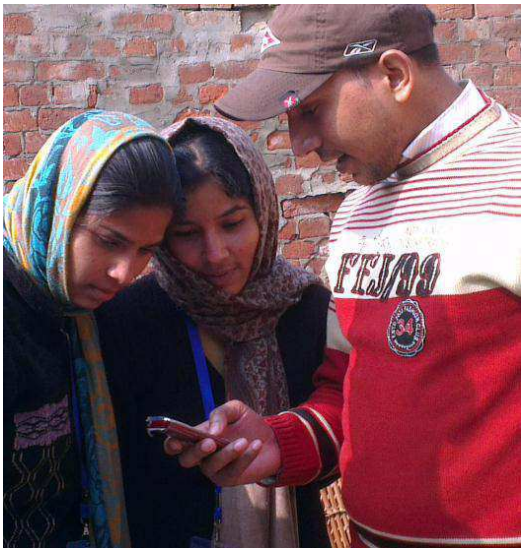
- **Number of confirmed cases of Wild Poliovirus over 10 years (WHO/MOH data)**



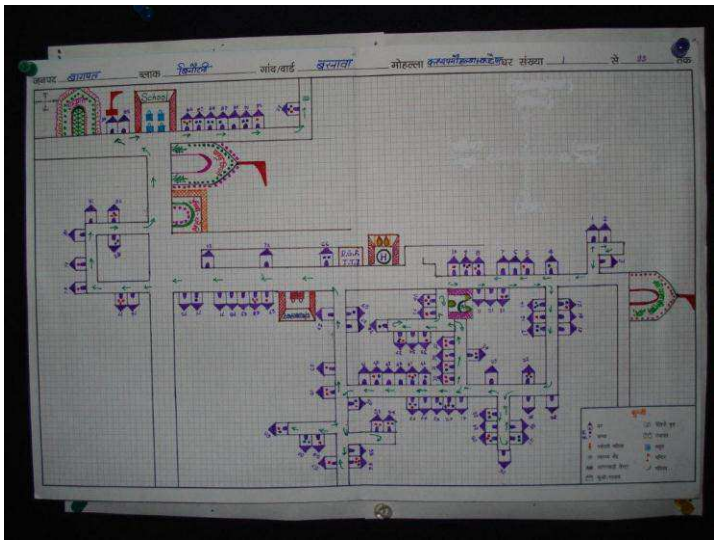
Objective 5: Support timely documentation and use of information

CGPP India has a very detailed and well executed health information system based on registries of all of the newborns, under fives, and pregnant mothers covered by the community mobilization coordinators. This system supports the execution of high quality SIAs through detailed mapping of households with children of vaccination age and their vaccination status and it also promotes strong routine immunization. CGPP India is now working to enhance and transform the current paper based system of data collection by using mobile phones to record and transmit the data formerly tabulated by hand.

- **mHealth:** Starting in 2012, CGPP piloted an m-health phone system seven blocks to get real time data of each child and household of the catchment areas and create an instant evidence base for planning, implementation and monitoring of project activities. Apart from rapid collation of data, the CMC will also be able to generate automated reports, graphs, etc. A mHealth (Mobile health) system for community and household mapping was developed that captures all the data in the presently used registers and formats to fulfill the. The technology will be expanded further to send reminders to caregivers for routine immunization over the mobile platform as well as internal communication to CMCs, BMCs, etc.



- **Community maps for SIA planning and implementation**
  A CMC deployed in a specific geographic area develops community maps for planning and execution of SIA and other project activities. All CGPP catchment areas (CMC areas) have two types of maps - a social map of their area including key landmarks as well as another map showing day-wise presentation of houses.



- **Polio *Chowk* at Moradabad:** The world's first 'Polio *Chowk*' was unveiled on February 23, 2013, at a prominent crossing (*Chowk*) in the city of Moradabad (U.P). A metal statue of a mother and child stands tall above the bustling traffic of the city, reminding people about continuing participation of civil society in the polio eradication programme until India is declared polio-free. Just a few years ago, Moradabad district was the epicenter of poliovirus circulation in the world and the program encountered huge communication challenges. Keeping this in mind, CGPP India conceptualized, designed and facilitated the installation of the statue in collaboration with district authorities of Moradabad city. The monument included the statue surrounded by the slogan "Two drops of life" and a polio vaccine vial sitting on a base with 4 panels describing the history of the polio effort in India, an acknowledgement of partners and other key messages including the eradication strategy.

CGPP India has contributed to numerous publications and presentations including the following:

1. Outcomes of polio eradication activities in Uttar Pradesh, India: the Social Mobilization Network (SM Net) and Core Group Polio Project (CGPP)
   William M Weiss, MH Rahman, Roma Solomon, Vibha Singh and Dora Ward
   BMC infectious diseases 2011, 11:117.
   Also presented at the Global Health Conference 2011 by Jitendra Awale
2. Purple Pinkies: Social Mobilization and LQAS for Hard-to-Reach Populations
   Roma Solomon, Manojkumar Choudhary
   Presented at the CORE Group Spring Meeting, Delaware US, May 2012
3. Determinants of Performance of Supplemental Immunization Activities for Polio Eradication in Uttar Pradesh,
   India: Social Mobilization Activities of the Social Mobilization Network (SM Net) and Core Group Polio Project

William M. Weiss, M. H. Rahman, Roma Solomon, Dora Ward (Awaiting publication)

4. Performance and Determinants of Routine Immunization Coverage within a Polio Eradication Program in Uttar Pradesh, India: Social Mobilization Network (SM Net) and CORE Group Polio Project (CGPP)
   William M Weiss, Manojkumar Choudhary and Roma Solomon
   (Awaiting publication)
5. Immunogenicity of supplemental doses of poliovirus vaccine for children aged 6–9 months in Moradabad, India:
   a community-based, randomised controlled trial
   Concepción F Estívariz, Hamid Jafari, Roland W Sutter, T Jacob John, Vibhor Jain, Ashutosh Agarwal, Harish Verma, Mark A Pallansch, Ajit P Singh, Sherine Guirguis, Jitendra Awale, Anthony Burton, Sunil Bahl, Arani Chatterjee, R Bruce Aylward
   Lancet Infect Dis 2012; 12: 128–35
6. Reaching Every Child: Communication for Polio Eradication in India
   Ellyn W. Ogden, Rina Dey
   Affiliation: United States Agency for International Development (Ogden); CORE Group Polio Project India (Dey)
   Presentation made at a meeting hosted by The Communication Initiative on March 29 2011 ("Social and Behavioural Change Research Results: Strategic Implications") in Geneva, Switzerland
7. A Drop Of Dialogue – Film by CORE
8. CMC Ki Kahani CMC ki Zubaani – Training film by CORE
9. The Science of Polio – A film by CORE
10. RI Drive – A photo essay by CORE
11. "Fight against polio" booklet.
12. Last Lap - a documentary film
13. Three YouTube clips, "Routine immunization", "Hygiene and sanitation" and "Strategies of polio eradication"
14. A study on migration
15. A study on sanitation in high risk blocks

Objective 6: Support PVO/NGO participation in either a national and /or regional certification activities

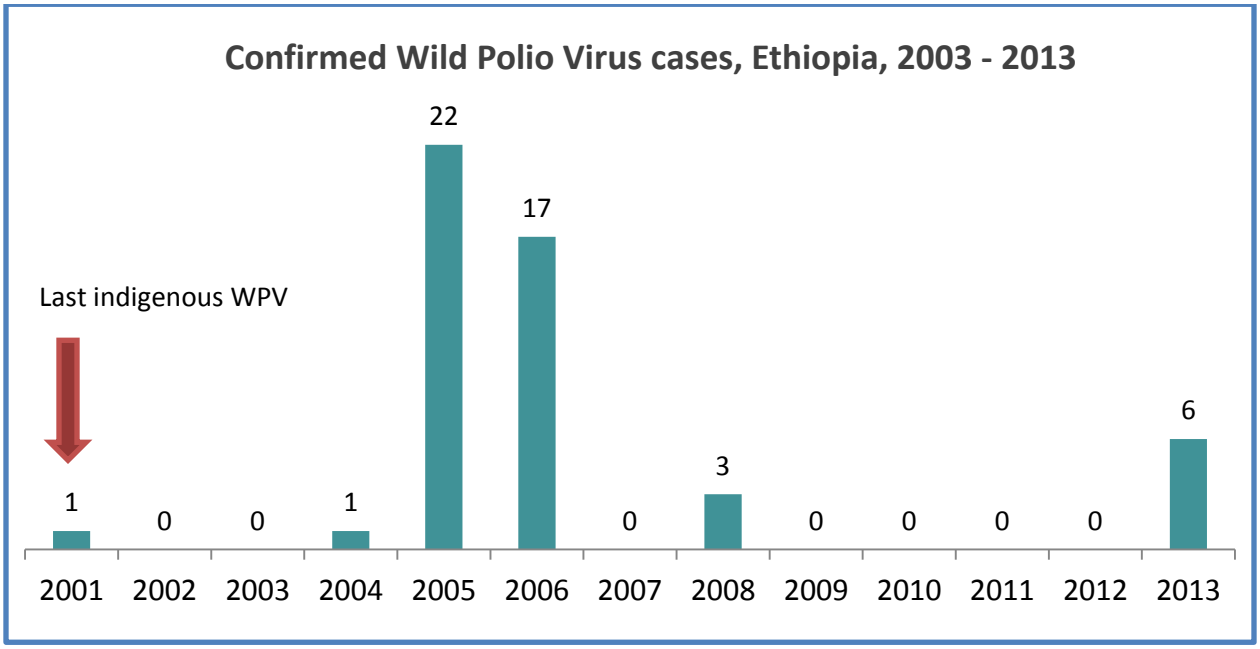
- **Information provided to national or regional certification committee**

The Director and Deputy Director, CGPP India met with Dr. NK Arora, Member – coordinator, National Certification Committee (NCCPE), to discuss the role of NGOs in the certification phase. Dr. Arora welcomed the involvement of NGOs and shared a letter that needed to go out to all partners asking three questions – Are we convinced that there is no virus transmission; is the system robust enough to pick up any virus if present and can we mount an emergency response.

CGPP ETHIOPIA

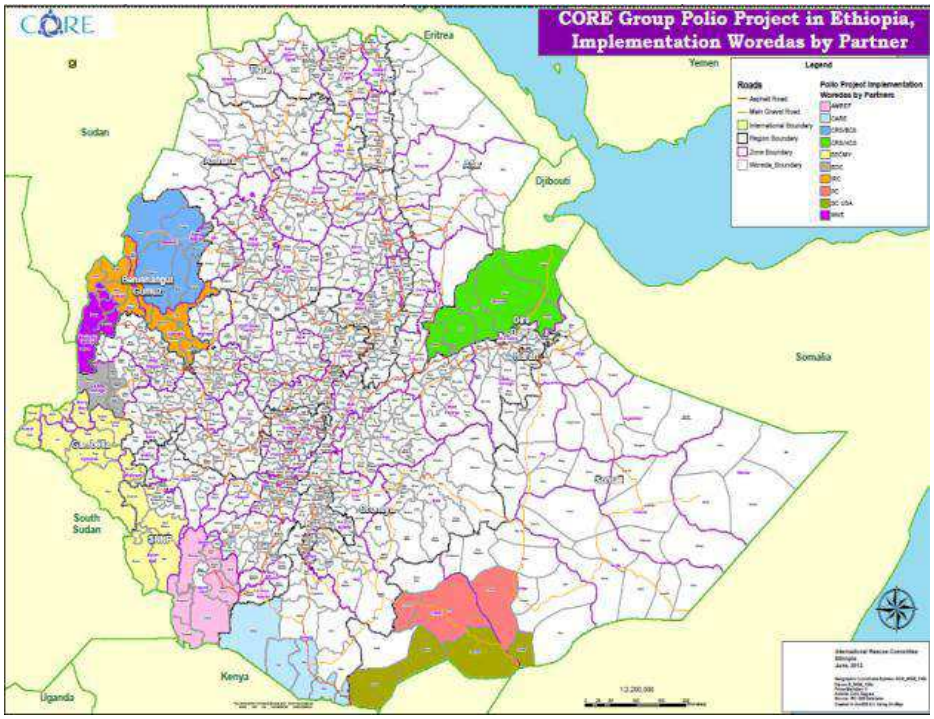
With a massive outbreak of wild polio virus in neighboring Somalia in 2013, Ethiopia is now at the forefront of a major outbreak response in the Horn of Africa. Ethiopia has confirmed six WPV1 cases from Dollo Zone in Somali Region in 2013 and has mounted a country-wide response with particular focus on the border areas of Somali Region. The national ICC, of which CORE is a member, conducted several emergency meetings to plan the response to the current outbreak. The ICC members decided to conduct immediate immunization campaigns in five refugee camps in Dolo Ado as well as the host community of the Woreda targeting children under 15 years of age. The ICC also decided to conduct repeated rounds of outbreak response campaigns in 17 selected zones from five regions including Somali, Oromia, SNNPR, Hareri, and five refugee camps in Dolo Ado Woreda of Somali Region. In addition, a command post was established at the national level which is being chaired by the Minister of Health and the Somali Regional Vice President to monitor and coordinate the current outbreak response.

The last indigenous wild poliovirus in Ethiopia was reported in Alaba special woreda in the SNNPR in 2001. Between Dec 2004 and Nov 2006, Ethiopia reported four different importations from Somalia and Sudan which resulted in forty wild poliovirus cases (1 in 2004; 22 in 2005, 17 in 2006) affecting four of the eleven regions of the country (Tigray, Amhara, Oromiya and Somali).



Following the interruption of these importations, the country reported no cases for 17 months, until April 2008 when 3 cases of WPV1 were confirmed in Gambella region. Ethiopia was again free of polio until the current outbreak in 2013. Given Ethiopia's history of rapid outbreak response and control, the prognosis for containment within six months is good.

CORE Group Ethiopia, in conjunction with the Ethiopian government and spearheading agencies, has made substantial contributions to the country's polio eradication effort, supporting community-based surveillance, supplementary immunization activities, and routine immunization. CGPP represents local perspectives to national players and builds the capacity of health workers within participating woredas. Project activities at the local level are implemented in pastoralist, semi-pastoralist, and particularly hard-to-reach agrarian areas. The CGPP maximizes impact by using the existing government health structure and international and local NGOs with demonstrated capacity in target areas.



Objective 1: Build effective partnerships between agencies

From FY2007 to FY2013, 11 partners (seven international PVOs and four local NGOs) implemented the CORE Group Polio Project in Ethiopia. CGPP activities served 748,760 children under five years of age in 55 woredas in seven regions of the country (Afar, Amhara, Beneshangul Gumuz, Gambella, Oromiya, SNNPR, and Somali). CGPP partners (AMREF, Alemtena Catholic Church, CARE, ChildFund, Ethiopian Evangelical Church Mekane Yesus, Harargie Catholic Secretariat, IRC, Pastoralist Concern, Plan, Save the Children, and World Vision) collaborate closely with their respective woreda health offices and Health Extension Workers to enhance AFP surveillance and promote childhood immunization. The table below details each partner's catchment area, the numbers of children they serve, and the number of community volunteers serving the project.

Implementing partners in Ethiopia (Oct. 2012 - Oct. 2013)

Partner PVOs and NGOs	Regional State(s)	No. Woredas	No. <5 children	No. <1 children	No. CVs
African Medical and Research Foundation (AMREF)	SNNPR	8	102,059	25,514	214
Catholic Relief Services (CRS)	B. Gumuz, Somali	13	88,035	25,758	384
CARE	Oromiya	5	64,959	15,052	113
Ethiopian Evangelical Church Mekane Yesus (EECMY)	Gambella, SNNPR	19	89,905	22,211	433
Ethiopian Orthodox Church (EOC)	Oromiya	5	70,222	16,271	105
International Rescue Committee (IRC)	B. Gumuz	9	49,818	11,378	174
Pastoralist Concern (PC)	Somali	3	19,850	6,682	270
Save the Children	Somali	4	51,481	17,330	236
World Vision	B. Gumuz	4	93,902	21,446	343
TOTAL	**5**	**70**	**630,231**	**161,642**	**2,272**

CORE Group Ethiopia holds a respected and valued place among polio eradication partners in Ethiopia, contributing to a variety of national and international forums, task forces, working groups, and committees this year. Below are details of CORE Group Ethiopia's partnership building efforts this year:

- Numerous partner meetings including visits by Ellyn Ogden and Dr. Roman Solomon from CGPP India including a workshop for polio partners; FMOH, WHO, UNICEF, Rotary International, JSI, FHI and all implementing partners of CORE Group Ethiopia.
- CGPP partner CRS-HCS collaborated with the Somali Regional Health Bureau to conduct a social mobilization workshop attended by the Regional Health Bureau Representative, religious leaders, clan leaders, woreda administers and health workers.
- The national PCV post introduction evaluation in Shinile Zone.
- The GAVI CSO Constituency meeting and the GAVI Partners Forum held in Dar-es-Salaam, Tanzania in December, 2012.
- The African Regional Conference on Immunization (ARCI) and 17th Africa Regional Inter-Agency Coordination Committee (ARICC) in December 2012.
- The Civil Society consultative special summit of African Union on HIV/AIDS, TB and Malaria conducted at Abuja, Nigeria
- The CORE Group Annual Spring Meeting in Baltimore
- The Nigeria start up workshop in Abuja.
- The East and South African countries EPI Managers meeting in Harare, Zimbabwe

- The HOA polio out break response Meeting for evidence based communication strategies in Kenya, Nairobi
- The ''Roadmap for Health Sector Disaster Risk management strategy ''meeting organized by FMOH.
- The MOH Communication Working Group advocacy visit and opening ceremony in Assela town of Oromiya Region,
- The quarterly WHO meeting.
- A consultative meeting on immunization and surveillance in the presence of representatives of Somali RHB, Moyale, Dolo Ado and Dolobay woreda health offices, SCI and PC partners'
- A CGPP multi-country experience meeting in India

- **Interagency Coordinating Committee** – CORE Group Ethiopia is a contributing member of the ICC and several of its off-shoots, including the Communications Subcommittee on IEC Materials Development, the Task Force for Cross-Border Collaboration, the Measles SIA Task Force, and the New Vaccine Introduction Core Committee
- **Quarterly surveillance and EPI review meetings –** Hosted by WHO
- **SIA coordination meetings and review meetings –** CORE Group Ethiopia represented the project at the national level and at the regional level in Gambella and Beneshangul Gumuz
- **Annual Woreda-Based Planning Meeting** – CORE Group Ethiopia staff represented its implementing partners at this gathering of all NGOs/CSOs working in the health sector in Ethiopia where they identified NGOs in CGPP areas with the capacity to contribute to micro-planning
- **African Vaccination Week Task Force** – CORE Group Ethiopia staff contributed to the organization of African Vaccination Week activities and delivered the keynote address at the flagship event

Cross-Border Collaboration Meetings:

CORE Group Ethiopia played a leading role in the organization and implementation of a series of cross-border collaboration meetings held in August. At the recommendation of the Horn of Africa Technical Advisory Group in February, the MOH, CGPP, Rotary, WHO, and UNICEF were tasked with organizing these meetings with the objective to strengthen surveillance, routine EPI, and coordinate activities in high risk areas along the borders. CORE Group Ethiopia was actively involved in the development of action points and meeting content; in the selection of meeting sites and advocacy to secure regional and local participation; in garnering the participation of local and national media outlets; and in the facilitation of the meetings, themselves.

The four meetings were attended by a total of 284 local and international participants who represented: Ministries of Health; WHO and UNICEF, CGPP, Regional Health Bureaus; administrative bodies and health professionals from the bordering districts of Ethiopia and neighboring countries; representatives from the Ethiopian Nutrition and Health Research Institute (ENHRI); and the media.

A set of key recommendations arose from these meetings and were presented at the HOA TAG in September. Implementation of these recommendations will commence in FY2013:

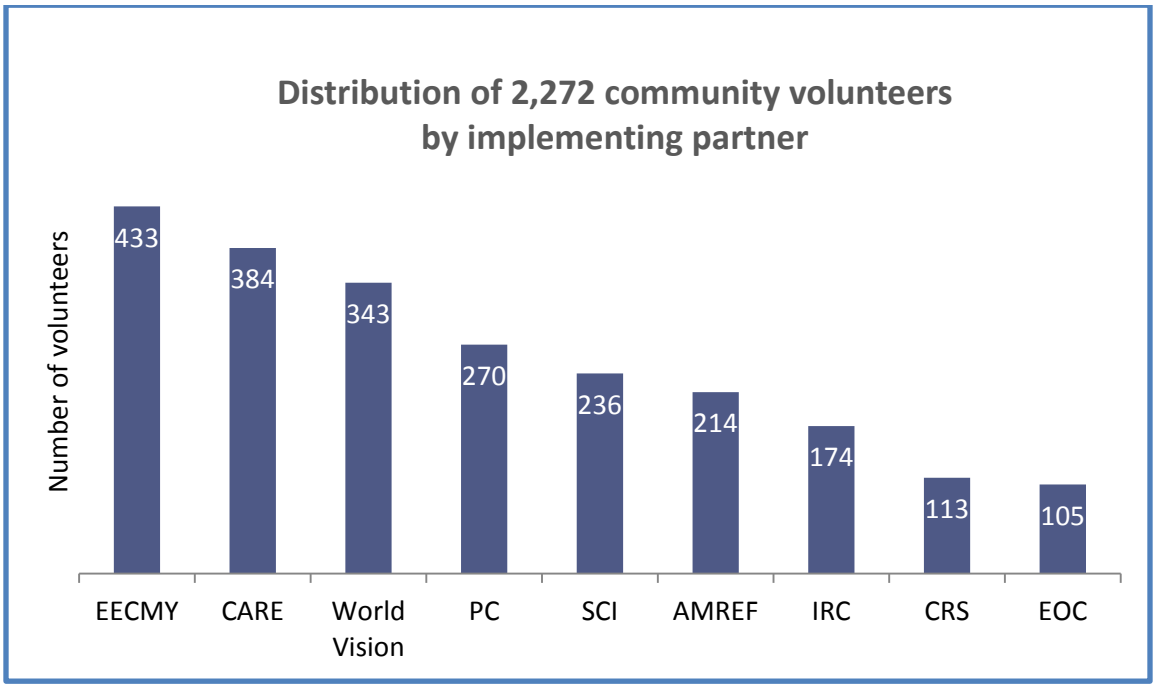
- Regular communication between district-level focal points on surveillance and immunization
- Collaboration on AFP case investigations
- Synchronization of SIAs
- Joint assessments of cold chain functionality and maintenance
- Support for joint capacity building activities for health workers
- Advocacy through local leaders
- Identification, documentation, and utilization of effective channels for special population

Objective 2: Strengthen routine immunization systems

Despite significant interventions, routine immunization coverage in the hard to reach border areas targeted by the project, remains dangerously low. For the most part, OPV3 coverage rates remained below 40% based on a final evaluation survey conducted in July 2012. The service delivery aspect of immunization in Ethiopia is done by government health staff at health facilities and outreach sites. The CORE Group Polio Project in Ethiopia supports the government in strengthening its immunization system through several strategies: technical support to health workers and health extension workers; logistics support to health centers and health posts; and community mobilization by community volunteers to increase the utilization of health services.

Community volunteers travel for immunization support in hard-to-reach areas, Gambella

Technical Support: Partner program officers, secretariat program officers, and woreda health staff provided Immunization in Practice (IIP) training, Cold Chain Users training, and Inter-personal Communication (IPC) training to health workers at the health center level and health extension workers from health posts using standard IIP modules. The CGPP organized trainings based on supervision findings and according to the joint annual plan developed by CGPP implementing partners and their respective woreda health offices during the annual partners planning meeting in Addis Ababa.



Community Health Workers

83% of the population of Ethiopia live in rural communities where CGPP community volunteers provide interpersonal health education and conduct AFP case detection in hard to reach, pastoralist and Semi pastoralist communities . The partners in collaboration with government health officers trained a total of 2,616 CHWs and Health Education Workers (Health Education Workers) on community based AFP case detection and newborn tracking. CHWs visited a total of 105,205 households in 2013 reaching an estimated 1,070,837 people. At every level the trainings were interactive supported by presentations, role play, group work and daily recaps.

Training support to routine immunization system (Oct. 2012 - Oct. 2013)

Type of training	Number of Health Workers/ Health Extension Workers trained
Immunization In Practice (IIP)	64
Cold Chain Users	95
Inter-Personal Communication	90

Social Mobilization/Demand Creation: Community volunteers worked to increase the utilization of routine immunization services by communicating the importance of and opportunities for vaccination through house-to-house visits, health education sessions, and discussions at public gatherings. With special knowledge of and access to their communities, volunteers collaborate with their respective

woreda Health Extension Workers to register all pregnant women and newborns, trace defaulting children, and spread the word about vaccination outreach events in their respective catchment areas. Volunteers supported routine immunization in their communities by making the following referrals:

Mobilization support to routine immunization system (Oct. 2012 - Sept. 2013)

	Number referred
Pregnant women identified and referred to HEW for TT	22,623
Newborns identified and referred to HEW for vaccination	14,384
Defaulters <1 identified and referred to HEW for missed vaccinations	1,648

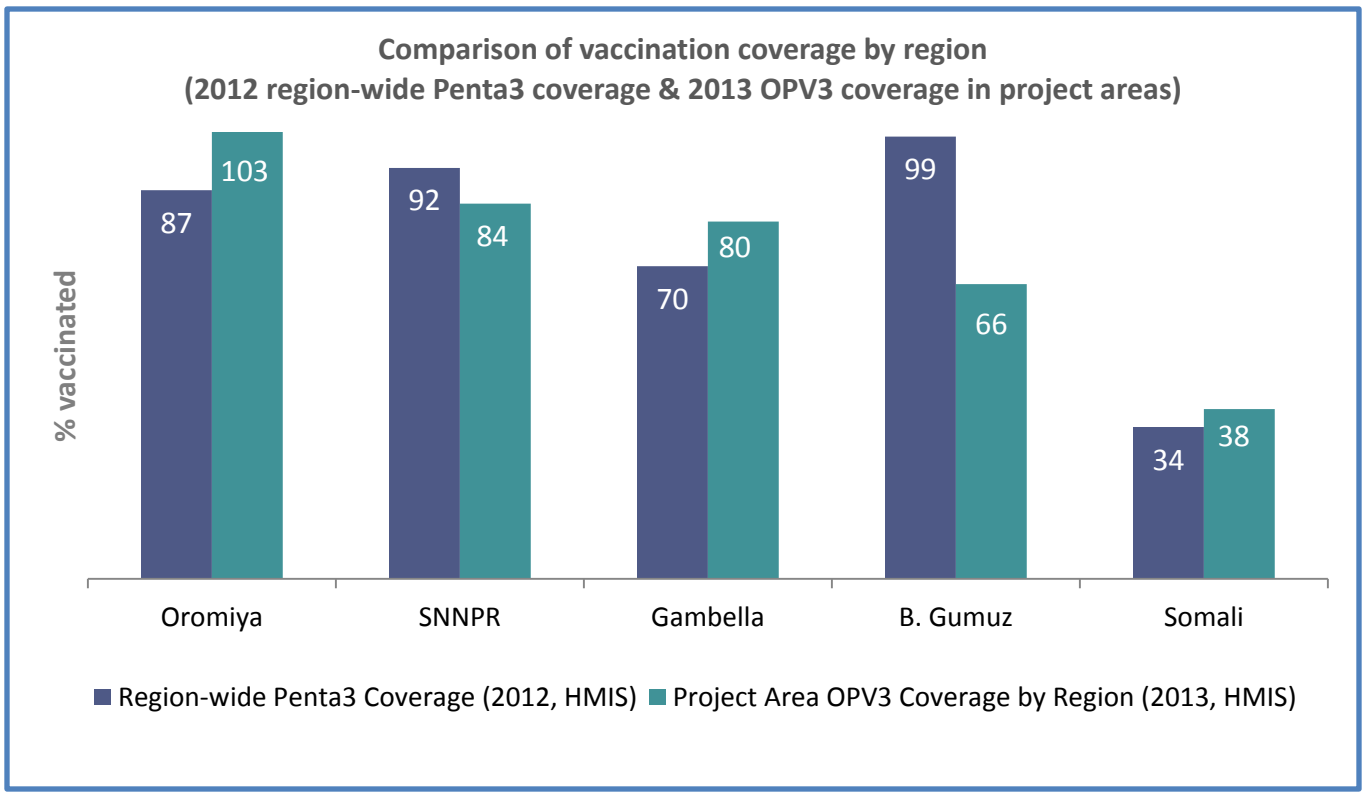
Logistics Support: CGPP implementing partners provided logistics support to health posts and health centers whenever a shortage or gap was identified to ensure the continuation of immunization services. Logistics support included the provision of kerosene for the refrigerators, benzene for motor bikes used for outreach services and diesel fuel for vehicles used for outreach services or to transport vaccines to health posts. Project staff repaired and maintained vaccine refrigerators to ensure uninterrupted immunization service delivery. Similarly, implementing partners coordinated the repair of motor bikes.

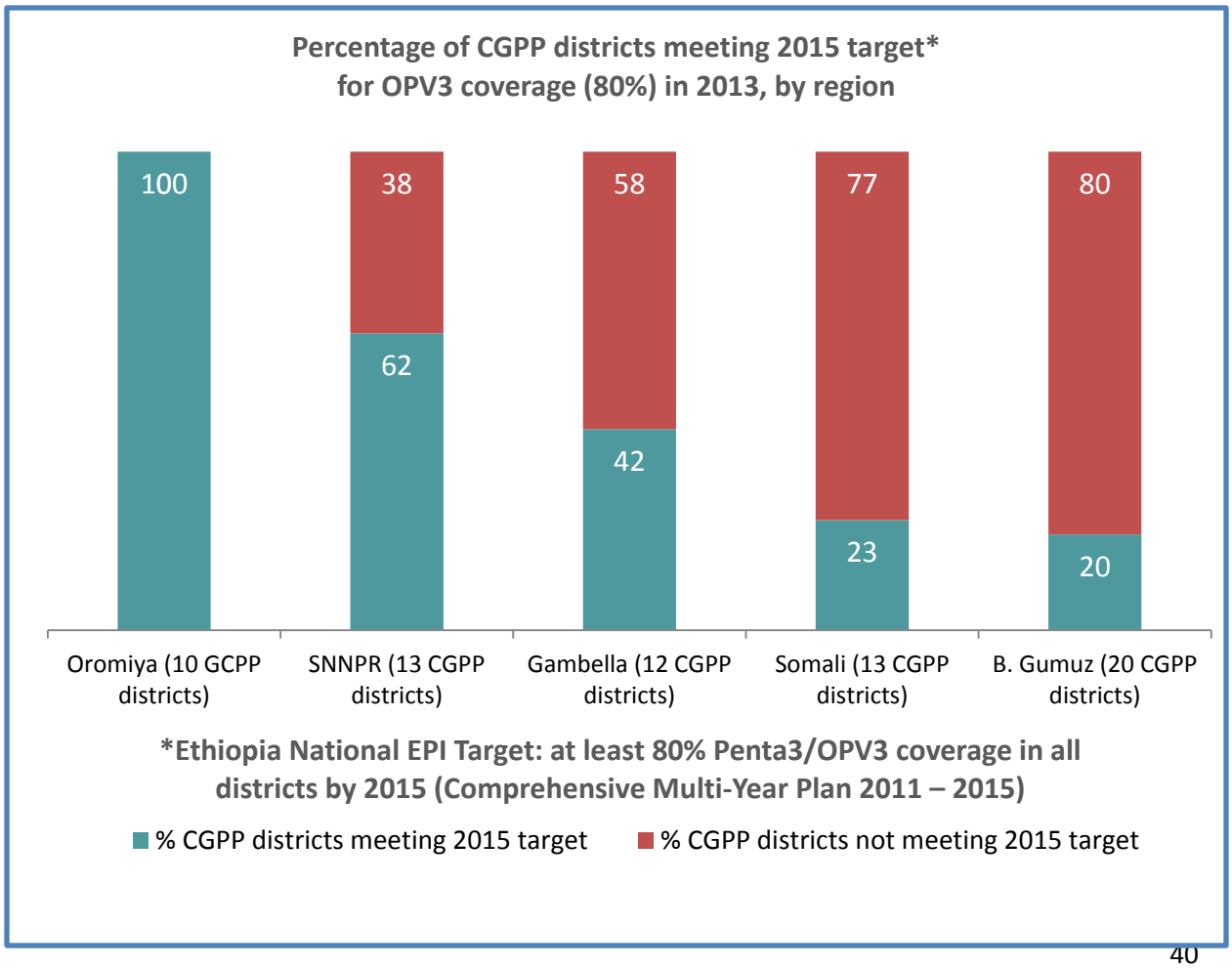
Cold Chain Users Training, Benchimaji zone, SNNPR

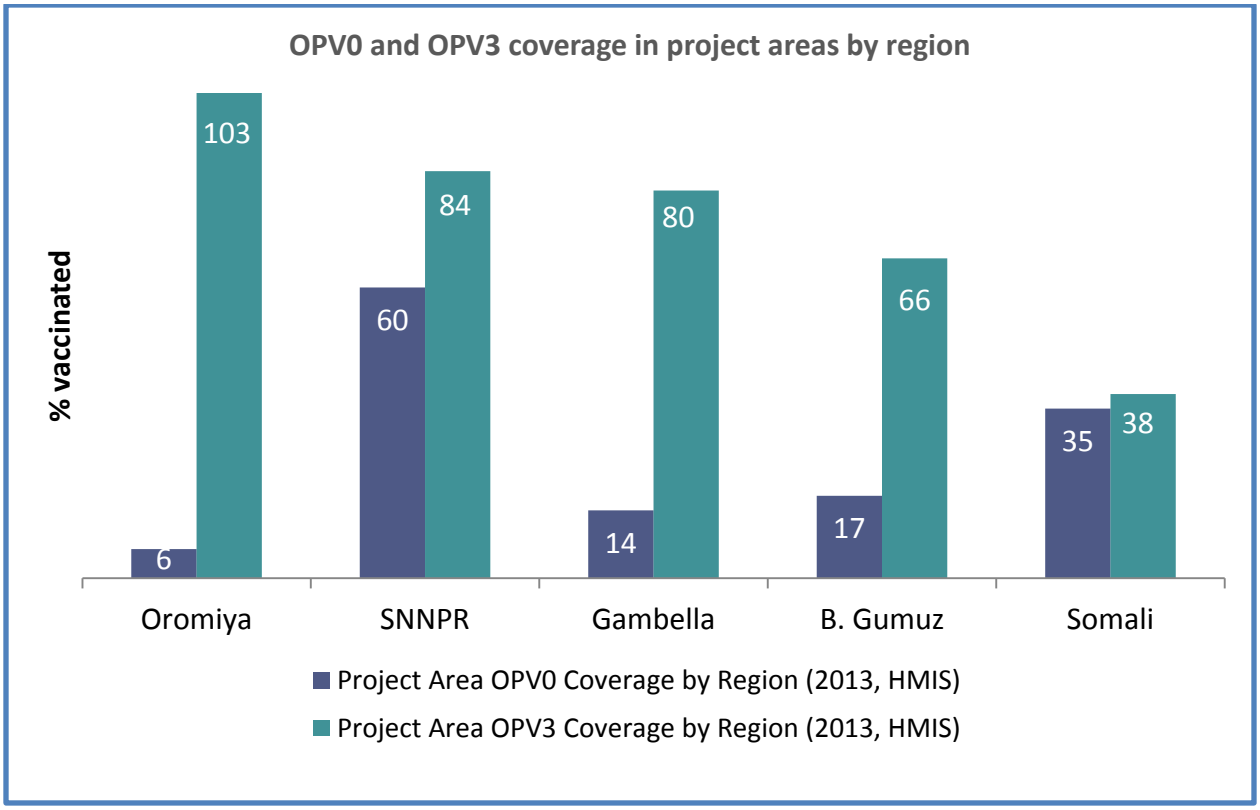
In project areas where the routine vaccination program has particular difficulty in reaching target infants, woreda health offices, in collaboration with CGPP field offices, conducted enhanced routine immunization activities (ERIAs) to ensure as many children as possible were reached.

Logistics support to routine immunization system (Oct. 2012 - Sept. 2013)

	Amount
Fuel distributed (liters)	32,928
Refrigerators requiring maintenance	12
Motorbikes requiring maintenance	18


Comparison of vaccination coverage by region
(2012 region-wide Penta3 coverage & 2013 OPV3 coverage in project areas)
% vaccinated
87
103
92
84
70
80
99
66
34
38
Oromiya
SNNPR
Gambella
B. Gumuz
Somali
Region-wide Penta3 Coverage (2012, HMIS)
Project Area OPV3 Coverage by Region (2013, HMIS)


Percentage of CGPP districts meeting 2015 target*
for OPV3 coverage (80%) in 2013, by region
100
38
62
58
42
77
23
80
20
Oromiya (10 GCPP districts)
SNNPR (13 CGPP districts)
Gambella (12 CGPP districts)
Somali (13 CGPP districts)
B. Gumuz (20 CGPP districts)
*Ethiopia National EPI Target: at least 80% Penta3/OPV3 coverage in all districts by 2015 (Comprehensive Multi-Year Plan 2011 – 2015)
% CGPP districts meeting 2015 target
% CGPP districts not meeting 2015 target



Objective 3: Support supplemental polio immunization activities

Two rounds of sub-national immunization days were held in October and November 2012 targeting high-risk zones primarily along the border where there is high population movement and low routine immunization coverage.

Ethiopia responded to the polio outbreak in Somalia, Ethiopia and Kenya with multiple rounds of SIAs starting in June in Dollo Ado woreda, Somali region in the five refugee camps and host communities for children under 15 years of age. During this campaign 59,758 children (98.2%) out of a target of 60,826 children were

Community volunteer working to mobilize his community during campaign, Somali

vaccinated and 399 (zero dose) children were vaccinated for the first time.

Independent monitoring of the October 2012 SNID was conducted in 12 of 26 participating zones. CORE Group implements the CGPP in six of these, four in Gambella and one each in Beneshangul Gumuz and Oromiya (see graph). Monitoring results from the six CGPP zones shows the percentage of children not immunized in the campaign to be at or below 20 percent for both house-to-house sampling and outside sampling in all but one instance (outside sampling in Asosa, Beneshangul Gumuz). According to results from house-to-house sampling, only one of six zones registered greater than 10 percent missed children. Likewise, according to outside sampling, two of six zones registered greater than 10 percent missed children.

Secretariat Involvement: As members of the SIA Task Force, the CORE Group Secretariat supported national-level decision-making and preparations for both polio rounds. Secretariat staff also deployed to Beneshangul Gumuz and Gambella regional states where they were actively involved in pre-, intra-, and post-campaign activities at the regional-level. Staff supported microplanning and intra- and post-campaign monitoring in both states and organized the high-profile regional launching ceremony in Beneshangul Gumuz.

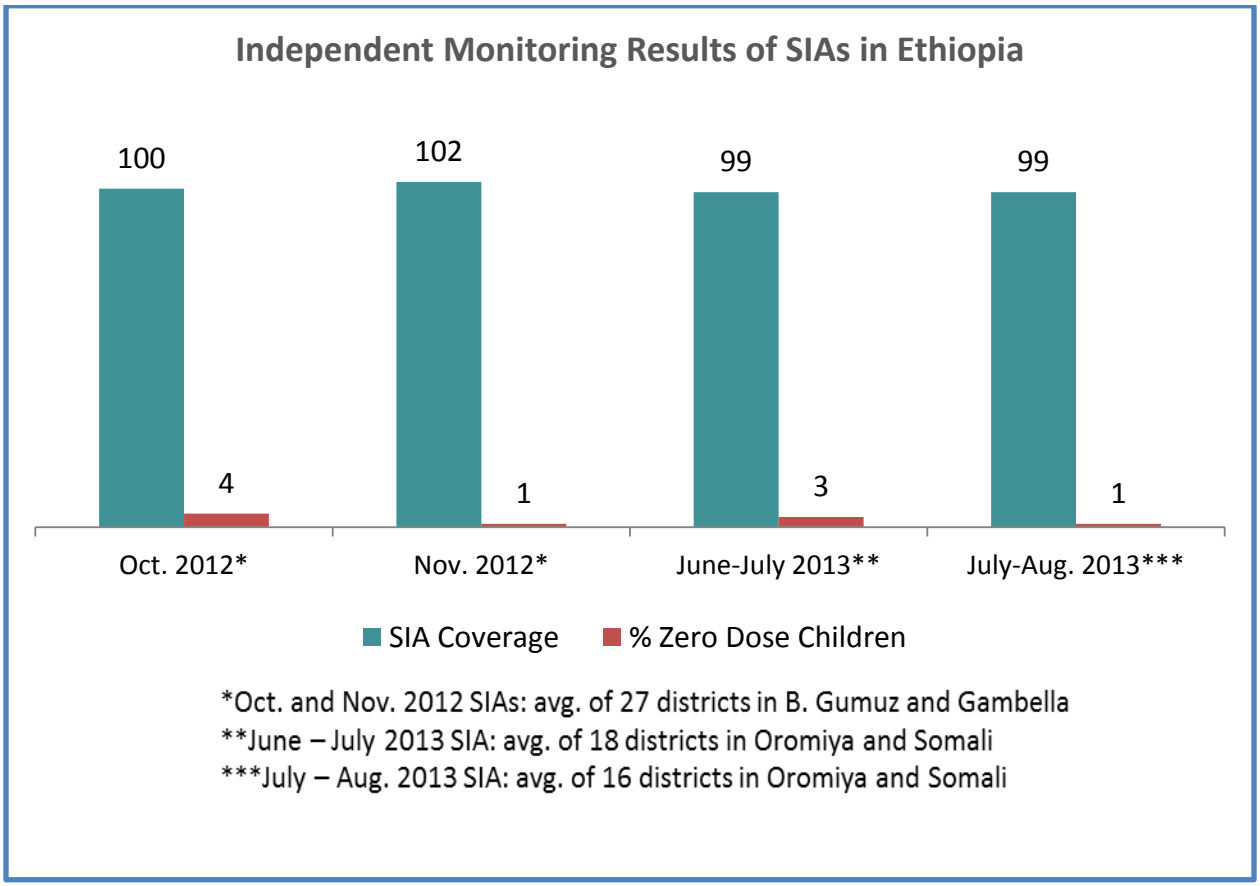
Partner Involvement: Six implementing partners provided technical and logistical support to the polio rounds in their respective woredas. Technical support included the provision of SIA social mobilization training for community leaders and project volunteers, the involvement of partner field officers as campaign supervisors and the participation of community volunteers on vaccination teams. Implementing partners provided fuel for refrigerators and supported the transport of vaccines, vaccination teams, and campaign supervisors.

The majority of woredas vaccinated 95% of the target population of children under five and due to high community mobility and pores borders the, the reported coverage is above 100%.

Campaign launching ceremony, Gambella

To raise awareness and mobilize the communities, launching ceremonies were conducted prior to the start of each campaign in the major regional or zonal cities.

When compared with the six non-CGPP zones, the percentage of missed children was five percentage points less in CGPP zones for both house-to-house and outside of house sampling.



Objective 4: Support efforts to strengthen AFP surveillance

The national Non-Polio AFP rate has remained above two per 100,000 for children under 15 years of age for the last seven years and in woredas covered by CGPP volunteers, a large number of those cases were reported by project volunteers. Six AFP cases in Somali Region were confirmed positive for WPV1 in 2013 marking the first polio outbreak since 2008.

Project volunteers are the cornerstone of community-based surveillance, bridging the gap between the community and formal surveillance mechanisms. As one Health Extension Worker reflected,

Community volunteers during CBS training

"I think working as an HEW could have been more challenging and daunting had it not been for the intervention of community volunteers. They go to remotest areas where I could not due to work overload here. They are also very good at educating the public about the signs and symptoms of vaccine preventable diseases."

Volunteers conduct active case searches for acute flaccid paralysis and other diseases through house-to-house visits, health education sessions, discussions at community events, and meetings with key community stakeholders (religious leaders, traditional healers, etc.). Volunteers also discuss the signs, symptoms, and consequences of polio and other diseases, disease prevention including routine immunization, and where to report suspected cases.

CORE Group Ethiopia also facilitated AFP case sample transportation from district to the national laboratory (Dollo Bay, Filtu).

Summary of AFP surveillance indicators by region, Ethiopia (Jan. 1 - Oct. 1, 2013)

Region	Expected Cases (2013)	Reported (same period 2012)	Reported (this period 2013)	NP-AFP Rate (annualized)	Stool Adequacy (%)	Stool Cond. (%)
B/GUMUZ	8	8	8	2.6	50	71
GAMBELLA	5	7	4	2.1	100	100
OROMIA	320	289	302	2.5	89	82
SNNPR	166	207	163	2.6	93	80
SOMALI	49	33	52	2.8	65	96
NATIONAL	806	789	743	2.4	88	80

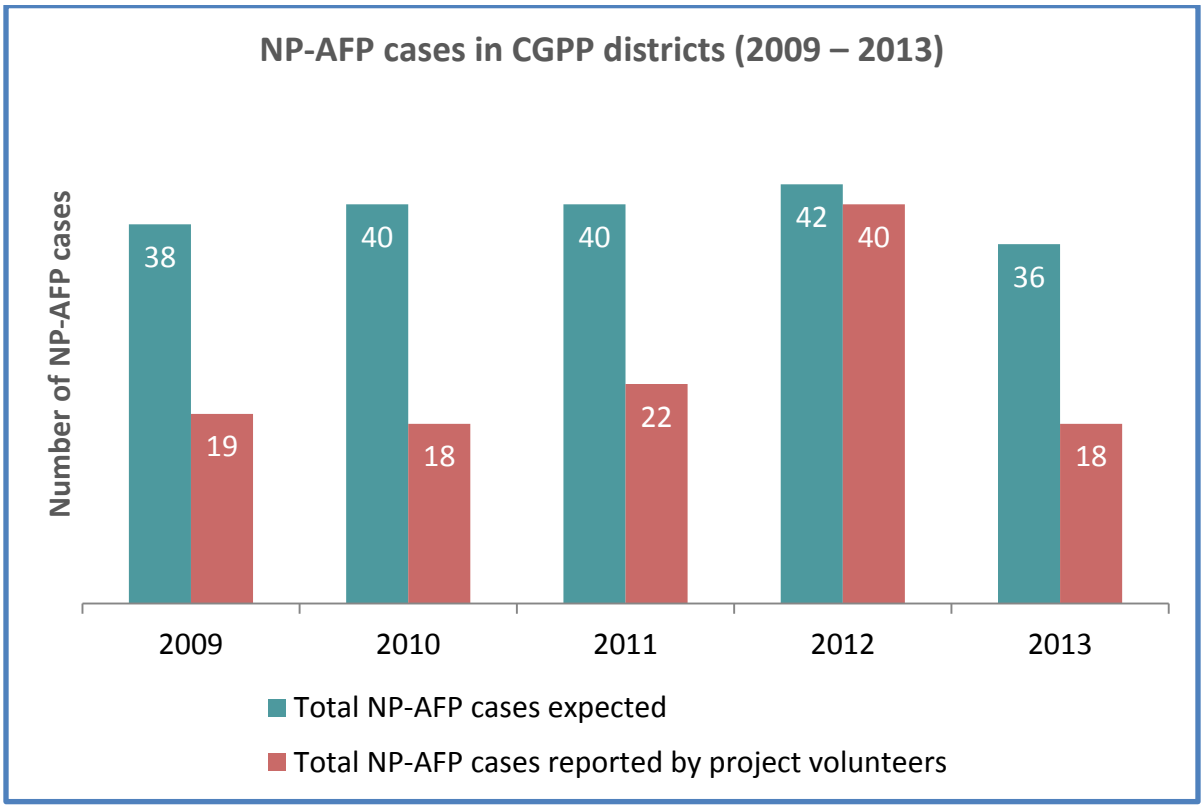
Source: WHO Polio Update, 2013

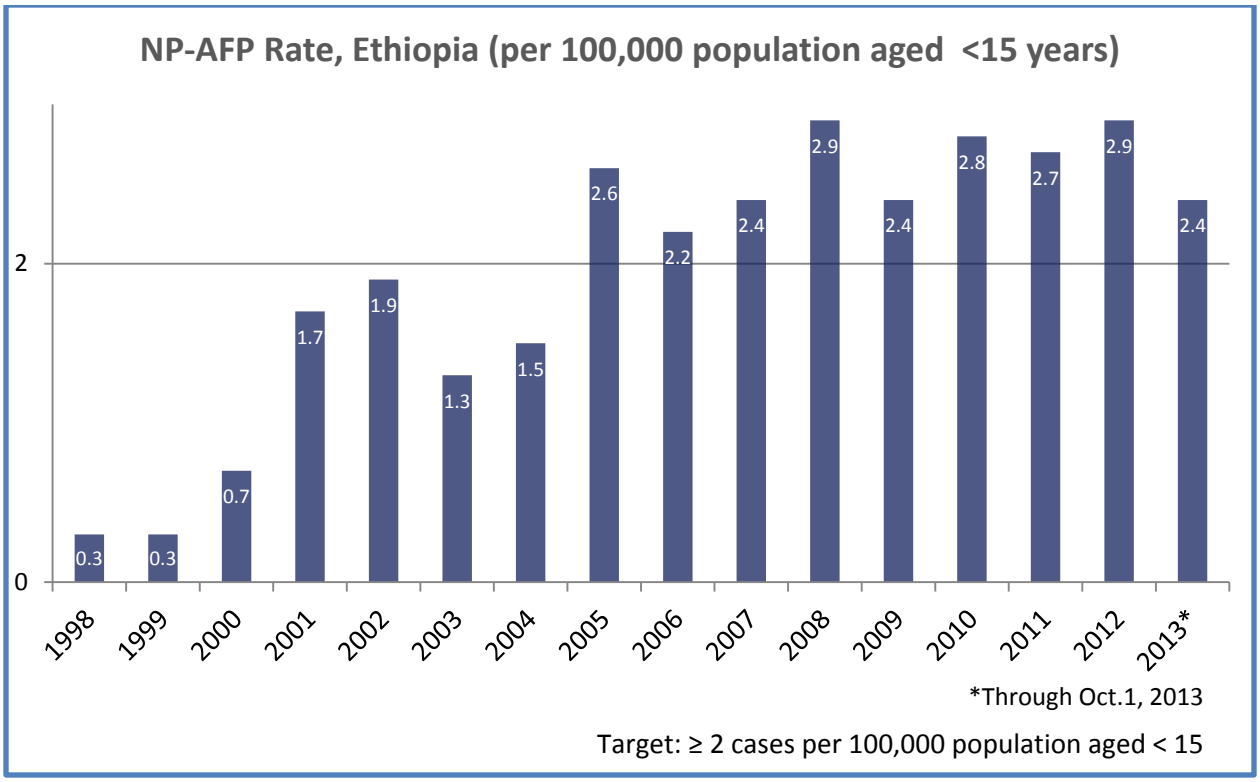
There were no silent areas for NP-AFP detection in CGPP implementation areas in FY2013, though Itang district, Gambella region reported no cases from January 2013 to October1, 2013. In FY2013, over 4,000 project volunteers were actively working in community-based surveillance and accomplished the following:

Support to AFP surveillance

# Community volunteers and HEWs trained on CBS and NBT	2,616
# House-to-house visits	166,272
Total # people reached through health education and case searching	1,657,428

The graph below shows project volunteers' contributions to NP-AFP surveillance through active case searching and reporting from FY2009 to FY2013. The numbers of total NP-AFP cases reported in CGPP woredas may also reflect cases of NP-AFP reported by community members directly to health facilities as a result of volunteers' education efforts.





Objective 5: Supporting timely documentation and use of information

CGPP Ethiopia contributed to a number of publications and presented at various venues in FY2013.

WCPH panel discussion and poster presentation: CORE Group Ethiopia coordinated the panel discussion 'Polio Eradication: Global Health Public Emergency' at the World Congress on Public Health held in Addis Ababa in April. The project also presented two posters: one on the collaboration between HEWs and project volunteers and the other on community-based surveillance and immunization data quality in project woredas. Both posters ranked in the top ten of all posters (560) presented at the conference.

Final evaluation and special study in pastoralist and semi-pastoralist areas: The project conducted both a final evaluation of all project areas and a special study looking specifically at the status of surveillance, newborn tracking and the polio birth dose, and cross-border immunization service delivery in pastoralist and semi-pastoralist project areas. The results of both are being combined and will be used to guide project strategies and strengthen activities in the new year as CORE Group Ethiopia turns its focus exclusively on border areas in pastoralist and semi-pastoralist areas.

Annual review meeting: The secretariat hosted its CGPP Annual Review Meeting in July with participants from partner country and field offices, woreda health offices, zonal health offices, and some regional health bureaus. The primary objective of the meeting is for partners and their respective government health officials to collaboratively plan the project's woreda-level activities for the coming year using

administrative, monitoring, and evaluation data, and current EPI and surveillance information presented by representatives from the MOH, WHO, and UNICEF.

Quarterly supportive supervision and review meetings: Partner project officers and woreda health office staff provided joint quarterly supportive supervision to Health Extension Workers, which focused on the partnership between HEWs and project volunteers, HEW competency on surveillance and EPI, and the quality and quantity of volunteer activities. General actions taken in response to supportive supervision visits included on-the-job training for HEWs, particularly in the areas of documentation, cold chain monitoring, and proper supervision of project volunteers.

Partner project officers and woreda health office staff also hosted quarterly review meetings attended by both HEWs and project volunteers where they were provided information and training on topics identified during quarterly supervision visits.

LQAS Utilization

At the end of FY2013, CGE staff conducted an annual project monitoring survey using LQAS. CORE Group Secretariat staff provided LQAS training for 22 EPI and surveillance officers from South Omo Zone woreda and AMREF staff.

Publication of Journals and manuals

CGE contracted Professor Mesganaw to conduct operational research on three major intervention areas; new born tracking, surveillance and cross border immunization issues. The secretariat utilized graduate students to assess project activities as a part of their thesis work. CGE in collaboration with Ethiopian Medical School published nine articles in the Ethiopian Medical journal Special issue on contributing towards Polio eradication in Ethiopia (July 2013, volume 51, supplemental 1).

The published titles are:

- Newborn tracking for polio birth dose vaccination in pastoralist and semi pastoralist CGPP implementation districts, in Ethiopia

- Acute flaccid paralysis surveillance status and community awareness in pastoralist and semi pastoralist community of Ethiopia,
- Assessment of Cold Chain Status for immunization in Central Ethiopia
- Cross border wild polio virus transmission in CGPP areas in Ethiopia
- Factors Associated with Immunization Coverage Among Children Age 12-23 months: The case of Zone 3, Afar Regional state
- Knowledge and practice of front line health workers (HEWs and CVSFPs) towards acute

flaccid paralysis case detection and reporting in pastoralist and semi pastoralist areas of Ethiopia.

- Knowledge of mothers on polio myelitis and other vaccine preventable diseases and vaccination status of children in pastoralist and semi pastoralist areas of Ethiopia
- Health facility preparedness for routine immunization services in Gambella region, Ethiopia and
- Linking CVSFPs with health extension workers on polio surveillance

In addition four quarterly CORE Group newsletters were printed and disseminated, a Community Based Surveillance Training Manual was revised and printed, a CGE calendar was designed and printed, and the CGE Brochure was redesigned.

Objective 6: Support PVO/NGO participation in either a national and/or regional certification activities

CGPP participated in an Independent Surveillance Review on polio eradication lead by WHO conducted in Ethiopia in August 2012.