

CORE
Group
Polio
Project

2015

PROJECT OBJECTIVES

- 1 Build effective partnerships PVOs, NGOs, and international, national and regional agencies involved in polio eradication.
- 2 Support PVO/NGO efforts to strengthen national and regional immunization systems to achieve polio eradication.
- 3 Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunization.
- 4 Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection (and reporting and detection of other infectious diseases).
- 5 Support timely documentation and use of information to continuously improve the quality of polio eradication (and other health-related activities).
- 6 Support PVO/NGO participation in national and/or regional polio eradication certification activities.

Secretariat Leaders

Ana Pinto
Angola

Filimona Bisrat
Ethiopia

Bal Ram Bhui
Horn of Africa

Roma Solomon
India

Samuel Usman
Nigeria

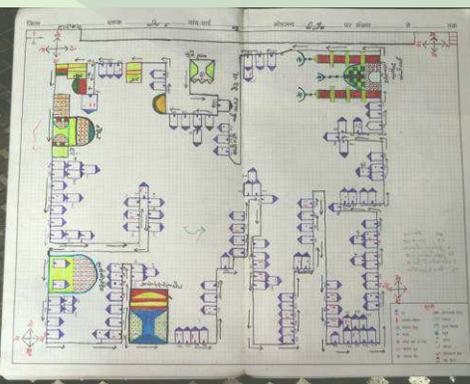
Anthony Kisanga
South Sudan

US-Based Staff

Frank Conlon
Director

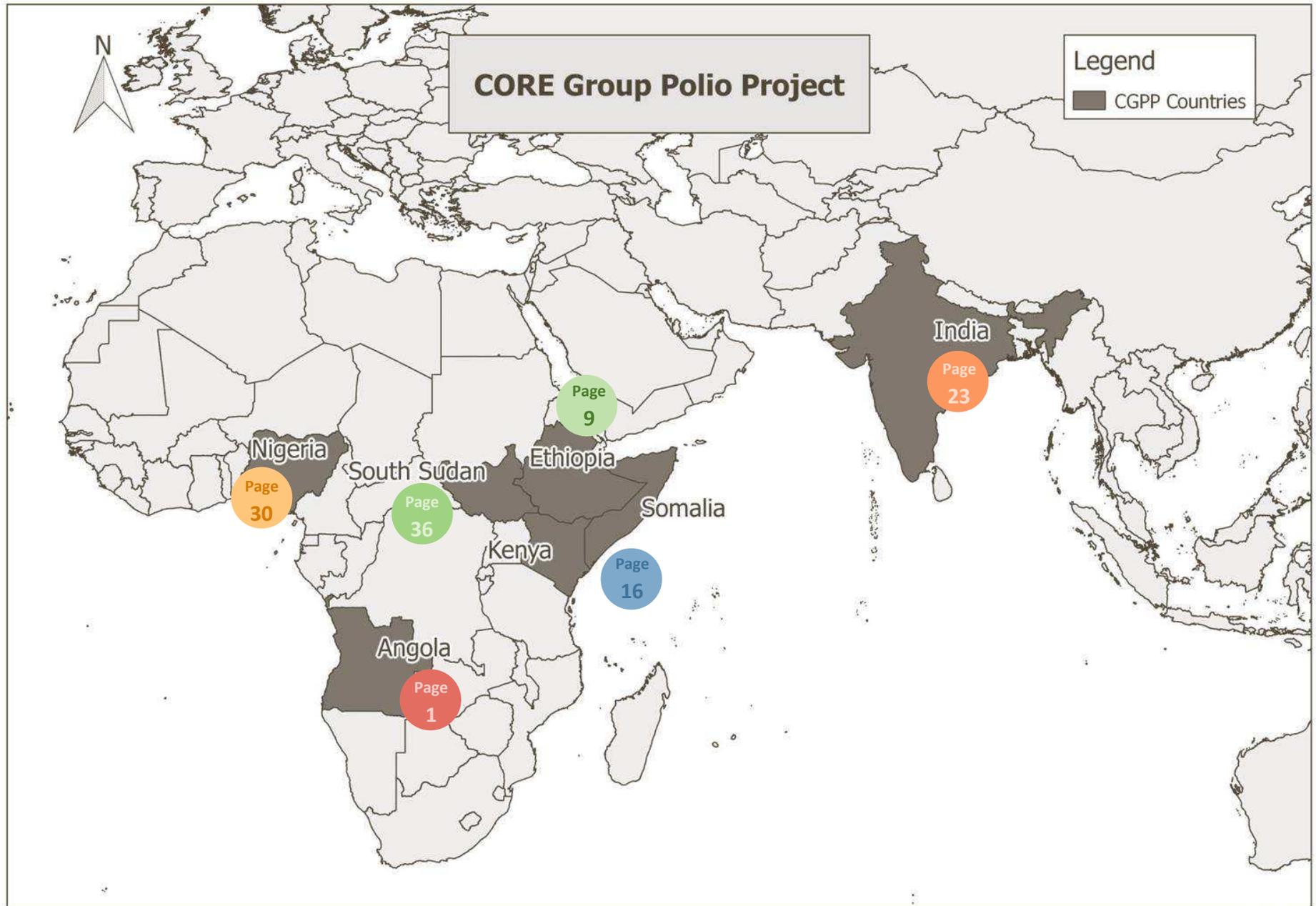
Lee Losey
Deputy Director-STA

Meghan Lynch
Technical Advisor



CORE Group Polio Project Partners

Adarsh Seva Samiti • Adventist Development and Relief Agency • African Healthcare Implementation and Facilitation Foundation • Africare • AMREF Health Africa • American Refugee Committee • Archdiocesan Catholic Healthcare Initiative • Asoder • Bahir Dar Catholic Secretariat • Bio Aid • CARE • Caritas Benguela • Caritas Dundo • Caritas Saurimo • Catholic Relief Services • Community Support and Development Initiative • Consortium of Christian Development and Relief Association • Ethiopian Evangelical Church Mekane Yesus • Ethiopian Orthodox Church • Family Health & Youth Empowerment • Federation of Muslim Women's Association in Nigeria • Gorakhpur Environmental Action Group • Haraghe Catholic Secretariat • Health Care Education & Support Initiative • Innovative Approach for Social Development Society • International Medical Corps • International Rescue Committee • Jan Kalyan Samiti • Jeevan Jyoti Community Center • Kenyan Red Cross • Mahila Jagriti Sewa Samiti • Malik Social Welfare Society Rampur • Meerut Seva Samaj • Network for Integration and Rural Advancement • Organization Welfare and Development in Action • Pastoralist Concern • PCI • Salvation Army World Service Office • Sarathi Development Foundation • Save the Children • Society for All Around Development • Somali AID • Wabishebele Development Association • Waka Rural Development Initiative • World Vision



EXECUTIVE SUMMARY

Fiscal Year 2015 is the first time in the history of the project, that no CORE Group Polio Project countries had a case of wild polio virus. Nigeria registered its last case in July 2014, Somalia in August 2014, Ethiopia in January 2014, Kenya in 2013 and Angola and India both in 2011. All of the CGPP countries have now been removed from the list of endemic countries and Africa is now polio free. There were only 70 cases of wild polio virus in the world in 2015; 51 in Pakistan and 19 in Afghanistan, which is the lowest number of annual cases ever registered. All signs indicate the very real possibility of global interruption of the wild polio virus in 2016 provided Pakistan and Afghanistan succeed and that we do not have another major outbreak anywhere else in the world. The likelihood of an outbreak is diminished by the reduction in global cases and endemic countries but it is still very much present. There was a major outbreak in 2013 and 2009 and many more before which indicates a need for cautious optimism and relentless vigilance as we drive the wild polio virus from its last hiding places.

Since its inception in 1999, CGPP has introduced and established a number of innovations to global polio eradication which have contributed to the elimination of wild polio virus in all of the CGPP countries. The CORE Group Secretariat model which coordinates a group of NGOs under the umbrella of a national Secretariat office with links to other partners and the government has proven very successful. CGPP introduced the use of community mobilizers to support polio eradication which has become a well-established component of the global polio eradication initiative (GPEI). CGPP piloted and initiated independent campaign monitoring (ICM) in Angola and continues to conduct ICM in Angola and South Sudan. CGPP introduced the concept of community based AFP surveillance which has identified many cases in numerous countries. CGPP has championed cross border collaboration through cross border meetings and the establishment of cross border committees. Most importantly, CGPP has consistently promoted and championed the inclusion and contributions of civil society to global polio eradication without which the global campaign would not have succeeded.

Globally, CGPP has actively promoted and represented civil society at various meetings including the Independent Monitoring Board for Polio Eradication (IMB), the Polio Partners Group which meets twice a year in Geneva, the Polio Working Group of the Center for Strategic and International Studies (CSIS), CORE Inc. bi-annual meetings, the Horn of Africa Technical Advisory Group (TAG), the GAVI Civil Society Steering Committee, the Nigerian Expert Review Committee (ERC), and the American Public Health Association (APHA) at which CGPP made a record 11 presentations this year.

As will be elaborated in the country specific sections of this report, CGPP contributes to polio eradication by working through more than 10,000 community health workers who support campaigns, conduct community based AFP surveillance, promote routine immunization, track the vaccination status of under fives, newborns, and pregnant women, and mobilize communities to actively participate in vaccination services. The project conducts independent campaign monitoring, cross border eradication activities, advocacy, supports campaign and routine logistics, and AFP surveillance.

All of this is done as a coalition of national and international NGOs whose dedication, experience, and professionalism demonstrate the value and contribution of civil society to polio eradication and community health throughout the developing world. All of the country programs are contributing to IPV introduction

and the switch from tri-valent oral polio vaccine (t-OPV) to bi-valent OPV (b-OPV) which should reduce the number of cases of vaccine derived polio (VDPs) and provide greater population immunity.

CGPP Angola conducts independent campaign monitoring for the entire country which is the primary measure of campaign quality. With no cases since 2011 and a stable economy, CGPP expects to discontinue support to the Angolan program after 2016. CGPP Ethiopia has established strong partnerships among NGOs, other partners and the government, stopped the 2013 outbreak in less than six months, and has established a large cadre of over 4,000 community volunteers. CGPP Horn of Africa has established a strong presence with sub-grants to NGOs, a focused cross-border initiative, and contributions to health information systems. The India program has significantly raised routine immunization coverage, maintained high quality SIAs, developed impressive communications tools, and provided technical support to other countries. CGPP Nigeria stopped the circulation of wild polio virus in 2014 and has taken on the challenge of working in the hardest to reach most security challenged parts of the country through a cadre of trained community health mobilizers. CGPP South Sudan conducts independent campaign monitoring for the entire country, greatly improved routine immunization coverage in target areas, and conducted community based AFP surveillance.

CORE Inc. Is a coalition of 70+ International NGOs working together to share best practices in community and maternal health. CORE Group emerged organically, beginning in 1997, when a group of health professionals from non-governmental development organizations saw the value of sharing knowledge and ideas about how to best help children survive. What began in this simple spirit of openness quickly gained momentum as participants realized significant savings in time, thought and resources—all made possible by collaborating. The group realized that this “community of practice” model was also fertile ground for the creation of new knowledge and ideas as well. In 2001, the group’s original moniker, The Child Survival Collaborations and Resources Group, was streamlined, and the newly named CORE Group incorporated as a coalition of non-profit global health organizations. Though the original scope has broadened from child survival to include women’s health and infectious diseases, the organizing principle for CORE Group membership remains the same: technical excellence in integrated, community-based global health programming.

The CORE Group Polio Project uses a **Secretariat model** to coordinate the work of 48 sub-grantees in seven countries. The Secretariat is a central country office headed by a director or team leader that coordinates and supervises the work of partner NGOs in each country, represents civil society engagement in polio eradication to ministries of health, WHO, UNICEF, CDC, Rotary, and donors, and communicates national and global policies to the member NGOs. Fundamentally, the Secretariats ensure that partner NGOs compliment rather than duplicate the work of other agencies and that NGO partners know and follow national and global polio eradication policies. The Secretariats also give civil society a voice and representation on national and regional polio eradication planning committees.

Acknowledgements

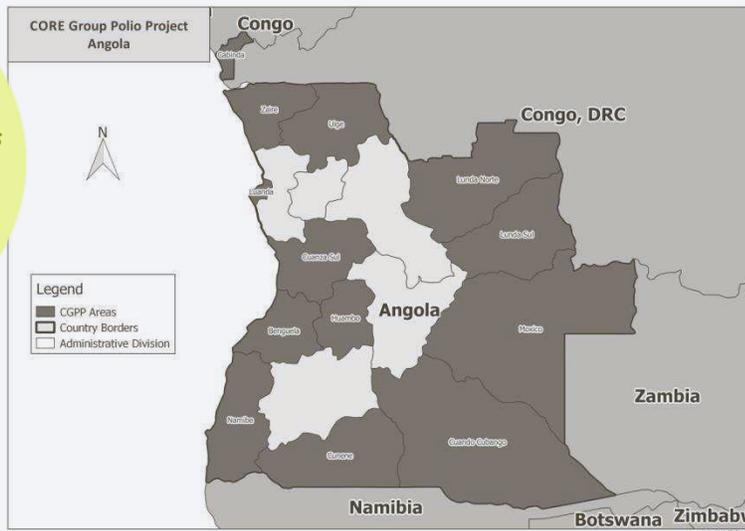
This report was developed with the contributions of many people, starting with the submission of annual reports from 48 implementing partners in seven countries. The Secretariats consolidated the partner reports into country reports. The final global report was written by Lee Losey, the Deputy Project Director, based on the country reports and with assistance from Technical Advisor, Meghan Lynch.





Angola

41 Districts
2,710 Community Mobilizers
Over 125,000 children under five



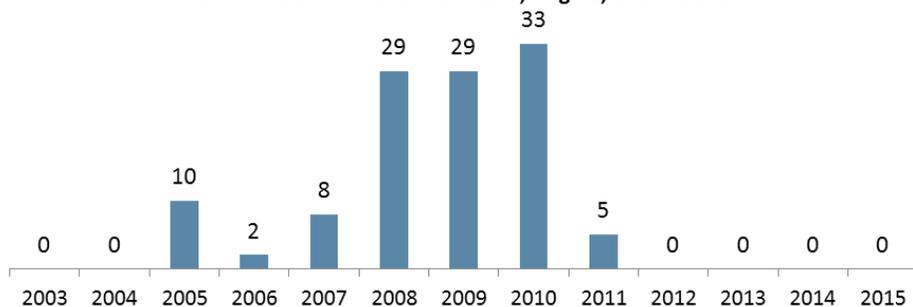
Long one of the leading endemic countries, Angola reported the last case of wild poliovirus in July 2011 and has now completed more than four years with no new cases. Although this is a major accomplishment, Angola’s history of reimportation, the continued presence of WPV in the world, coupled with persistent challenges to the quality of routine immunization, SIAs, and surveillance present a strong case for continued interventions in Angola which is listed in the IMB reports as one of the “Red” or at risk countries.



- PARTNERS**
- Africare
 - Asoder
 - Caritas Benguela
 - Caritas Dundo
 - Caritas Saurimo
 - Catholic Relief Services
 - Salvation Army World Service Office
 - World Vision

- SECRETARIAT**
- Ana Pinto
DIRECTOR
 - Wirsiy Peter Njofon
DEPUTY DIRECTOR
 - Yowani Brais
LOGISTICIAN
 - Goncalves Buto
PROGRAM ASST. FOR M&E
 - Alexandre Luis Jose
PROGRAM OFFICER
 - Marcelina Santana
ADMIN. & FINANCE OFFICER

Confirmed Wild Poliovirus cases, Angola, 2003 - 2015



Angola conducted its first national census since 1970 in 2014, documenting a population increase from 5.6 million to 24.3 million inhabitants. The capital, Luanda, now has 6.5 million residents which poses a major risk for virus importation and

spread due to population density, poor sanitation, and inconsistent health services for the poor. Following a decades long civil war, Angola has been at peace since 2002, which makes access for vaccination campaigns and health services much easier, while also making it easier for diseases to spread should the country face a new importation. The global slump in oil prices has negatively impacted the Angolan economy and government spending on social services including health and immunization.

CGPP-Angola is currently working in 41 high-risk districts in 12 of the 18 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 (*município*) and sub-district (*communa*) levels.

1

Build effective partnerships

CGPP-Angola has established a strong working relationship with the MOH and spearheading partners, 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 mid-term project evaluation in 2015, 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 project partners are also very active in coordination with the provincial and district-level health departments.

As a member of the national EPI technical team, the CORE Group Secretariat participated in various meetings to prepare the multi-year EPI plan, the measles elimination plan, and worked closely with the MOH and WHO to prepare a report for the National Certification Committee. The Secretariat also participated in a meeting organized by GAVI from August 31 to September 4th, 2015 to evaluate the surveillance system, routine

immunization, and supplemental vaccination. This meeting not only served to evaluate the activities financed by GAVI but also to advocate with the government of Angola to cover cofinancing requirements.

The current project coordinates the participation of four international NGOs; Africare, Catholic Relief Services, World Vision, and the Salvation Army, and two local NGOs; CARITAS and ASSODER. The partners support 2,710 community volunteers, 43 supervisors, and 4 project coordinators. To better coordinate and plan activities and build the capacity of project staff, CGPP Angola held two partner forums in 2015 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 throughout the country. The Secretariat also coordinated a planning and orientation meeting for the project coordinators and supervisors from all of the partner NGOs which included that participation of the MOH and WHO. Secretariat staff also conducted various trainings for the project coordinators and supervisors to improve the quality of evaluation, establish goals, plan activities, and donate materials to support and build the capacity of the community volunteers.

CGPP Partners in Angola

	Province	Nº project municipalities	Nº of volunteers	Total population	Nº children <1	Nº children <5	Nº families served
World Vision	Huambo	1	80	45,986	1,908	4,936	8,844
	C.Cubango	5	230	80,033	13,092	24,294	15,503
	Cuanza Sul	5	350	64,535	10,098	17,335	12,907
Salvation Army	Cabinda	1	60	11,970	2,687	3,001	2,394
	Luanda	2	170	31,350	3,397	5,907	6,270
	Moxico	2	150	14,135	1,984	2,923	2,827
	Lunda Sul	2	140	14,835	1,433	2,756	2,967
Africare	Luanda	3	280	32,185	11,333	24,292	10,957
	Zaire	3	170	23,385	2,186	4,949	5,477
	Namibe	2	100	20,820	2,885	3,827	4,164
	Cunene	2	100	47,314	5,311	11,484	10,799
	Uige	4	190	27,505	1,382	4,956	5,501
GRS, ASSODER, & CARITA	Benguela	5	490	47,268	9,202	13,248	9,506
	Lunda Sul	2	100	13,540	1,683	2,658	2,708
	Lunda Norte	2	100	12,370	1,452	2,542	2,534
Total		41	2710	487,231	70,033	129,108	103,358

Africare is one of the key partners of the ministry of health working with WHO and UNICEF to improve health care and disease prevention. Africare participates in weekly meetings with the Luanda and Uige Provincial Directors of Health in which they review routine vaccination coverage and AFP surveillance and plan campaigns. They are actively working with the MOH to identify causes of low immunization coverage and to create strategies to improve coverage. They promote outreach vaccination teams and action plans. They are also active in AFP surveillance supporting both facility based active case searches and community based surveillance. In FY 2015, Africare participated in 138 technical planning meetings at the provincial and district levels. They are also working with local radio stations to promote vaccination.

World Vision participated in 150 meetings with the MOH, WHO, and UNICEF to plan and implement social mobilization and vaccination including discussions on district-level indicators and vaccination services. They participated actively in the preparation of micro-plans for the NIDs and participated in the Huambo Province weekly meetings with the Provincial Director of Health.

CRS, working with Caritas and Asoder partnered with the MOH and WHO to conduct 20 health facility supervision visits in the districts of Benguela Province to review the cold chain and vaccination services. They meet regularly with the Provincial Director of Health and play a key role in the planning, implementation and supervision of NIDs. They mapped areas of low NID coverage and developed strategies to increase coverage. They are working with community volunteers and actively working with community leaders.

The Salvation Army participates in weekly meetings with the Luanda Provincial Director of Health to analyze the weekly health activities, identify problems and elaborate strategies. They participated in 141 provincial meetings and 527 district-level meetings including meetings to plan independent campaign monitoring.

CGPP planned and implemented cross border meetings with the Democratic Republic of Congo to the North and Namibia to the south.

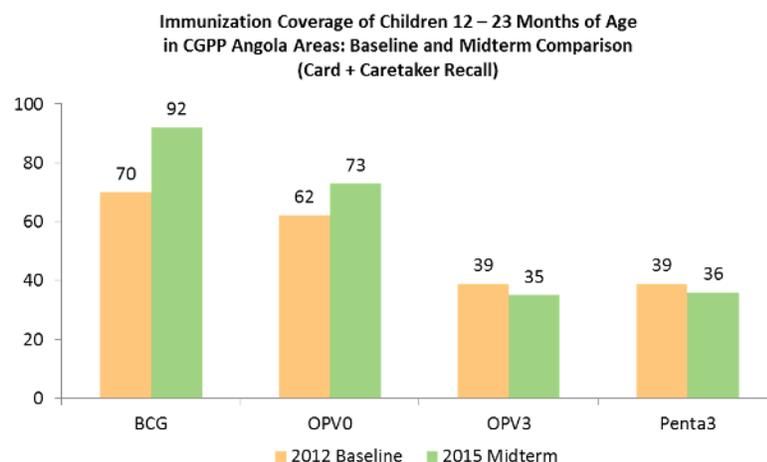
CGPP Angola Participation in Meetings and Supervision

Partner	Technical meetings			Joint Supervisions			Microplanning meetings			Surveillance meetings		
	Plan	Held	CGPP Part	Plan	Held	CGPP Part	Plan	Held	CGPP Part	Plan	Held	CGPP Part
AFRICARE	12	6	6	4	0	0	4	4	4	4	2	2
CRS	32	8	8	108	25	25	2	2	2	4	3	3
ASODER	12	5	5	54	6	5	2	0	0	4	1	1
CARITAS	36	13	11	216	17	17	2	0	0	4	1	1
W.VISION	50	45	45	80	71	71	3	3	3	20	16	16
S. ARMY	60	66	61	138	137	134	10	9	9	2	2	2
TOTAL	202	143	136	600	256	252	23	18	18	38	25	25

2

Support PVO/NGO efforts to strengthen national and regional immunization systems

Based on data from two 30 cluster project evaluation surveys, OPV3 coverage rates in project areas based on card plus caretaker recall were 39 percent in 2012 and 35 percent in 2015. Ministry of Health (MOH) administrative data also shows a downward trend in routine OPV3 coverage rates nationally from 86 percent in 2012 to 75 percent in 2013.



Source: 2012 and 2015 CGPP Household Surveys

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.

Since Angola's economy and the vast majority of the government's income is dependent on oil revenues, record low oil prices in 2015 have induced an economic crisis which has had a very negative impact on health services in general and routine immunization in particular. This has caused a reduction in services, stock outs, a reduction in vaccine acquisition, and a reduction in social mobilization activities. There was a general reduction in routine immunization coverage in 2015 due to a reduction in routine vaccination activities, outreach vaccination, and a delay in the national measles campaign. The 2015 mid-term evaluation survey also documented that 83% of respondents said they had to walk more than an hour to access vaccination services.

The government estimates that approximately 60 to 70 percent of the population has access to basic health services and there are additional inequalities in the distribution of those services. Private health clinics tend to be concentrated in the cities and cater to those who can afford to pay while facilities supported by NGOs and churches are also scarce. Angola suffers from a scarcity of trained health staff which limits the extension of routine immunization services. Although the number of fixed post vaccination sites increased from about 460 to 1,050 in 2014, the government estimates that approximately one third of the population still lacks access to immunization services. Among the problems facing the routine immunization services are constant stock outs, poor administrative support for outreach vaccination teams, and a scarcity of trained vaccinators.

There is clearly a pressing need to prioritize routine immunization as a pillar of polio eradication in order to reduce the country's reliance on SIAs and protect the country from potential importations. In 2015 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.

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. Project coordinators and supervisors held 1,052 meetings with the MOH and partners. The CGPP has 2,710 trained CHWs covering approximately 25 to 50 households each in 41 districts of 12 provinces covering 430 health facilities offering vaccination services. The community volunteers

Activities performed by community volunteers

Data	Number
N° of HF with RI	479
N° of visits to HF with RI	4,927
N° of U5 zero-dose children	16,860
N° of children referred for vaccination	64,178

conducted 6,972 visits to health facilities to check whether the 10,913 children referred for vaccination received the correct vaccinations for their age. They also conducted 597 health education skits, 15,994 health education talks, 8,761 visits to traditional healers, 7,626 visits to traditional birth attendants, 9,914 visits to community leaders, and over 400,000 house visits.

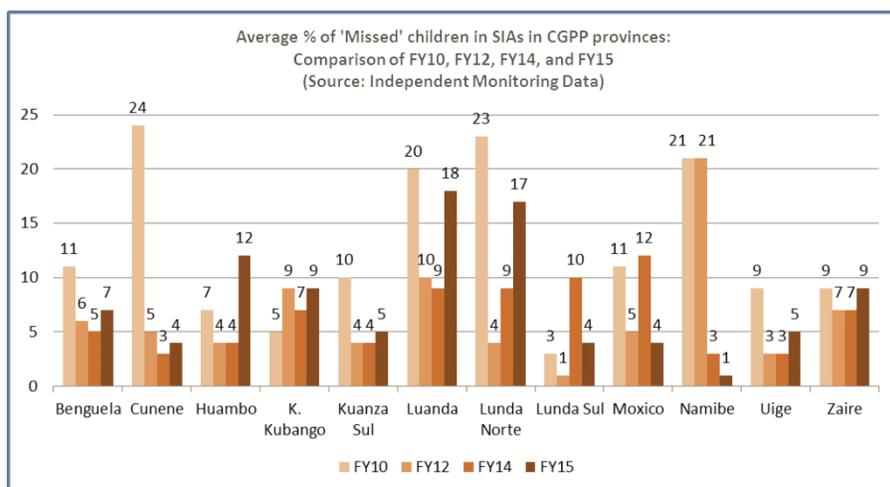
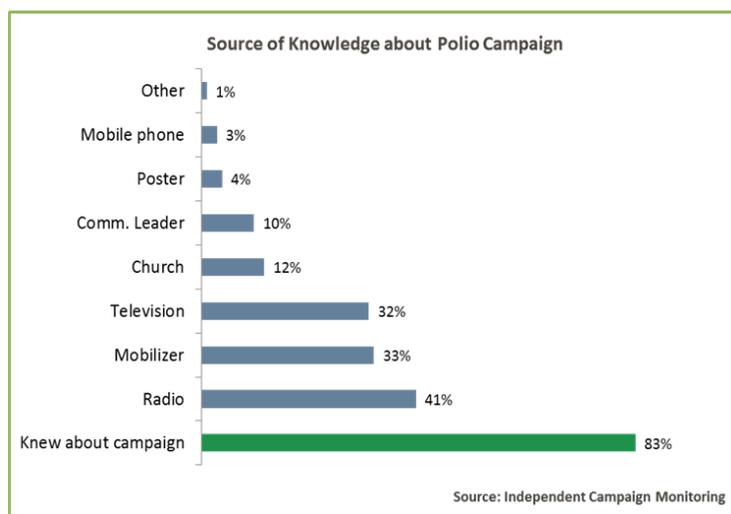
Post-war demographic shifts have significantly increased the population in the large urban areas of Luanda and Benguela without necessarily providing the increased capacity to meet the health needs of these populations. Based on the 2014 census, the population of Luanda is now over six million. Demographically, 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.

3

Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunization

As the following charts demonstrate, 95 percent of parents reported that their under five children were vaccinated in the most recent NID, up from 91 percent at baseline. 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. CGPP



funded and collaborated with the MOH and WHO to conduct a nationwide training for the monitoring coordinators. Based on the independent monitoring data, approximately 2.36 percent 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. CGPP used smart phones using the MagPi system to collect and record campaign monitoring data.

4

Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection

Following four years of no case detections and high quality surveillance, Angola was declared polio free in 2015. 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 percent in the majority of project areas and a national NPAFP rate of 3.5 in 2015. 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 2,710 Community Health Workers (CHWs) to promote community level case detection to ensure that no cases are missed and to identify cases earlier. 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. To improve the quality of CBS, project coordinators conducted 6,992 supervision visits to community volunteers. 15 CGPP staff participated in a national meeting to improve AFP surveillance. Now that Angola has been polio free for more than four 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 Surveillance Performance by Province, 2010 – 2014 (Source: WHO Weekly Polio Updates)

	10/15/10 – 10/14/11		10/21/11 – 10/20/12		10/21/12 – 10/21/13		4/20/14 – 10/19/14		12/14/14 – 12/13/15	
	NPAFP Rate	Stool Adequacy	NPAFP Rate	Stool Adequacy	NPAFP Rate	Stool Adequacy	NPAFP Rate	Stool Adequacy	NPAFP Rate	Stool Adequacy
Benguela	2.7	92%	2.0	80%	3.0	93%	2.6	96%	3.8	100%
Cabinda	2.3	62%	3.4	100%	3.2	100%	3.9	100%	4.5	100%
Cunene	2.0	75%	1.7	100%	1.7	100%	4.1	100%	3.0	93%
Huambo	2.3	100%	2.1	94%	3.0	84%	2.9	94%	3.6	94%
K. Kubango	7.0	95%	3.8	89%	2.6	100%	1.7	67%	4.1	100%
K. Sul	1.4	89%	3.0	88%	3.2	95%	2.5	100%	4.2	100%
Luanda	1.9	77%	2.6	81%	2.2	86%	1.1	75%	2.9	90%
L. Norte	4.0	100%	4.9	88%	5.9	90%	5.2	89%	3.4	93%
L. Sul	5.5	100%	4.6	88%	1.7	100%	4.4	100%	4.8	92%
Moxico	2.3	91%	2.2	100%	1.5	100%	5.2	81%	3.7	100%
Namibe	6.0	100%	11.5	100%	6.7	100%	NA	NA	5.3	92%
Uige	3.7	70%	4.3	87%	3.1	76%	2.1	100%	4.5	97%
Zaire	6.0	88%	2.3	100%	3.5	100%	4.1	100%	2.9	100%

5

Support timely documentation and use of information to continuously improve the quality of polio eradication

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 international presentations and data presentations to the national ICC. CGPP made three presentations to the ICC on independent campaign monitoring, presentations to the Governor of Luanda, and ten presentations at cross border meetings.

CGPP Angola's Deputy Director, Dr. Peter Wirsiy made an oral presentation on independent monitoring at the Annual American Public Health Association meeting in Chicago. CGPP Angola also participated in the publication of an article on the progress of polio eradication in the Journal of Angola.

6

Support PVO/NGO participation in national and/or regional polio eradication certification activities

CGPP participated in the following meetings in support of certification:

- Preparation and implementation of an external review of the national EPI.
- Preparation and implementation of a GAVI evaluation.

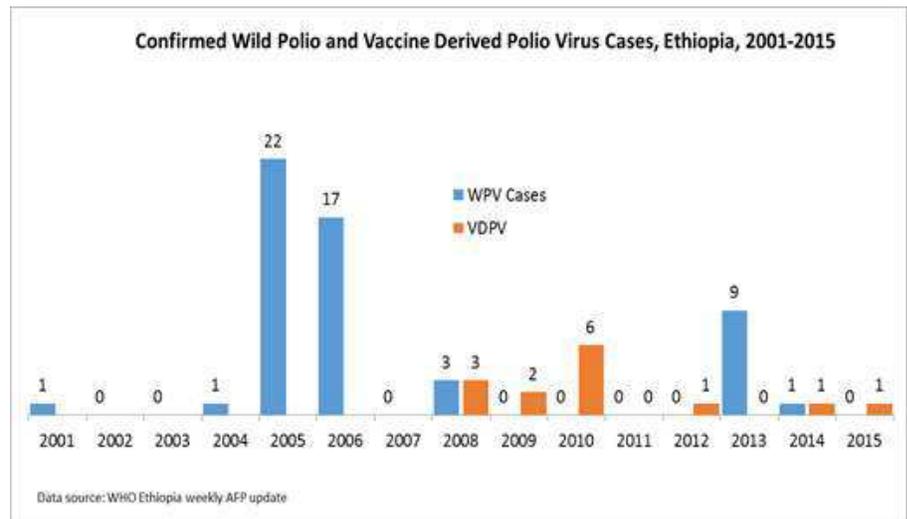
FUTURE PLANS

In light of Angola's successful completion of more than four years without a case of wild polio virus and the interruption of wild polio virus transmission in Africa, FY2016 may be the final year of the CGPP program in Angola which started in late 1999. In the coming months CGPP Angola will focus on legacy planning and work on a transition and exit strategy to hand over essential functions to the MOH and or other partners. CGPP will continue to monitor the needs and donor environment to determine whether the program should continue past September 30, 2016 or transition to focus on other health issues. In what may CGPP Angola's last year, the project will focus on documenting lessons learned over the last 15 years and inventorying critical polio assets from the project that should be transitioned to the government or other agencies. CGPP will work with the ICC to identify a new partner or government agency to take over independent campaign monitoring.

Eleven CGPP implementing partners have trained and placed nearly 8,000 community volunteers along the most vulnerable borders of South Sudan, Kenya, and Somalia. CGPP also provided training, supervision and logistical support in the form of vehicles, fuel, vaccine transport, and other supplies for both routine and supplemental activities. The project serves approximately 800,000 children under five years of age in 81 hard to reach and porous border districts of five regions, namely: Gambella, SNNPRS, Oromia, Somali and Benshangul Gumuz. CGPP Ethiopia works through the following twelve implementing partners: AMREF Health Africa, Organization Welfare Development in Action (OWDA), CARE, Catholic Relief Services, International Rescue Committee, Save the Children, World Vision, Ethiopian Evangelical Church Mekane Yesus, Ethiopian Orthodox Church, Pastoralist Concern, Wabishebele Development Association, and CCRDA which houses the secretariat. The implementing partners and their community volunteers collaborate closely with district health offices and Health Extension Workers to enhance AFP surveillance and promote childhood 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.

Ethiopia successfully stopped the 2013 wild polio virus outbreak in the Somali Region of Ethiopia in six months through repeated rounds of SIAs. Although the Horn of Africa identified more than 400 cases during the outbreak, only nine were in Ethiopia. This was unfortunately only the last in a series of importations since the last indigenous case in 2001.



1

Build effective partnerships

The CORE Group Secretariat based in CCRDA in Addis Ababa works hard to coordinate and guide the activities of the eleven partner organizations through regular meetings and field supervision visits. 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.

Meetings

- **Partners Meetings:** CGPP implementing partners meet once a month to discuss new immunization information and to review project implementation, challenges, and budget utilization.
- **Annual planning forum:** 175 persons attended the CGPP national planning forum in July which brought together CGPP implementing partners, government health officials, donors, and UN agencies to discuss project output, strategies, budgets, work plans, outbreak response; routine immunization; surveillance; the tOPV to bOPV switch; IPV introduction; communication and Social

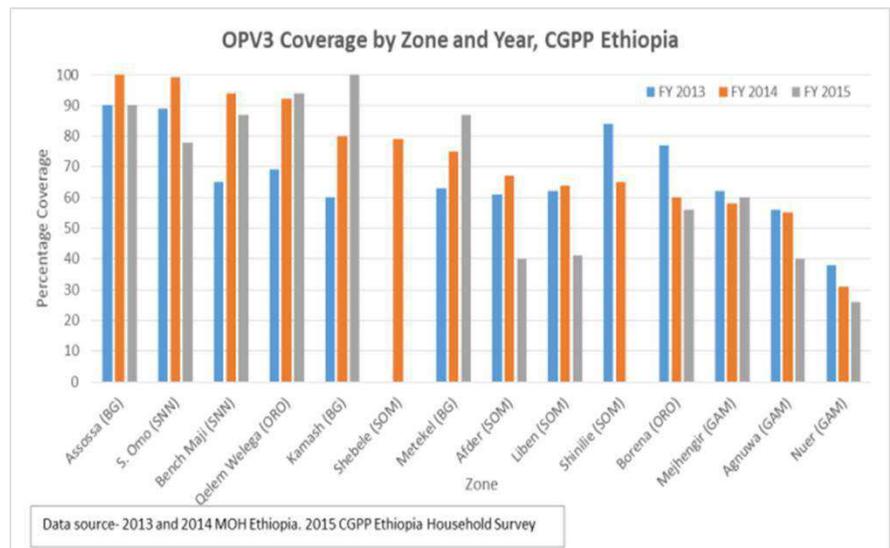
Mobilization; the role of religious leaders, health development armies (HDAs), and the GAVI CSO Support fund

- National Interagency Coordinating Committee Meetings.
- The CGPP “Horn of Africa Monitoring and Evaluation and Program Management Information System” workshop in Kenya
- The 15th annual international Vaccine Institute (IVI) in Seoul, South Korea
- The Horn of Africa outbreak final assessment debriefing meeting in June in Nairobi, Kenya
- The 13th Horn of Africa polio eradication Technical Advisory Group (TAG) meeting in Kenya in August.
- A “results based M&E for development project” workshop in South Africa in December 2014.
- National EPI Task Force and Communication Working Group at the Ministry of Health
- Three National EPI review meetings
- The Secretariat organized and facilitated three midyear review meetings to track partner activity implementation and budget utilization.

2

Support PVO/NGO efforts to strengthen national and regional immunization systems

Project partners have made steady gains in routine immunization coverage over the past five years but the coverage rates for OPV3 are still highly variable by region with a low of 26% OPV3 coverage in Nuer and a high of 100% in the 2015 mid-term coverage survey. Rural and pastoralist border zones encounter numerous challenges including nomadic populations, unreliable cold chains, long distances to vaccination sites, sparse population in some areas, and a high rate of turn over for health staff. CGPP partners conduct training, provide logistical support, transport vaccines, supervise vaccinators and conduct social mobilization.



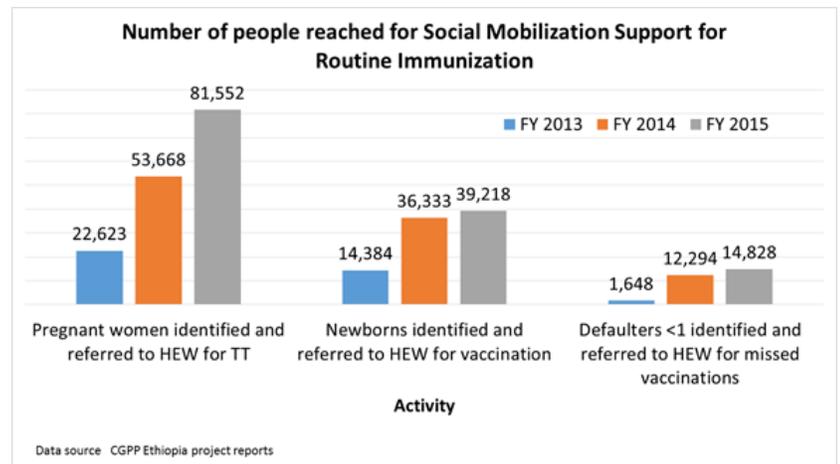
The Secretariat and implementing partners conducted the following trainings in FY 2015:

- 96 trainings for a total of **4,642** immunization service providers to improve quality.
- **1,954** health workers and Health Extension Workers (HEWs) on IIP, Interpersonal Communication (IPC), and cold chain
- 21 secretariat and partner staff participated in an EPI Mid-Level Management training

- 34 Christian religious leaders in Gambella in Communications to mainstream immunization in to the religious system.

Africa Vaccination Week: CGPP partners participated in African Vaccination week to mobilize communities and vaccinate more children. The Secretariat produced 500 caps, 500 t-shirts, 15 banners in different languages and 1000 fact sheets delivered to the MoH for 2015 FY AVW conducted in Afar region, Semera town from April 18 – 25, 2015. The CGPP Director also attended the 5th AVW Celebration launching at Semera.

Community participation: CGPP Ethiopia trained, supervised and supported **7,942** Community Volunteers (CVs) and Health Development Army Volunteers (HDAs) who conducted active community based surveillance, tracked **39,218** newborns and **81,552** pregnant women, traced and referred **14,828** vaccination defaulters and visited **571,041** households to teach **1,375,994** people about health and immunization, and provided social mobilization during routine immunization and campaigns.

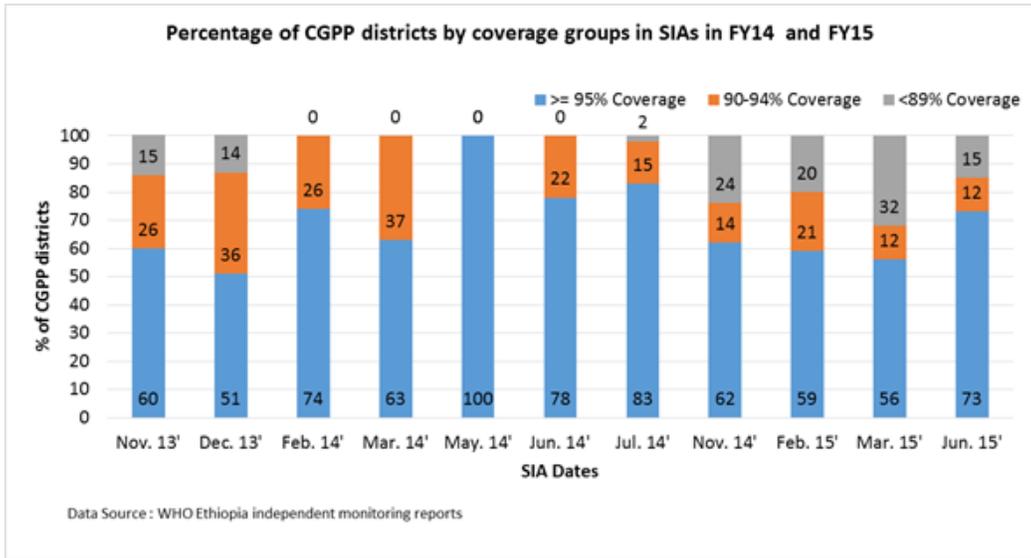


CGPP partners supported routine immunization services in pastoralist and border communities with **132,493** liters of fuel including kerosene for 104 vaccine refrigerators and fuel and maintenance for 134 motorcycles which is the primary means of supervision, vaccine supply, and outreach services. CGPP also established one zonal level and **64** Woreda level EPI taskforces to support routine immunization activities.

3

Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunization

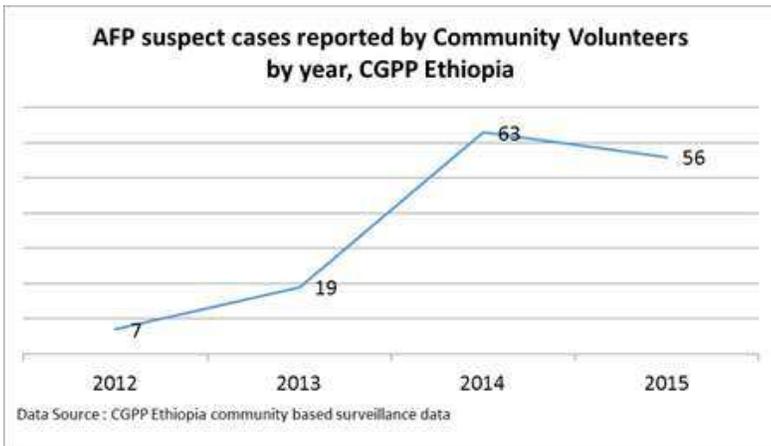
CGPP provided extensive logistical support to SIAs including transportation, fuel, and social mobilization. Partner NGOs distributed **1,761** Social mobilization materials (Megaphones and batteries) and the Secretariat produced and distributed **3,000** bags and aprons for CVs/HDAs and 150 jackets with immunization messages for project staff.



4

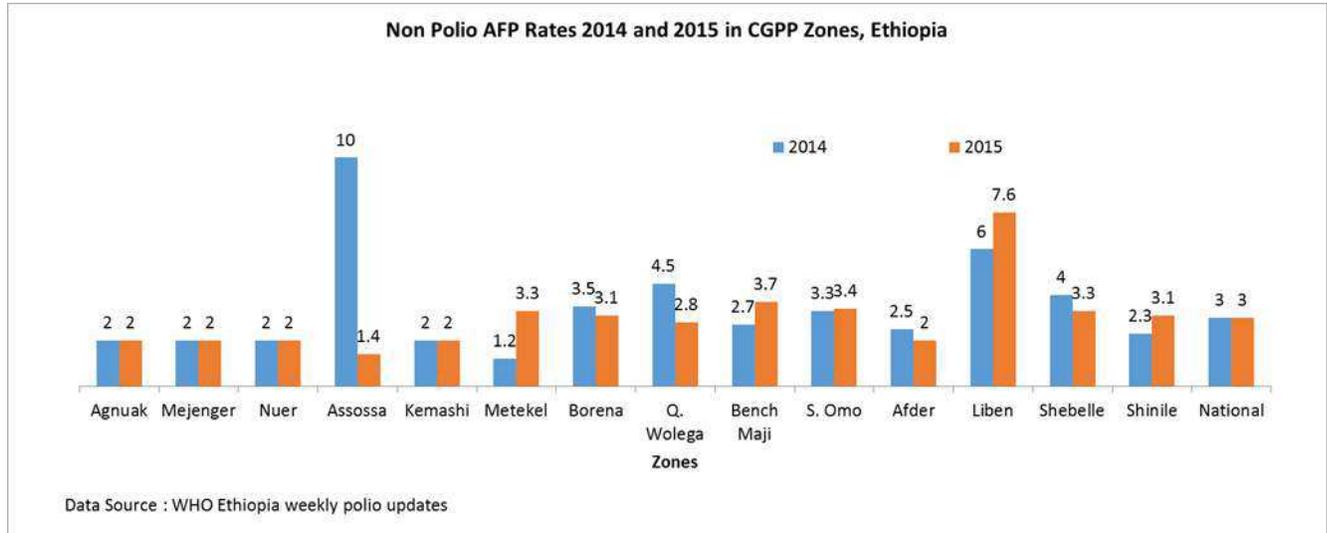
Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection

CGPP is the pioneer of community based surveillance in Ethiopia, previously working with 4,296 Community Volunteers and now expanding to include a total of **7,942** CVs and HDAs based on the new community level structure called Health Development Army (HDAs). This structure includes a female supervisor or head for every five women and a command post leader for every thirty women. In the reporting period, **2,479** Community Volunteers/HDAs were trained on Community Based Surveillance (CBS) and Newborn Tracking (NBT), 46 CGPP field staff trained on Mobile device and web based data collection and Open Data Kit (ODK)



and **209** religious, community and political leaders were provided orientation on Community Based Surveillance. CVs and HDAs conducted **571,041** household visits reaching **1,375,994** people and reported **56 AFP** and **465 measles** cases. The project also transported seventeen (**17**) stool samples. CGPP conducted a three day TOT workshop on CBS and NBT for new partner, Organization Welfare Development in Action (OWDA) in 2015.

There were no silent zones or Woredas from CGPP target implementation areas.



5

Support timely documentation and use of information to continuously improve the quality of polio eradication

CGPP Ethiopia and IPs are working to establish recording, reporting and filing systems at target health facilities, Woreda health offices and project field offices. CGPP distributed **17,969** reporting formats and CBS training manuals and conducted on the job coaching on documentation and use of information for action carried out by CGPP head and field staffs during joint and individual supportive supervision visits.

The Secretariat prepared and distributed three quarterly newsletters to government offices and other partner organizations to share experiences and update partners on current EPI related information.

CGPP secretariat staff presented papers at the 2014 APHA Annual Conference in New Orleans and the 2015 APHA meeting in Chicago, the 1st IGAD International Conference on Health in Addis Ababa in December 2014 and the Ethiopian Public Health Association Annual Conference at Bahir Dar, Ethiopia.

Joint supportive supervision: Secretariat staff conducted supportive supervision visits jointly with the partners at the Woreda field level in 33 Woredas and 12 zones in five regions. The visits included partner field offices, zonal health departments, Woreda health offices, health posts, interviews with the CVs/HDAs and mothers with young children using a standardized checklist. Financial staff also conducted supervisory and follow up visits to project partners to ensure adequate financial oversight and reporting.

Staff retreat: CGPP Ethiopia organized and conducted a staff retreat in Tigray, Northern Ethiopia in August to review the 2015 Secretariat performance, plan future programmatic areas and build the team.

Mid Term Evaluation: CGPP Ethiopia conducted a 30 cluster Mid Term Evaluation survey in June and July 2015.

6

Support PVO/NGO participation in national and/or regional polio eradication certification activities

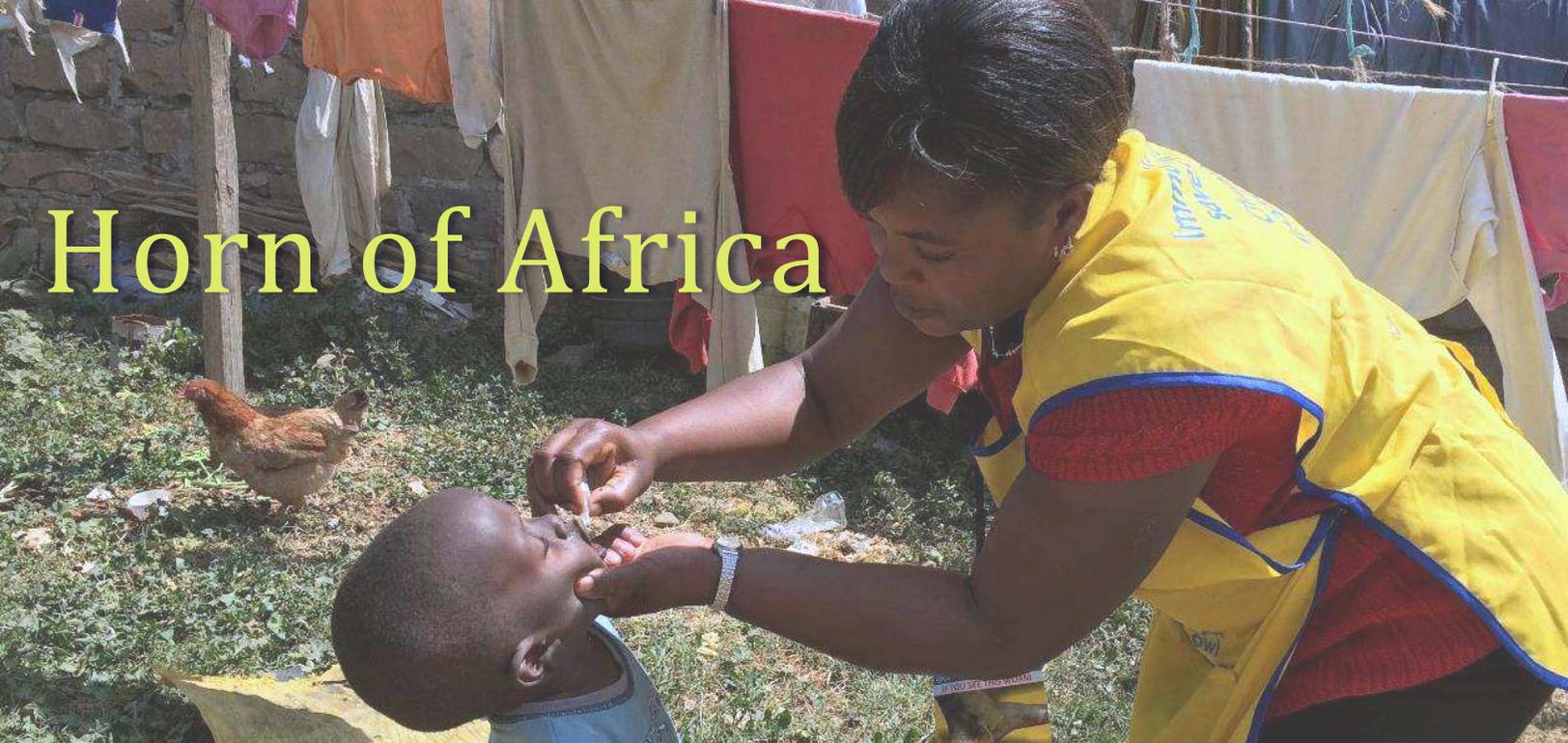
Outbreak Assessment: CGPP Ethiopia participated with an international team of experts to conduct an external outbreak response assessment.

Polio Legacy: Based on 14 years of experience, CGPP Ethiopia has been expanding its donor base through additional grants and is developing a comprehensive polio legacy plan which focuses on mainstreaming essential polio functions (immunization, disease surveillance and response) into ongoing/secured project; documenting and sharing lessons learned; and transitioning assets and infrastructure.

FUTURE PLANS

- Strengthen Mobile device and web based data collection and reporting systems
- Strengthen Routine Immunization
- Strengthen and work with the new Health Development Army system
- Strengthen cross border activities

Horn of Africa



PARTNERS

Adventist Dev't
& Relief Agency

American Refugee Committee

Catholic Relief Services

International Rescue Committee

Kenyan Red Cross

Somali AID

SECRETARIAT

Bal Ram Bhui

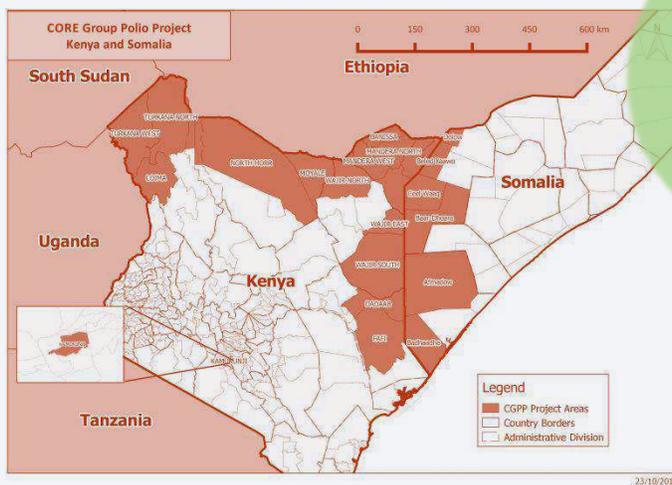
REGIONAL POLIO TEAM LEADER

Mercy Lutukai

PROJECT OFFICER, KENYA

Somane Mohamed

PROJECT OFFICER, SOMALIA

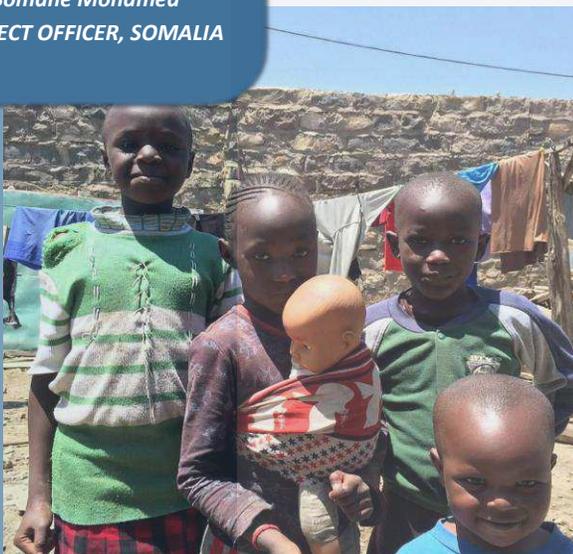


6 Partners

22 Districts

**Nearly 400,000
children under 5**

The CGPP Horn of Africa (HOA) program is the youngest of the CGPP secretariats, established in Nairobi in response to the 2013 outbreak to cover Kenya and Somalia with additional technical support to Ethiopia and South Sudan. The HOA also suffered outbreaks in 2006, 2009 and 2011 and continues to be vulnerable to outbreaks due to the porous nature of the country borders and the fluid movement of people across borders that often split ethnic and tribal groups. Nomadic populations are also very prevalent in the area. Political instability in Somalia and South Sudan further complicate the situation creating large numbers of refugees and internally displaced persons (IDPs) and denying access to significant portions of Somalia and South Sudan.



[Visit the CGPP Horn of Africa webpage!](#)

On a positive note, Nairobi is an ideal place for a regional office due to its proximity and access to numerous countries in the region and the large number of other agencies such as WHO and UNICEF who have offices there.

While the health infrastructure including immunization services are fairly reliable in much of Kenya, the counties bordering Somalia are host to a large population of IDPs, nomads, and ethnic Somalis with very low immunization coverage. Within Somalia the formal health system is almost entirely dysfunctional and has been largely replaced by an ad hoc private system which relies on private dispensaries, clinics, and health care workers to provide health services and vaccination for a fee. NGOs also provide health services including immunization in accessible parts of the country. The situation is further complicated by bans on polio vaccination by the Islamic insurgency group known as Al Shebab in parts of southern Somalia.

To address this situation, CGPP has given sub-grants to seven local and international NGOs to work primarily in border counties on both sides of the Kenya/Somalia border. CGPP has also opened a regional HOA Secretariat office in Nairobi housed by CRS to manage the HOA sub-grants, provide technical assistance to polio eradication, and represent CGPP in regional and country meetings.

1

Build effective partnerships

CGPP coordinates polio eradication activities in Kenya and Somalia through a secretariat office in Nairobi and sub-grants covering six counties in Kenya and six counties in Somalia. The implementing partners in Kenya are IRC, The Kenyan Red Cross, Adventist Development and Relief Association (ADRA), and CRS. The implementing partners in Somalia are the American Refugee Committee (ARC) and Somali Aid, a local NGO. The project covers the Kenyan border counties of Turkana, Marsabit, Wajir, Garissa, and Mandera and also Nairobi. In Somalia the project targets six districts along the border with Kenya in Gedo and Lower Juba regions. The districts are Doolow, Belet Xaawo, El Waq, Baardheere, Afmadow and Badhaadhe.

The NGO partners meet on a monthly basis to coordinate activities, learn about new policies and share ideas and concerns. The Secretariat Team Leader coordinates these meetings and also supports the implementing partners through numerous field visits. The Secretariat also coordinates very closely with the MOH, WHO, UNICEF, Rotary, the CDC, the BMGF, and USAID participating in various regional and country specific meetings on polio eradication, routine immunization, campaigns, and surveillance.

CGPP Kenya Project Beneficiaries, 2015

County	Pop.	Sub-county	Border Health Facilities **	Project Sub Counties Population			
				Total Pop.	Under 1	Under 5	Under 15
Nairobi	3,994,003	Kamukunji	5	269,787	10,252	44,434	109,830
Garissa	660,932	Dadaab, Fafi & Hulugho	9	267,135	8,985	44,037	109,569
Marsabit	343,636	Moyale & North Horr	12	211,251	6,961	53,428	95,126
Turkana	1,256,150	Loima, Turkana & W. Kibish	19	625,021	13,635	83,870	312,072
Wajir	800,577	Wajir E., Wajir N. & Wajir S.	20	457,345	14,667	65,671	219,526
Mandera*	265,724	Lafey, Mandera E. & Mandera S.	14	132,862	6,643	22,586.54	55,802.04
Total	7,321,022		79	1,963,401	61,143	314,027	901,925
* Mandera population to be verified.							
** Kamukunji is not a border area, rather a sub county in capital Nairobi							

CGPP Somalia Project Beneficiaries, 2015

Region	Districts	Total Pop.	Under 1	Under 5	Under 15	Implementing partner
Gedo	Dolo	50,000	2,000	8,500	21,000	Somali Aid
	Beled-xawo	105,041	4,202	17,857	44,117	Somali Aid
	Elwak	77,600	3,104	13,192	32,592	Somali Aid
	Bardera (Fafadhun)	22,941	918	3,900	9,635	Somali Aid
Lower Juba	Afmadow	157,865	6,315	26,837	66,303	ARC
	Badade	67,676	2,707	11,505	28,424	ARC
	Total	481,124	19,245	81,791	202,072	

CGPP works closely with the Kenyan Ministry of Health Disease Surveillance and Response Unit (DRSU) for SIA planning and APF surveillance and the unit of vaccine and immunization services (UVIS) for routine immunization. CGPP is a member of the IPV and M&E subcommittees in UVIS who are preparing for the b-OPV to t-OPV switch and IPV introduction. CGPP is an active member of the HOA polio coordination group which meets to share information, plan activities, and coordinate collaboration between the MOH, UNICEF, WHO and others.

The CGPP hosted a meeting on IEC materials for use in campaigns, AFP surveillance, Routine Immunization, and cross border communities with participation by NGOs, the MOH, WHO and UNICEF. CGPP India's Communications expert, Rina Dey, designed a Community Health Workers Immunization Flipbook and helped train staff. CGPP participated in the preparation of country presentations for the HOA Polio Technical Advisory Group (TAG) meetings in February and August 2015.

The Secretariat conducted a joint meeting of CGPP Implementing Partner NGOs, the MOH, WHO, UNICEF and other stakeholders to present project's activities. The meeting provided a forum for partners to learn each other's roles, activities and project areas, and to coordinate at the regional, national, county and sub county levels to avoid duplication of effort and maximise existing structures.

2

Support PVO/NGO efforts to strengthen national and regional immunization systems

CGPP conducted a 30 cluster coverage survey in target counties in Kenya in July 2015. Based on card plus recall for children 12 to 23 months of age, the survey found 36% of children fully vaccinated, 89% had BCG, 77% had measles, 76% had Penta3, 64% had OPV0 and 57% had OPV3. CGPP has been assisting the MOH in the development of routine immunization micro-planning tool and participating in national and sub-national immunization meetings. Partner NGOs have been training health workers and community volunteers on immunization and cold chain maintenance.

CGPP-CRS trained 30 service providers and seven county health managers in Nairobi on EPI service delivery, monitoring of vaccines, and reporting. CGPP partner NGOs supported the repair of vaccine refrigerators and supported outreach vaccination to the refugee population in Kakuma refugee camp. CGPP-IRC advocated with the county government to add four outreach vaccination sessions per quarter per sub-county targeting hard to reach nomadic populations. IRC participated in Routine Immunizations (RI) supervision in Loima and Turkana West sub counties and Kakuma refugee camp. IRC trained 10 CHEWS and 190 CHVs from Loima, Kibish and Turkana West Sub-Counties on SIAs and routine immunization. CGPP-KRCS organised a planning and review meeting at Moyale, Marsabit Hospital in September to discuss routine immunization in the hard to reach and mobile populations.

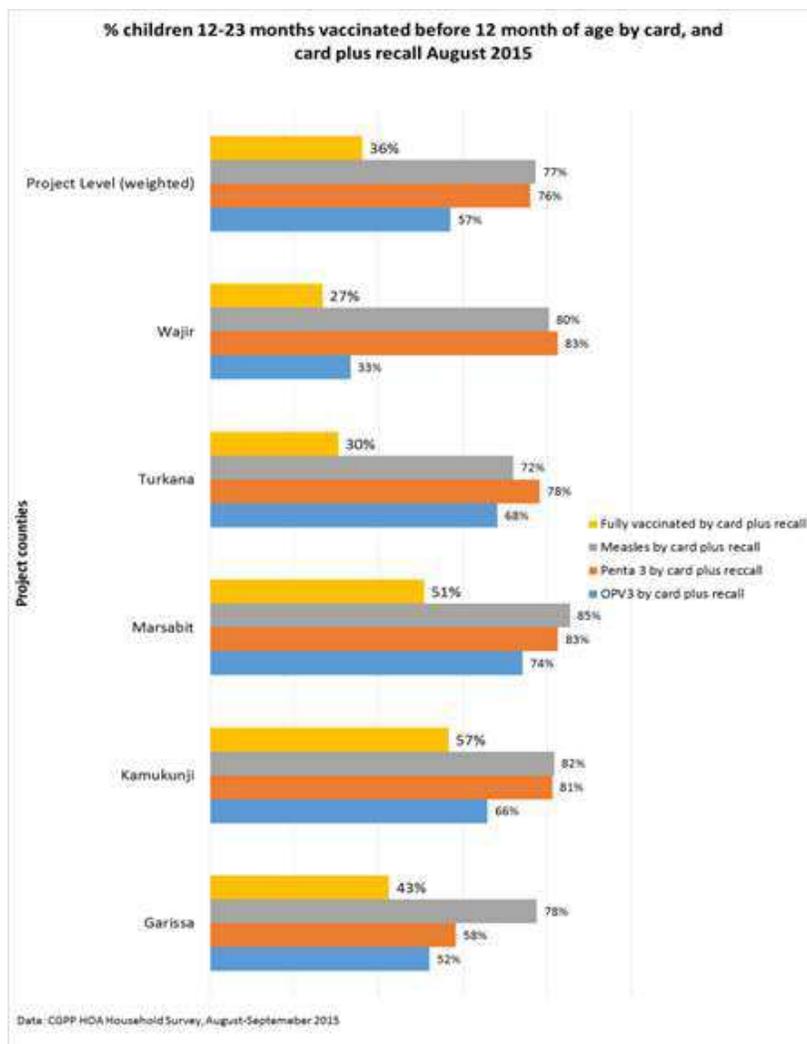
3

Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunization

Kenya conducted a national SIA in August covering 6.1 million children under five and a sub-national SIA in September covering 1.9 million children under five in 32 counties. Based on independent monitoring data, all of the CGPP target counties achieved coverage over 90%. The CGPP 30 cluster survey also found campaign coverage above 95% with the exception of Kamukunji. CGPP is a member of the national SIA steering committee and working groups on operations, training, monitoring and evaluation. CGPP partner NGOs provided logistical support to the campaigns including transportation, training, extra teams, and support to vaccination teams.

CGPP-CRS provided Kamukunji with 5 megaphones, 100 gumboots, 20 thermometers, 50 torches and 100 umbrellas, and additional funds for extra teams to reach special populations and hard to reach areas.

Partner NGO community volunteers provided important social mobilization for the SIAs and were mentioned in independent monitoring as the most common source of knowledge about the campaign. CGPP also helped to update the border micro-plans and taught staff how to use them.



CGPP trained 15 MOH and 8 NGO staff on Health facility SIA micro-planning at the national, County, sub-county, and facility levels who then trained health facility workers in Nairobi, Wajir, Garissa, Turkana and Marsabit Counties.

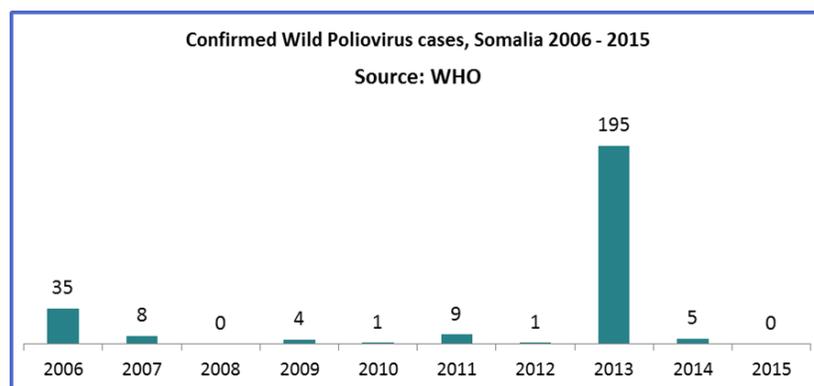
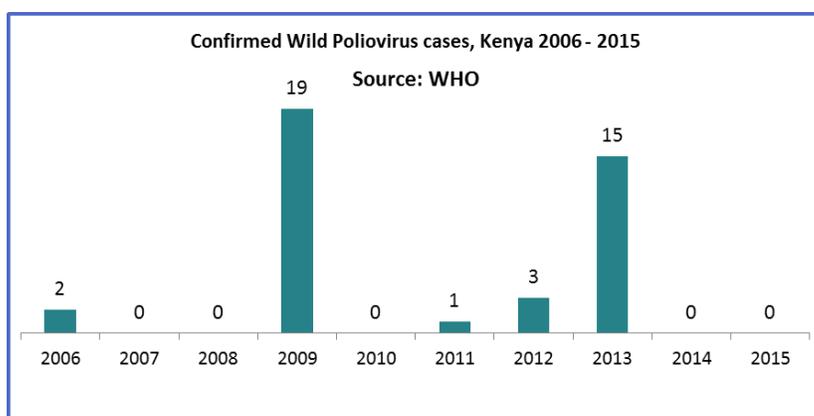
Health facilities trained on health facility SIAs micro plan

County	Border sub county	Border health facilities	CGPP Partner
Turkana	Kibish (7), Turkana West(6) & Loima (3)	16 health facilities	International Refugee Committee (IRC)
Marsabit	Moyale (14) & North Horr (3)	17 health facilities	Kenya Red Cross (KRC)
Wajir	Wajir East (5), Wajir North (8) & Wajir South (7)	20 health facilities	Kenya Red Cross (KRC)
Garissa	Dadaab (3), Hulugho (3), Fafi (3)	9 health facilities	Kenya Red Cross (KRC)
Nairobi	Kamukunji	5 health Facilities	Catholic Relief Services

One percent of children vaccinated were zero dose children in both rounds, receiving polio vaccination for the very first time. The proportion of zero dose children in Mandera went down from 3% to 1% and in Turkana from 2% to 1%. Some of the major reasons children were not vaccinated was that children were not at home, vaccinators did not visit the house, and parents refused. This indicates that the use of extra teams to cover children not at home might not have worked as hoped, some teams might not have been diligent in visiting every house and that some parents have a negative view of the campaigns.

4

Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection



As of week 44, Kenya reported 525 non polio AFP cases against the expected annual number of 364, which translates into a national non-polio AFP rate of 3 per 100,000 children under age 15 which exceeds the target of 2 per 100,000. Four out of six CGPP target counties exceeded the target NP-AFP rate while rates remained sub-optimal in Marsabit and Wajir counties. The national stool adequacy rate was 83% but only 70% in the six CGPP counties combined. Among the CGPP counties, only Wajir county met the 80% target.

CGPP has a strong record in community based AFP surveillance in Ethiopia and South Sudan and has begun to introduce it in Kenya and Somalia by identifying, recruiting, and

training community health volunteers to search for cases at the community level. Project partners have also conducted training for health facility staff which includes case definition, detection, and reporting.

The Cross Border Initiative

Based on the history of cross border virus spread in past outbreaks, CGPP has dedicated significant time and resources to establishing a cross border initiative which encompasses five sites along the borders between Kenya and Uganda, South Sudan, Ethiopia, and Somalia. CGPP organized six cross border meetings with health officials, WHO, UNICEF, and NGO partners from both sides of the borders to map vaccination sites, share data, synchronize NIDs, map population movements and cross border crossing points, and establish cross border vaccination points.

5

Support timely documentation and use of information to continuously improve the quality of polio eradication

The HOA Secretariat has designed and implemented a project monitoring information system which includes reporting tools based on the project framework and objectives. It includes various forms to record and report project activities including training, meetings, social mobilization, and health facility statistics. Each of the partner NGOs are using these forms to report to the Secretariat which in turn compiles and collates the reports into generalized data to track project progress. CGPP has developed a data management plan to ensure that data flows upwards and downwards (feedback), is properly stored, analysed and used. CGPP uses MS Excel spreadsheets to collect, compile, analyse and present the summary data in a dashboard. As mentioned earlier, CGPP assisted the MOH to develop health facility micro-plans for SIAs and routine immunization. CGPP HOA has also been actively introducing the use of mobile technology using ODK to collect and store real time data from the field.

CGPP conducted a health information, monitoring and evaluation workshop in Kenya in February for all of the CGPP country teams. Two representatives responsible for data collection and M&E from each country presented their health information systems (HIS) and the group discussed the best options for developing and implementing a global more standardized reporting system.

Surveys

- CGPP HOA conducted 30 cluster surveys in five project counties
- Implementing partner-IRC conducted two post SIA Lot's Quality Assessment Surveys (LQAS) in August and September 2015, in Turkana County to measure polio campaign coverage.
- In November 2014, CGPP participated in an LQAS pilot application using Open Data Kit (ODK) software for post campaign evaluation in South Sudan.
- An independent consultant hired by CGPP Global visited Kenya in August to conduct a qualitative assessment of polio eradication in Kenya and Somalia.

Papers and Presentations

- 1) CORE Group spring meeting presentation on '*Reaching Border Populations for Polio Eradication*'
- 2) American Public Health Association (APHA) presentation on The Cross Border Initiative for Polio Eradication – Operationalization and Strengthening.
<https://apha.confex.com/apha/143am/webprogram/Paper326771.html>
- 3) CORE Group HOA is featured in <http://www.coregroup.org/our-technical-work/initiatives/polio/471-horn-of-africa>

- 4) Co-authored articles on The Cross Border Initiative in the HOA and Community Based Surveillance with WHO published in WHO African Health Monitor, 2014
https://www.who.int/sites/default/files/ahm/issues/2456/ahm192_0.pdf
- 5) CORE Group HOA is featured in a paper submitted by Whitney Isenhower, CORE Group Inc. to USAID Collaborate, Learn and Adapt case competition <http://usaidelearninglab.org/cla-case-competition>
- 6) Presentation on the Cross Border Initiative Model to a Regional Meeting of Challenge TB in Nairobi in July.

6

Support PVO/NGO participation in national and/or regional polio eradication certification activities

CGPP participated in a WHO polio outbreak response assessments in Ethiopia in November 2014 and June 2015. CGPP participated in the outbreak assessments for Somalia and Kenya in June and contributed a section on cross border eradication work for the Kenya outbreak response report.





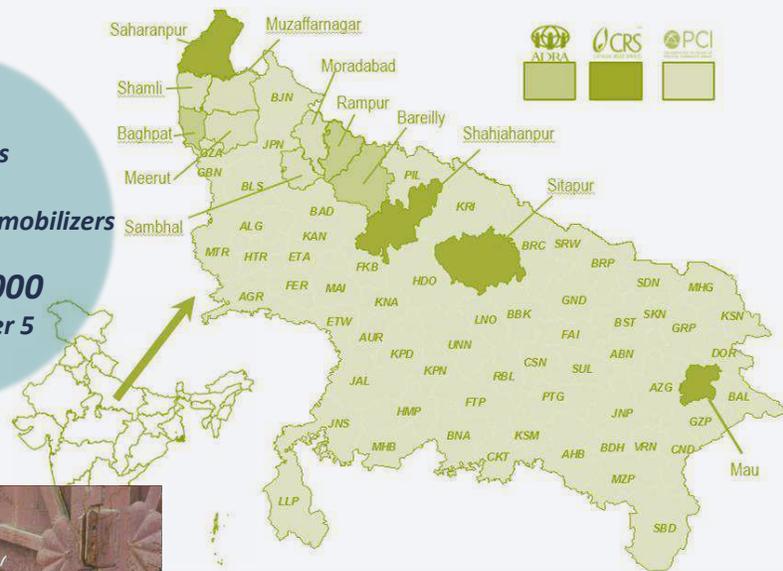
India

PARTNERS

- Adarsh Seva Samiti
- Adventist Dev't & Relief Agency
- Catholic Relief Services
- Gorakhpur Environmental Society
- Holy Cross Welfare Trust
- Innovative Approach for Social Dev't Society
- Jan Kalyan Samiti
- Jeevan Jyoti Community Center
- Mahila Jagriti Sewa
- Malik Social Welfare Society Rampur
- Meerut Seva Samaj
- PCI
- Sarathi Dev't Foundation

India, long expected to be the last country in the world to eradicate polio, registered the last case of wild polio virus in January 2011, and the South-East Asia Region was declared polio free on March 27th, 2014. Now, nearly five years since the last case, India continues to maintain high levels of population immunity through a reduced number of high quality NIDs and SNIDs, improved routine immunization, and solid AFP surveillance. The lessons and tools that the CGPP India team developed in their struggle to defeat polio in India are now being used to support programs in Africa and the remaining two endemic countries, Pakistan and Afghanistan.

12 Districts
1,183 Community mobilizers
Nearly 400,000 children under 5



SECRETARIAT

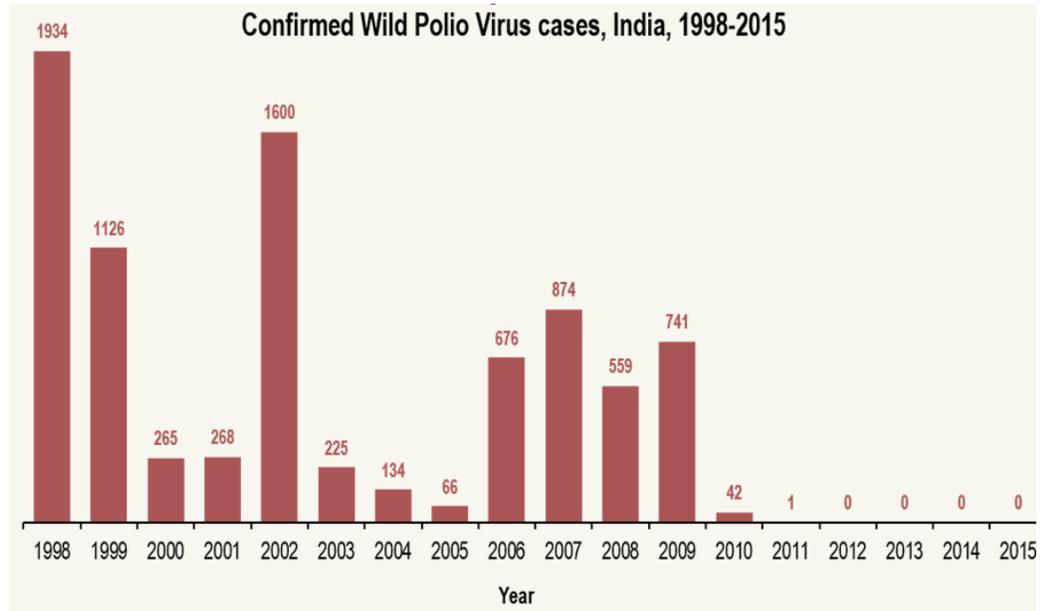
- Roma Solomon
DIRECTOR
- Jitendra Awale
DEPUTY DIRECTOR
- Manojkumar Choudhary
M&E SPECIALIST
- Rina Dey
BCC SPECIALIST

Visit the CGPP India webpage!



Despite these tremendous accomplishments, the continued circulation of wild polio virus in neighboring Pakistan poses a threat to India’s polio free status. There are numerous daily flights and buses entering India from Pakistan which could easily import the virus back into India if immunity levels were allowed to drop. India conducted two NIDs and three SNIDs in fiscal year 2015, down from a peak of ten a year prior to the interruption of WPV circulation. The reduced number of SIAs places a greater burden on the routine immunization system and requires continued high quality surveillance to ensure that children are protected and potential outbreaks are promptly identified.

CGPP India has begun work on legacy planning including discussions on incorporating the community mobilizers into the government system, documenting best practices, inventorying resources, and considering alternative sources of funding and other diseases to focus on.



1

Build effective partnerships

CGPP India is working with an experienced consortium of three international NGOs; ADRA, CRS, and PCI and ten local NGOs in 58 high risk blocks of 12 districts of U.P with high population density and poor sanitation. The backbone of the project is a cadre of 1,183 trained and experienced CMCs (Community Mobilization Coordinators) who conduct an array social mobilization activities including new born and pregnant woman tracking, defaulter tracing, and health education. The Secretariat and partners have developed strong working relationships with WHO, UNICEF, Rotary and the MOH and they meet often to discuss and plan implementation strategies. In addition to monthly partner meetings of the consortium members, CGPP conducted various longer retreats, workshops and meetings to build the capacity of project staff at various levels and provide opportunities to share ideas and concerns. The Secretariat and partners also participated in numerous meetings organized by the government, donors, and spearheading partners.

Secretariat partners in India, FY15

International PVO Partner	Local NGO Partner	Work Districts
ADRA	Innovative Approach for Social Development Society (IASDS)	Baghpat
	Malik Social Welfare Society Rampur (MSWS)	Rampur
	ADRA India	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	Meerut Seva Samaj	Saharanpur
	Sarathi Development Foundation	Shahjahanpur & Sitapur
	Holy Cross Welfare Trust	Sitapur
	Gorakhpur Environmental Action Group	Mau

Meetings and Trainings

The India Expert Advisory Group on Polio (IEAG) met in March and found that; 1) both quality supplementary immunization and enhanced routine immunization are needed to maintain high population immunity, 2) the national AFP surveillance system is adequate to detect outbreaks, 3) the emergency response system is adequate to mount a rapid and effective response, 4) the Government of India should follow global guidelines for the tOPV to bOPV switch and IPV introduction, and 5) that a polio legacy planning process should be initiated.

India's Immunization Action Group (IAG) (ICC) attended by the Secretariat Director

Strategic Advisory Group of Experts (SAGE) on immunization, Geneva-14-16 April 2015

WHO SEARO, New Delhi: tOPV/bOPV switch Dry Run Briefing at WHO SEARO on 25 May 2015

CGPP – HoA, Monitoring and Evaluation Workshop in Kenya, 5 -8 February 2015

UP State Polio EPRP– Rapid Response Team (RRT) Training, Lucknow, 12 Feb. 2015

UP Polio partner's meeting: two meetings on 13 Feb and 22 May 2015 at Lucknow.

UP Polio partner's meeting 13 Feb 2015

UP Polio Partners Meeting, Hotel Taj Vivanta, Lucknow, 22 May 2015

SRC Review Meeting, 13 Nov. 2014 at CGPP secretariat: one day program review meeting with the three sub-regional coordinators (SRCs).

Tactic workshop: The CGPP secretariat, organized a “Tactic Workshop” in Gurgaon from 16-17 December 2014 to add creative ideas through innovative approaches in social mobilization activities to reach and increase people's participation.

ADRA India Review meeting, Saputara -24-27 May 2015: ADRA India organized a program review meeting on 25th and 26th of May 2015 at Saputara in Gujarat.

Training of 30 Master Trainers: From 2nd to 6th August 2015

Training for interventions & activities: In August the secretariat trained 111 DMCs, DUCs, BMCs and MIS coordinators at Gurgaon.

Rina Dey visited CGPP Ethiopia and Kenya in April to provide technical support in developing BCC strategy and material.

Rina Dey visited Kenya in September to train CGPP staff and help them develop behavior change education materials

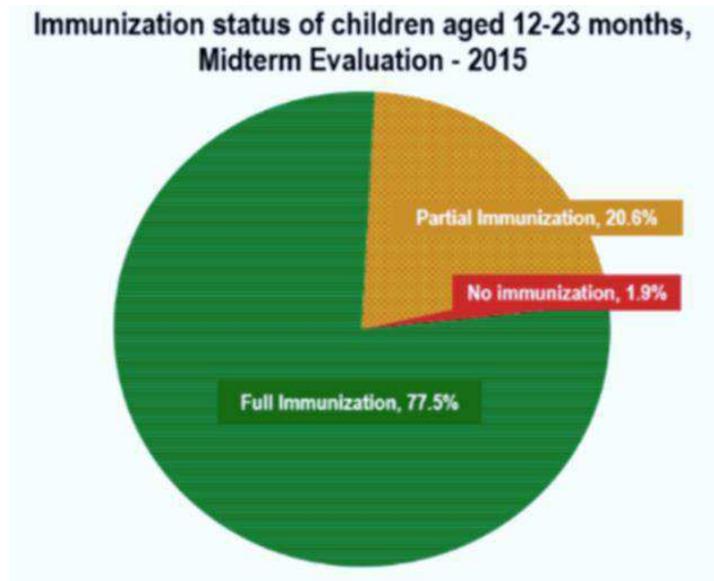
Rina Dey visited Nigeria to train 69 NGO staff on Behavior Change Communication and materials

Manojkumar visited CGPP Nigeria to assist them in the implementation of a midterm evaluation and the development of a health information system

2

Support PVO/NGO efforts to strengthen national and regional immunization systems

The project has made very substantial gains in routine immunization. OPV3 rates have increased from barely above 50% five years ago to 87% in project areas in 2015, birth dose has increased from 53% in 2013 to 76%, and 87% of survey respondents had 8 or more doses of OPV. The percentage of fully immunized children 12-23 months old also increased 10% to 82% in the 2015 survey. These gains are extremely important in light of the significant reduction in SIAs. CGPP's primary impact on routine immunization is through 1,183 Community Mobilizers (CMCs) who promote immunization in 543,637 households. Each CMC covers approximately 500 households, tracking the immunization of children in registers to ensure that all of their target children receive all of their required vaccinations. The CMCs also track pregnant women, newborns, and defaulters to encourage them to start and complete the full series of recommended vaccinations.



In addition to the intensive CMC interventions, CGPP Teams are actively participating in various forums and meetings at the national, state, district and sub-district levels such as the IAG, State Task Force on RI, Task Force on RI. Block Mobilization Coordinators (BMCs) and District Mobilization Coordinators (DMCs) have assisted government medical officers to improve micro plans by regularly updating data about high risk groups such as nomads, slum dwellers, and hard to reach areas.

At the district level, the field staff provide support in improving micro plans, monitoring of routine immunization sessions and during Special Immunization Weeks (SIW). CGPP is also part of the deliberations for the introduction of IPV and the tOPV to bOPV switch. India will introduce a single dose of IPV (Inactivated Polio Vaccine) with DPT3 to all children at the age of three and a half months starting in November 2015. India will withdraw OPV2 in April 2016. Pentavalent vaccine containing 'DPT+Hib+ Hep.B' will also be introduced starting in November 2015.

Special Awareness Campaign: An awareness campaign was launched in September 2015 by PCI and ADRA on RI and diarrhea management. Under this campaign two **Kushi (Happy) Express** (mobile vans) were designed and decorated with pictorial messages on immunization and hand washing. Both of the vans were accompanied by Nukkad Natak (street play) teams.

Hoarding: "Hoarding" in this context is a large display board in public spaces, similar to billboards in the U.S designed to create mass awareness on routine immunization and hand washing, 71 hoardings were installed at public places such as the bus and railway station, PHCs/district hospitals, brick kiln sites, etc.

CGPP supported the government's **Mission Indradhanush (MI)** program to accelerate improvements in RI coverage in 201 districts with very low RI coverage in India. From April to July 2015, four MI rounds (special immunization weeks) were organized.

District Mobilization Coordinators participated in District Task Force (DTF) Meetings and prepared social mobilization plans.

Rina Dey participated in a two-day workshop on 'Immunization Coverage Improvement Plan' for strengthening RI at Lucknow in September 2015.

Community Mobilization Coordinators did special mobilization activities like IPC with families of all eligible children, puppet shows, mother's meetings, mosque announcements, inauguration of sessions, etc. Puppet shows were organized in Moradabad, Sambhal, and Bareilly; in Moradabad, Sambhal and Meerut, E-Ricksha rallies were taken out and in Meerut very large-scale influencers meetings were followed by small corner meetings.

Barrier Analysis study 2015 – CGPP India conducted a formative research study titled "Maintaining High Levels of Immunity against Polio in Children by Unmasking Barriers to Routine Immunization in U.P., India". The study identified key barriers to immunization including the need to involve men and local influencers.

CGPP-facilitated trainings in India, FY15

Training	Participants	Dates	No. of batches	No. of participants		
				Male	Female	Total
Review Meeting	All DMCs, DUCs & SRCs	Dec. 12 – 14,	1	23	3	26
U.P. Polio Partner's Meeting	Representatives of Government of UP, WHO-NPSP, UNICEF, Rotary and CGPP	May 22 nd	1	14	3	17
Training of master trainers	Selected DMCs, DUCs & BMCs	Aug. 2 – 6	1	30	7	37
CGPP Partner's Meeting		Aug. 17 th	1	18	8	26
Interventions & activities for FY15	All SRCs, DMCs, DUCs, MIS Coordinators, BMCs	Aug. 17 – 23	4	80	31	111
			8	165	52	217

3

Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunization

India conducted five rounds of polio campaigns in CGPP target areas in the months of November, January, February, April and June down from a high of ten campaigns per year prior to the interruption of polio. Approximately 5% of houses and 8% of children under five were missed in the SIAs indicating that India is

maintaining high quality campaigns with greater than 90% coverage. Combined with the increased routine coverage and solid surveillance, these numbers are an encouraging sign that the Indian program is on track and maintaining sufficient population immunity to prevent re-importation.

House-to-house vaccination teams in CMC areas visited about 543,974 households in each SIA. The biggest reason for missing houses (81%) was short-term (5%) or long-term (76%) migration. A very small proportion, (0.4%) were missed due to resistance to OPV.

According to the latest midterm evaluation conducted in June 2015, none (0%) of the children aged 12-23 months from CGPP catchment areas were never vaccinated. All the children have received at least one dose of any vaccine either during the SIA campaign or routine immunization.

Key Social Mobilization Activities in India, FY15

# IPC visits		Number of group meetings								Number 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
484365	444963	19696	19211	335	326	2926	2746	22957	22283	518	437	2935	2522	6840	9171

4

Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection

India's AFP surveillance system is highly sensitive, meets certification standards and has the capacity to detect any importation. An Emergency Preparedness and Response Plan (EPRP) is in place to address any poliovirus importation. In addition to the facility based surveillance system developed by the WHO and the MOH, CMCs and polio vaccination teams also search for AFP cases during their house visits for health communication and vaccination rounds.

The non polio AFP rate in the 12 CGPP target districts was 18.9 per 100,000 children under 15 with a stool adequacy rate of 86.8% as of October 2015. India reported five VDPV case in 2013, three in 2014, and one in 2015 from the state of Madhya Pradesh.

5

Support timely documentation and use of information to continuously improve the quality of polio eradication

CGPP India has a very well developed health information system which helps to monitor the project through the collection and collation of data on daily project activities, campaigns, routine immunization, and training. The project collates and analyzes the CMC register data and conducts regular qualitative and quantitative surveys. CGPP India also presented project outcomes and activities at various meetings in FY2015.

Ranbaxy Round Table Consultation, 11 October 2014: The Secretariat Director presented a paper on Civil Society's contribution to India's polio eradication program.

14th World Congress on Public Health at Science Centre, Kolkata from 11-15 February 2015: Manojkumar presented a paper on "*Unsung Heroes of the polio eradication program in Uttar Pradesh, India - Role of influencers in acceptance of polio vaccine: A case of CORE Group Polio Project India*" during the free paper session on 'Immunization'.

Prince Mahidol Award Conference, Bangkok 25 Jan. - 2 Feb 2015: Jitendra presented a poster: '**Reducing inequity by reaching marginalized groups to improve immunization coverage - Lessons from India Polio Eradication Program for health system strengthening and universal coverage.**'

The Global Health Practitioner Conference -CORE Spring meeting:

- **Small Data Add Up: Data for Decision Making on the Ground and in Real Time:** April 14th
 - Moderator: Todd Nitkin, Medical Teams International. Presenter : Dora Curry,CARE; Mark Kabue, Jhpiego; Jitendra Awale, CGPP/India; Henry Perry, JHU.
- **Reaching the Hard-to-Reach: Migrants, Nomads, IDPs, and Border Communities, Lessons from the CORE Group Polio Project:** April 16th ; Moderator: Lee Losey, CGPP.
 - Presenter: Jitendra Awale and Rina Dey, CGPP/India; Bal Ram Bhui, CGPP/Horn of Africa; Anthony Kisanga Lomoro, CGPP/South Sudan.
- **Supporting National Community Health Worker Programs:** April 17th
 - Moderator: Joseph Naimoli, USAID; Presenters: Alfonso Rosales, World Vision US; Megan Christensen, Concern Worldwide; Lee Losey and Rina Dey, CGPP.

Presentations can be accessed at: coregroup.org/polio

Midterm Evaluation 2015: CGPP India conducted a midterm 30 cluster evaluation study through an external agency, the Goa Institute of Management,

6

Support PVO/NGO participation in polio eradication certification activities

Regional certification was completed on 27th March 2014.

CONCLUSION: Challenges, innovations, and future plans

CGPP India has contributed immensely in keeping India polio-free. It has aligned its activities with Global Polio Eradication and the Endgame Strategic Plan and recommendations of the India Expert Advisory Group on Polio. It is fully involved in the country level strategic planning and implementation of the introduction of IPV and the switch from tOPV to bOPV in RI. The program has made tremendous efforts in strengthening the RI system to sustain the gains of polio eradication. Community involvement in the program remained unchanged even after four years without a polio case due to the sustained efforts of the CGPP community mobilisers and the relations they have developed in the community. This rapport with the community and commitment of the community need to be further exploited for other public health programs like TB, sanitation, etc. Legacy planning is one of the objectives of GPEI but it also requires a strong commitment from the government and donors who should utilize polio structures and capacities for other health programs.



Nigeria

The last case of wild polio virus was detected in Nigeria in July 2014 and Nigeria was officially removed from the WHO list of endemic countries on September 25, 2015. It was a long hard battle against formidable odds in a

vast country with a large population and enormous logistical and security challenges. Despite these challenges, CGPP worked in the hardest to reach and most dangerous states to ensure that all of Nigeria's children had access to polio vaccination through repeated SIAs, strengthened routine immunization, hit and run campaigns, IDP vaccination, transit point vaccination, and the use of permanent vaccination teams. At the request of the



EOC, CGPP took on the daunting challenge of working in Borno, Yobe, and Kano, which were not only the final reservoirs of wild polio virus but also home to the Boko Haram terrorist insurgency group adding serious security challenges and personal risk to the project staff.

PARTNERS

- African Healthcare Implementation & Facilitation Foundation
- Archdiocesan Catholic Healthcare Initiative
- Catholic Relief Services
- Community Support & Dev't Initiative
- Family Health & Youth Empowerment
- Federation of Muslim Women Assn. of Nigeria
- Health Care Education & Support Initiative
- International Medical Corps
- Network for Integration & Rural Advancement
- Save the Children
- Waka Rural Dev't Initiative

CORE Group Partners Project - Nigeria Project Areas- Implementing PVOs & NGOs



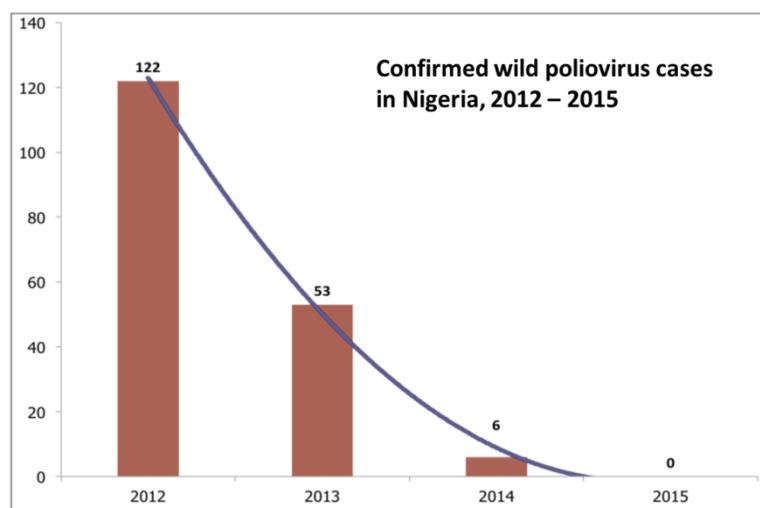
22 Districts
1,500 Community mobilizers
Over 400,000 children under 5 years

SECRETARIAT

- Samuel Usman
DIRECTOR
- Opeyemi Aanuoluwapo
STRATEGIC INFORMATION OFFR.
- Joy Bassej-Popoola
ADMINISTRATIVE OFFICER
- Mohammed Zango
SOCIAL MOBILIZATION OFFICER

CGPP is working with three international NGOs; CRS, Save the Children and IMC and five national NGOs in five states; Kano, Katsina, Kaduna, Borno and Yobe and 25 districts deploying 1,500 community volunteers and an additional 157 volunteer supervisors. The project has contributed significantly to campaign quality through logistical support, supervision, and social mobilization at the community level achieving fewer than 5% children missed in their target areas. Routine immunization coverage continues to be low at only 49% for OPV3 in the 2015 mid-term survey and is currently being targeted through additional USAID mission funding to specifically target routine immunization.

The project and the polio eradication initiative achieved the long unattainable goal of polio interruption through numerous high quality SIAs and now must maintain a high level of surveillance and continued high quality campaigns to ensure that the virus is not reintroduced before Pakistan and Afghanistan stop polio circulation. Boko Haram activity in the North East States of Kano, Yobe, and Borno limit access to some areas although many of the children in these areas are still accessible as IDPs.



1

Build effective partnerships

CGPP continued to work with three International NGOs; Catholic Relief Services (CRS), International Medical Corps (IMC), and Save the Children (SCF) and five local NGOs, DACA, FOMWAN, in five states and 25 local government areas (LGAs).

CGPP Implementing Partners, Nigeria

Partner PVOs and NGOs	Regional State(s)	No. <5 children	No. <1 children	No. VCMs 2014	No. VCMs 2015
Health Care Education & Support Initiative (HESI)	Katsina	38,454	6,025	25	50
Family Health & Youth Empowerment (FAHYE)	Katsina	48,485	6,882	25	50
Community Support & Development Initiative (CSADI)	Kano	83,000	12,500	130	300
Archdiocesan Catholic Healthcare Initiative (DACA)	Kaduna	38,384	5,399	50	100
Waka Rural Development Initiative	Yobe	164,754	8,413	100	250
Federation of Muslim Women Assn. of Nigeria	Yobe		8,110	150	250
Network for Integration & Rural Advancement (NIRA)	Yobe	DNA	DNA	0	0
African Healthcare Implementation & Facilitation Foundation (AHIFF)	Borno	44,656	11,400	167	500
TOTAL		417,733	47,329	647	1,500

As a member of the EOC and the EOC working groups at the state and national levels, the CGPP partner NGOs actively participated in national, state, and district planning and implementation of polio campaigns, surveillance, and routine immunization. The Secretariat worked closely with the MOH, UNICEF, WHO, CDC, Rotary, and the Gates Foundation, meeting at least once a week to discuss polio eradication plans and strategies. CGPP partner NGOs met on a monthly basis to coordinate strategies, communicate national policies, and listen to NGO field and community level perspectives so that they could be shared with the other EOC members who are less engaged at the community level.

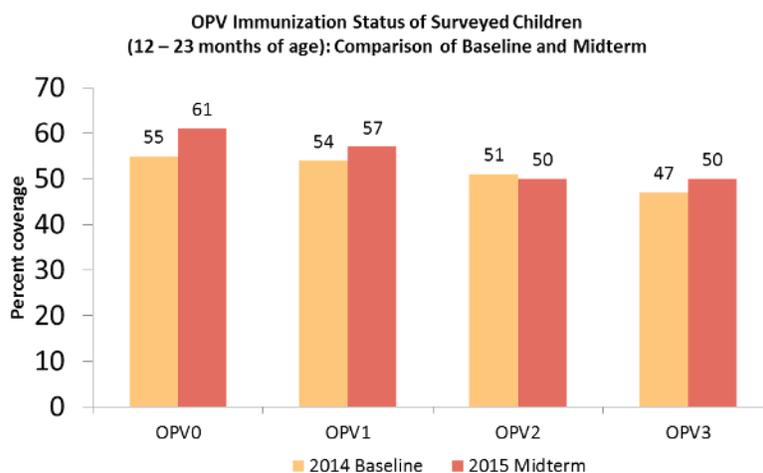
2

Support PVO/NGO efforts to strengthen national and regional immunization systems

Despite Nigeria's impressive success at stopping the transmission of wild polio virus, routine immunization coverage is still far too low to maintain sufficient population immunity without supplemental immunization activities. OPV3 rates measured through 30-cluster surveys in CGPP target areas remained roughly constant from baseline (47%) in 2014 to mid-term (49%) in 2015. The percentage of children fully immunized increased from 33% at baseline to 41% at mid-term but there is still a great deal of work to be done to bring these rates above the 80% herd immunity threshold. The percentage of children one year and older with seven or more doses of OPV increased from 52% at baseline to 65% at mid-term which is largely due to numerous increasingly high quality SIAs.

USAID Nigeria has recently awarded CGPP a grant to focus specifically on routine immunization in Borno, Yobe, Kano, and Katsina through a cadre of 1,455 community volunteers who conduct house-to-house visits, compound meetings to address Non-compliance, health talks, referrals, and outreach vaccination activities. CGPP has also trained field personnel on Behaviour Change Communication (BCC), Interpersonal Communication Skills (IPC) and Social Mobilization, distributed IEC materials, supervised field workers, and provided logistical support to cold chain operations and vaccine delivery.

In the coming months, CGPP plans to analyze existing data and conduct a barrier analysis to determine the reasons for the low routine immunization rates and develop a more targeted approach to raise the rates by ensuring that families have both access to vaccination services and a sense of demand motivated by improved behaviour change communication.



OPV0, OPV1, and OPV3 all showed moderate increases from baseline in 2014 to mid-term in 2015 while OPV2 showed a moderate decrease.

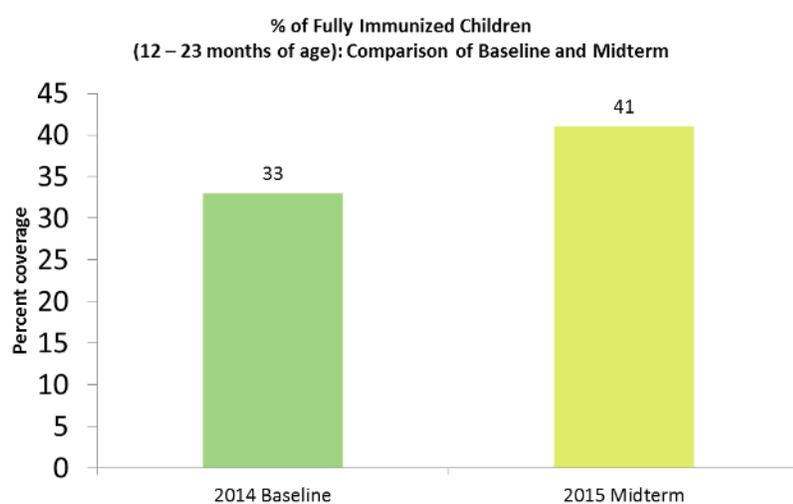
In addition, the program conducted several trainings to boost the capacity of both NGO and CBO staff on the field (LGAs, VWS and VCMs). A summary of these trainings is shown in the table below.

Trainings conducted in Nigeria, FY15

Type of Training	Number of Participants
M&E Training on use of VCM Register	174
M&E Training on Smartphone (ODK)	174
Training on BCC Tools	2,252
Community AFP Case Detection	1,249
Grand total	3,849

Social mobilization tools deployed in Nigeria, FY15

		M&E Tools		BCC Tools							
s/n	States	VCM Register	Smart phones	Streamers	Danglers	Flip book	Bags	Leaflets	T-shirts	Hijabs	Wrist Bands
1	Kaduna	101	10	150	325	100	100	1200	25	110	146
2	Kano	301	30	200	450	300	300	2500	38	310	374
3	Katsina	101	10	150	325	100	100	1200	55	160	147
4	Yobe	501	100	250	450	500	250	2600	45	530	598
5	Borno	501	57	250	450	500	250	2500	30	544	589



Source: CGPP Baseline and Midterm Evaluations

The percentage of fully immunized children 12 to 23 months of age increased from 33.2% at baseline to 41.2% at mid-term. This increase was also found at the state level with the exception of Yobe which registered a decrease in fully immunized children.

3

Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunization

CGPP community volunteers used newly developed behavior change communication tools to reduce resistance to vaccination and increase awareness of the program. This is exemplified by VCMs in Kaduna who used advocacy and BCC tools to negotiate the vaccination of 243 pupils in an Islamic School in 1 day.

Based on independent campaign monitoring data, the percentage of children missed in CGPP target areas



went from an already low 5% in September 2014 to a very impressive 3% in September 2015. CGPP VCMs conducted house-house Social Mobilization, and sensitization and awareness raising activities to reduce the number of children missed in campaigns and raise the quality of the Nigerian SIAs which was instrumental in the interruption of polio transmission in Nigeria. CGPP supported Directly Observed Polio Vaccination (DOPV) to vaccinate children absent from the home which is one of the main reasons for missed children. Teams vaccinated children in the streets, playgrounds, schools, churches, mosques etc. where children usually cluster.

4

Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection

Now that Nigeria is polio free, the ability to identify and rapidly respond to an outbreak is critically important. Nigeria needs to not only maintain certification levels of AFP surveillance but also develop robust outbreak response plans. To bolster community based surveillance, CGPP supported the deployment of over 2,000 community informants across CGPP's 25 target LGAs in five focal states. This includes Traditional Birth Attendants (TBAs), Patent Medicine Vendors (PMVs) and Traditional Bone Setters who serve as informants when a child suffering paralysis is brought to them since in most cases, they are the first point of contact. This has resulted in an increase in the Non-polio AFP rate (NPAFPR) from 13.6 in September, 2014 to 17.3 in September, 2015. The stool adequacy rate also remained high at 97% in September, 2014 and 98% in September, 2015.

National AFP surveillance indicators: comparison of 2014 and 2015

	Sept. 2014	Sept. 2015
Non-Polio AFP rate of at least 2 per 100,000 in children under 15	13.6	17.3
% of NPAFP cases with 2 stool samples within 14 days of onset of AFP	97	98

National EOC surveillance update, 2014 and 2015

5

Support timely documentation and use of information to continuously improve the quality of polio eradication

CGPP conducted a review of its M&E processes and also conducted a Mid-term Evaluation using smart phone technology. CGPP Nigeria recruited an experienced M&E specialist and invited CGPP India's M&E expert, Manoj Choudhary, to visit Nigeria to assist the team in the development of a national project health information system. Two Nigeria team members also participated in a week long work shop in Kenya on M&E and health information systems.

CGPP Nigeria worked with the national EOC to publish an article ***“Mass immunization with inactivated polio vaccine in conflict zones – Experience from Borno and Yobe States, North-Eastern Nigeria”*** in the Journal of Public Health Policy (Journal of Public Health Policy advance online publication, 5 November 2015). This article details the successes, challenges and lessons learnt in the largest IPV roll-out ever implemented in Africa. This roll-out was carried out with CGPP support in the insecure Northeast Nigerian states of Borno and Yobe which are known as the strongholds of the Boko Haram insurgency.

CGPP Nigeria's Secretariat Director presented two abstracts at the 143rd American Public Health Association (APHA) meeting in Chicago; a Roundtable on the ***“Use of Mobile Phone Technology for Improved Quality of Reporting”*** and a poster presentation on the ***“Role of GIS Mapping in Improving Quality of Immunization Program Delivery”***.

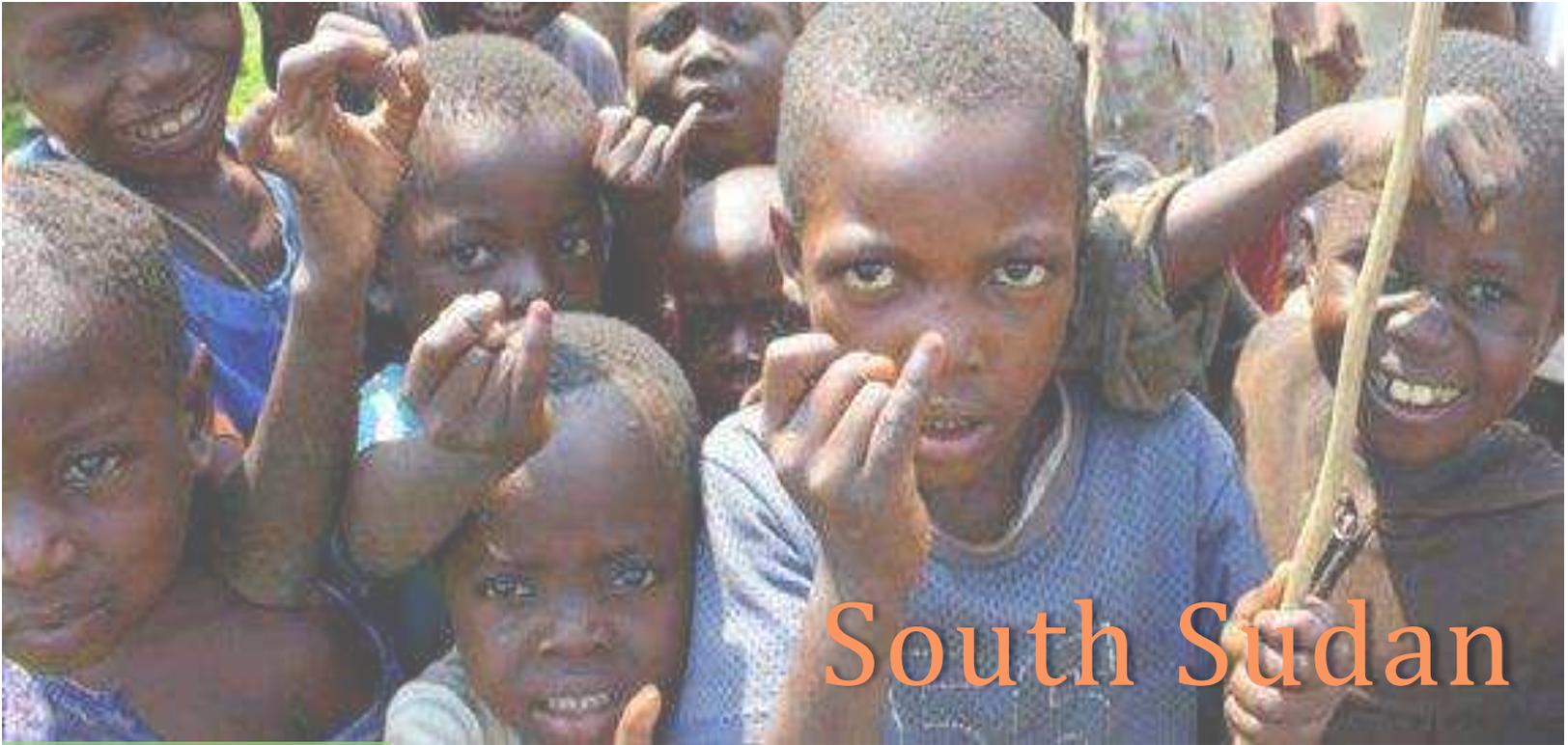
6

Support PVO/NGO participation in national and/or regional polio eradication certification activities

The CGPP Secretariat Director is a member of the EOC Legacy Planning Working Group which is currently mapping all of the government and partner assets working on polio eradication. The central theme of the legacy planning process is to utilize the polio infrastructure to address other pressing health care needs. This is exemplified by the use of polio structures to stamp out Ebola from Nigeria. One of the guiding principles of the transition planning is ***“Under the leadership of the national government, a BROAD RANGE OF STAKEHOLDERS must be involved in the polio legacy planning process at the country level, including donors and civil society.”*** CGPP represents the voice of civil society in the implementation of the legacy planning for the Nigeria polio program. CGPP has mapped and estimated the cost of all its polio assets including human resources, physical assets, intellectual assets and other resources deployed by CGPP to support Nigeria's polio eradication initiative (PEI).

CONCLUSION

CGPP has become an integral part of the successful Nigeria Polio Eradication program contributing meaningfully to campaign quality and community based AFP surveillance. CGPP's plans to increase the number of VCMs in Borno and Yobe States and increase support to routine immunization through cold chain and logistical inputs, outreach, supervision and training. CGPP also plans to actively support advocacy on polio at the community and national levels.



South Sudan

PARTNERS

American Refugee Committee

Bio Aid

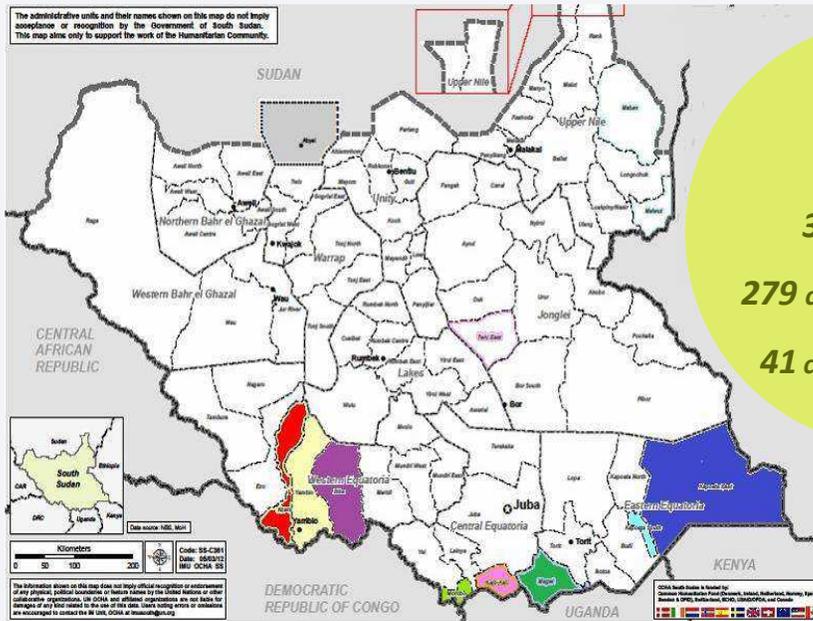
AMREF Health Africa

World Vision

SECRETARIAT

Anthony Kisanga
DIRECTOR

Anthony Laki
M&E OFFICER

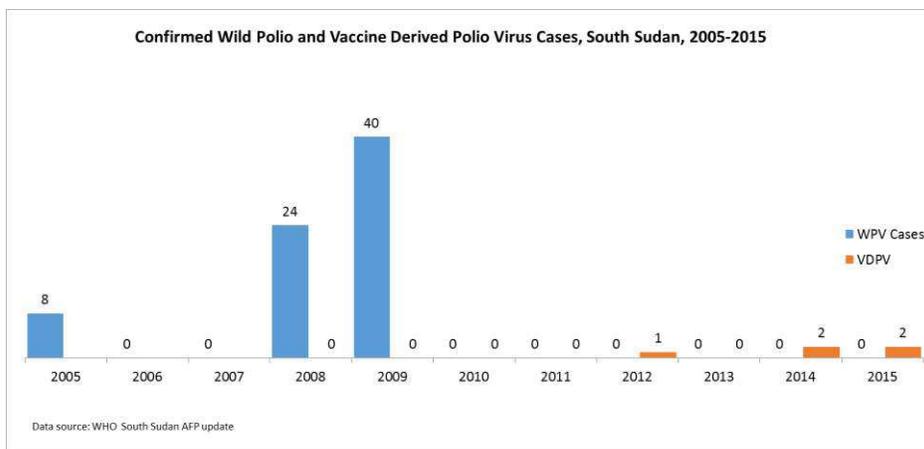


Despite numerous contributions by civil society to build and improve South Sudan's weak health system in recent years, the outbreak of fighting in late 2013 and the ensuing humanitarian crisis have created a perilous situation. More than 1.5 million internally displaced persons (IDPs) and more than a half million refugees have fled insecurity and violence in Unity, Upper Nile, and Jonglei states; while hundreds of thousands of children remain in the worst-affected areas with little access to health services or vaccination campaigns. The appearance of circulating vaccine-derived poliovirus (cVDPV) in IDP camps in 2014 and 2015 illustrate the vulnerability of these populations to a polio outbreak.

Visit the CGPP South Sudan webpage!



In response to the 2013 wild polio outbreak in the Horn of Africa and in coordination with the MOH and WHO, CGPP South Sudan consolidated its efforts in eight southern border counties, improving demand and access to vaccination services – routine and supplemental, supporting AFP surveillance efforts at the grassroots level, taking a leadership role in strengthening polio eradication activities along international borders through the CGPP-facilitated Cross-Border Initiative (CBI), and leading and advancing independent monitoring of polio SIAs at the national level.



However, as the landscape in South Sudan evolves so does CGPP South Sudan. As the project focused on quality implementation of its current mandate in FY15, the project also collaborated with donors, the MOH, and WHO to determine where CGPP South Sudan, with its unique strengths, skills and available funding, could make the largest impact to improve the current situation. Based on these discussions, CGPP will focus on two primary areas of contribution in fiscal year 2016 – community-based surveillance and independent campaign monitoring – while also continuing its participation in the Horn of Africa Cross-Border Initiative.

Geographically, CGPP has been requested by the South Sudan Technical Committee for Polio Eradication including the MOH, WHO, and UNICEF, to shift project focus from South Sudan’s southern border to the conflict-affected states of Jonglei and Upper Nile to the north. CGPP South Sudan will increase the total number of counties covered from eight to 24.

1

Build effective partnerships

The CORE Group Polio Project secretariat and its implementing partners – AMREF Health Africa, American Refugee Committee (ARC), and World Vision – continued an effective partnership to strengthen routine immunization, community-based surveillance, and polio campaign activities in eight counties along South Sudan’s southern border in FY15.

In April, CGPP forged a new partnership with national NGO, Bio Aid. Through Bio Aid, CGPP established four special vaccination posts in two counties sharing a border with the conflict-affected state of Jonglei. Nearly 7,000 child IDPs (aged 0 – 15 years) were vaccinated with OPV at these special posts between April and September as they travelled from Jonglei and other conflict-affected states into more stable areas.

South Sudan Secretariat Partners and Locations in FY15

	STATE	COUNTY	PARTNER
<i>8 counties implementing full CGPP package in FY15</i>	Central Equatoria	Kajo-Keji	American Refugee Committee
		Morobo	AMREF Health Africa
	Eastern Equatoria	Kapoeta East	American Refugee Committee
		Kapoeta South	
		Magwi	
	Western Equatoria	Ibba	AMREF Health Africa
		Nzara	World Vision
Yambio			
<i>2 counties with special vaccination posts for IDPs</i>	Central Equatoria	Terekeka	Bio AID
	Lakes	Awerial	

CGPP South Sudan is well-integrated into the national Interagency Coordination Committee (ICC) and technical working group, collaborating with WHO, UNICEF and the MOH to coordinate, plan, and implement polio eradication activities at the national and county levels. CGPP South Sudan represents the views of the implementing partners at national ICC meetings and during national Expanded Program on Immunization (EPI) meetings conducted monthly.

Through the project's strong partnership with the MOH, WHO, JSI, and UNICEF, CGPP South Sudan was made the lead civil society organization in the implementation of cross-border activities and polio campaign independent monitoring in 2014.

2

Support PVO/NGO efforts to strengthen national and regional immunization systems

In FY15, CGPP South Sudan continued its time-tested, traditional support of EPI and routine immunization systems in eight project counties while also piloting the establishment of permanent vaccination sites in strategic locations along borders with conflict-affected counties.

EPI support to 8 project counties

CGPP South Sudan supported **118 facility-based vaccinators** and **190 community-based vaccinators** with training, supervision, monthly incentives and transportation assistance such as bicycles and motorbikes. The project also supported **41 cold chain assistants** to ensure reliable vaccine management and supply including temperature checks, stock-out prevention, refrigerator maintenance and record keeping. The project recruited, trained, supervised, and supported **279 community mobilizers** to create greater demand for immunization services, mobilize communities during outreach, refer both pregnant and newborn children to the nearest health facility for vaccination, conduct defaulter tracing, and educate communities on vaccine preventable diseases.

In order to ensure quality vaccination and surveillance services, the project conducted trainings on Immunization in Practice (IIP), Health Management Information Systems (HMIS) to improve data

management and reporting, the introduction of IPV, disease surveillance, cold chain management, social mobilization for demand creation. The workshops targeted health workers, vaccinators, and social mobilizers to provide them a wider understanding of the vaccines and MOH/WHO guidelines.

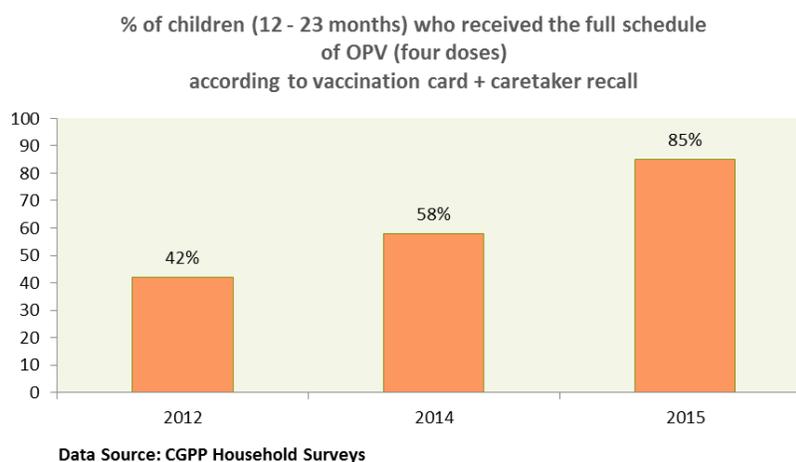
Interstate Vaccination Posts in Central Equatoria and Lakes States

Population movements due to instability, conflict, and nomadism create an ideal environment to spread the wild poliovirus. Mobile populations are usually unvaccinated or under-vaccinated compared to stable populations as opportunities to access vaccination services are low.

To mitigate the risk of virus circulation, CGPP South Sudan established three permanent vaccination posts at major transit points in and out of Jonglei state through local implementing partner, Bio Aid, in FY15. In FY16, CGPP South Sudan will expand the network of permanent vaccination posts, housing permanent vaccination teams, to number 17 interstate and international posts.

Routine Immunization Outcomes

OPV3 coverage improved from 42 percent in 2012 to 58 percent in 2014 and 85 percent in 2015 based on CGPP 30 cluster surveys.



3

Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunization

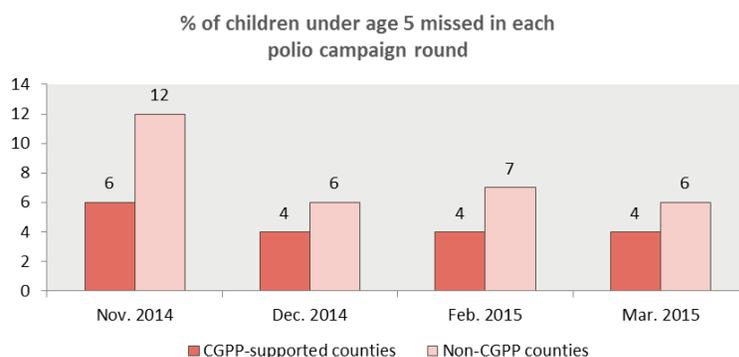
Supplemental Immunization Activities in South Sudan have never been more important. As conflict flares in three northern states (Jonglei, Unity, and Upper Nile), an estimated 120,000 zero-dose children remain isolated in the states' worst-affected areas. Large internal population movements due to political instability, the appearance of circulating vaccine-derived poliovirus in IDP camps in Unity, and the ever-present threat of virus importation across porous international borders make boosting population immunity an urgent priority.

The CORE Group Polio Project conducted independent campaign monitoring throughout the accessible areas of the country in 2015 and provided logistical support and supervision to SIAs in the project's eight target counties. CGPP implementing partners supported all four rounds of National Immunization Days in FY15 in eight counties in three states. The project trained vaccinators, provided fuel to freeze ice packs, transported and distributed vaccine to counties and villages, hired vehicles for supportive supervision, and mobilized communities to participate in the campaigns through the efforts of CGPP community mobilizers.

Missed children under five years of age and missed houses in each SIA

CGPP-supported areas recorded lower percentages of missed children in all four campaign rounds than areas not directly supported by CGPP. Within CGPP-supported counties, the highest percentage of children less than five years of age missed in a polio round was six percent in November.

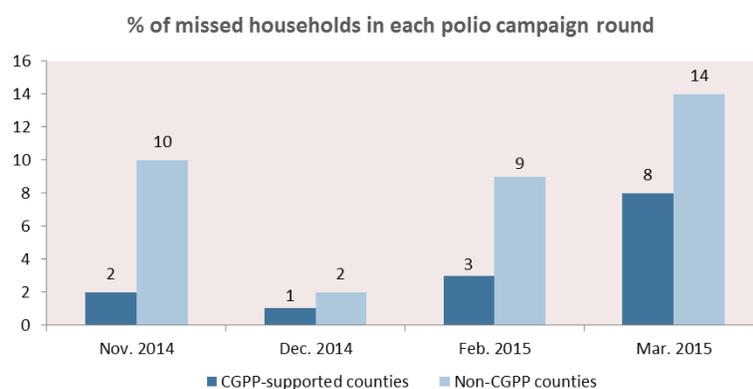
Likewise, counties receiving technical, logistical, and mobilization support for SIAs consistently recorded a smaller percentage of missed households during campaigns than those counties not receiving CGPP support.



Data Source: CGPP Independent Campaign Monitoring Data

Campaign coverage over four years (Caretakers' Recall – Household Survey)

The percentage of children in CGPP areas, aged 12 to 23 months of age, whose caretaker reported they were vaccinated in the most recent polio campaign rose from 82 percent in 2012 to 97 percent in 2015, according to CGPP household surveys. This marks a 15 percentage point increase in three years and puts campaign coverage (according to recall) above the national target of 90 percent.



Data Source: CGPP Independent Campaign Monitoring Data

National Leadership in Independent Campaign Monitoring

In October 2013, the EPI Technical Working Group in South Sudan tasked the CORE Group Polio Project with leading the implementation of national independent campaign monitoring in all 10 states with an objective to monitor the coverage and quality of polio campaigns in a more independent manner. After a small pilot, CGPP expanded ICM to all 79 counties in December, mere weeks before conflict erupted in the north and rendered a large number of counties inaccessible to SIA vaccinators. Since that time, CGPP has implemented ICM during each SIA across all seven 'stable' states. Activities were suspended in the three conflict states since the campaigns were suspended due to conflict and lack of access.

CGPP's Independent Campaign Monitoring Strategy

- Train and deploy central supervisors to each state
- Train county supervisors on ICM
- Identify and train teachers to serve as data collectors
- Provide logistical support and incentives to all monitoring personnel
- Supervise house-to-house and community (markets, schools, mills, water points, churches) data collection
- Enter and analyze data
- Provide independent monitoring results within 15 days of campaign completion
- Advocate for the use of ICM results at the central, county, and payam levels

While in the past central supervisors have collected and transported data to Juba for entry and analysis – a lengthy process, in FY15 CGPP pilot-tested the use of mobile technology to transmit data in real-time, significantly shortening the period stakeholders must wait for ICM results from an average of five weeks to just three days. In FY16, the project will continue to lead ICM and expand the use of mobile technology wherever ICM is conducted nation-wide.

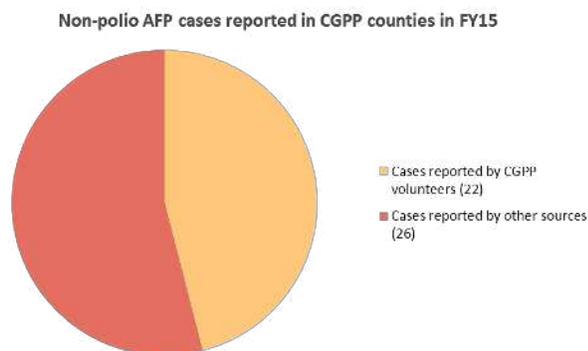
4

Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection

Community-based Surveillance

In FY15, CGPP South Sudan implemented community-based surveillance in the eight project counties through a network of 279 community mobilizers who are based at the boma (village) level. In each boma (village), between one and two community mobilizers work two to three days per week and are supported by the project through training, supervision and monthly performance incentives. The mobilizers provide information on the signs and symptoms of AFP and conduct active case searches of suspected AFP among households and community members likely to have contact with paralysis cases, reporting them to the nearest health facility or their supervisors. They are provided with bicycles to move from house to house. Community-based surveillance strengthens villages' awareness of AFP and their connections to the local health system.

In FY15, a total of 38 suspected AFP cases were reported within the eight counties supported by the project. Out of the 38, community mobilizers reported 24, representing 63 percent of suspected AFP cases that may not have reached health facilities.



CGPP South Sudan transported the stool specimens of suspected AFP cases locally from villages to county headquarters as they were shipped to laboratories for testing and identification. The project also provided local logistical assistance (transportation and communication) to surveillance field officers working with WHO on case investigations, for which adherence to time protocols is critically important.

AFP surveillance outcomes

These efforts combined have resulted in the improvement and maintenance of key surveillance indicators in CGPP-supported counties.

Non-Polio AFP Rates

Both project-supported counties and non-CGPP counties attained national and international targets for non-polio acute flaccid paralysis (NP-AFP) rates – 2 cases per 100,000 children under age 15 – in 2014 and 2015.

The NP-AFP rate in CGPP counties rose from 6.5 cases per 100,000 children under age 15 in 2014 to 7.3 cases in 2015.

Stool Adequacy Rates

CGPP community volunteers consider the timely reporting and investigation of suspected AFP cases a key component of their mission. The stool adequacy rate is defined as the percentage of suspected AFP cases for which two stool samples are collected 24 hours apart, within 14 days of paralysis onset, and arrive at the laboratory in good condition. Both CGPP and non-CGPP counties met the stool adequacy target of greater than or equal to 80 percent of cases.

Support to AFP surveillance in FY16

A surveillance review conducted in mid-2015 showed that roughly half of all counties in the conflict-affected northern states (Jonglei, Upper Nile, and Unity) had been reporting zero non-polio AFP cases, exposing a surveillance system not sensitive enough to detect poliovirus cases. There is also a continued risk of cross-border virus circulation which requires continued vigilance.

In close collaboration with the MOH, UNICEF and WHO, CGPP will place one surveillance officer in 16 counties in the conflict states of Jonglei and Upper Nile and in three southern border counties where CGPP is already working. The community based surveillance officers will supervise active facility and community-based surveillance activities at the county level. A cadre of community surveillance assistants based in each payam will maintain maps of health facilities and community-based informants (including traditional healers, traditional birth attendants, community leaders, pharmacists, faith healers and religious leaders) and schedule and prioritize regular visits based on the probability of receiving an AFP case.

CGPP-Led Cross-Border Initiative (CBI) in the Horn of Africa

CGPP has taken a lead role in planning, organizing and implementing cross-border coordination meetings with neighboring countries to synchronize immunization activities and ensure that border areas are protected from virus importation via mobile and nomadic populations, refugees and returning South Sudanese.

CGPP South Sudan collaborated with the MOH and WHO to coordinate two cross-border meetings in FY15. Resolutions include the appointment of cross-border focal persons, formation of cross-border health committees, follow up cross-border meetings, information sharing between neighboring counties/districts, establishment of cross-border vaccination teams at busy crossing points during NIDs, creation of permanent border vaccination posts, and social mapping of border districts.

5

Support timely documentation and use of information to continuously improve the quality of polio eradication

Piloting of LQAS for Independent Campaign Monitoring in South Sudan

In continued efforts to improve the accuracy and efficiency of independent campaign monitoring, the CORE Group Polio Project conducted a two-phase pilot in the first quarter of FY15 evaluating the combined use of the clustered Lot Quality Assurance Sampling (LQAS) methodology and mobile technology in Central Equatoria State.

CGPP's ultimate objective in using LQAS and mobile technology is to provide timely evidence-based information to counties with poor ICM outcomes so they can identify issues and implement corrective actions quickly. The use of mHealth and the resulting availability of real-time data reduced the wait time for independent monitoring results from an average of five weeks to just three days.

Midterm Evaluation

CGPP South Sudan conducted a midterm evaluation in May and June to evaluate progress on the project's indicators and document best practices and challenges to inform future programming. The secretariat organized quantitative data collection in the form of a household survey, while an external evaluator conducted qualitative interviews with project stakeholders. Final global results will be released in early 2016.

6

Support PVO/NGO participation in national and/or regional polio eradication certification activities

Transition from tOPV to bOPV

CGPP South Sudan participated in discussions with representatives from the MOH, WHO, UNICEF, JSI and JPHEIGO in September on the transition from tOPV to bOPV, which will begin in April 2016. During these meetings, the group drafted a national transition plan and specified roles and responsibilities at all levels to avoid duplication of effort. Currently, CGPP is tasked with monitoring the volume of tOPV in CGPP-supported counties.

CONCLUSION

Despite numerous challenges including insecurity, diminishing funds for polio eradication, shifting donor priorities, high inflation, and a shortage of basic commodities (e.g. fuel), the project has made tremendous progress in creating networks between implementing partners and the Ministry of Health, strengthening immunization systems, improving access to vaccines among hard-to-reach communities, sustaining satisfactory campaign coverage, and maintaining surveillance levels that meet national and international standards.

The project will shift focus in FY16 from a comprehensive EPI approach to a more focused strategy targeting community-based surveillance, cross-border initiatives, and national independent polio campaign monitoring. The project will establish strong community-based surveillance networks in the currently silent counties of two, conflict-affected states, Upper Nile and Jonglei, while also continuing cross border activities and expanding special permanent vaccination posts in Central and Eastern Equatoria. The project will also scale-up cross-border activities along borders with Ethiopia and Sudan.

