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Annual Report



**Report Period:
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Executive Summary

The Global Polio Eradication Initiative began 2016 with high hopes that we would see the final case of wild polio virus in the world. With only 74 cases in 2015 and the virus limited to only two countries, the goal seemed to be within reach. Ultimately four new cases were identified in a previously inaccessible area of Nigeria and the virus continued to circulate in Pakistan and Afghanistan to produce a year-end total of 37 cases. Nevertheless, the downward trend continued to half of the previous year's total and there is a very real opportunity to see the last case of polio in the first half of 2017.

The CORE Group Polio Project (CGPP) continued to make important contributions to polio eradication through the active engagement of international and national Non-Governmental Organizations/Civil Society organizations (NGOs). CGPP partner NGOs actively supported polio eradication in seven countries in 2016; Angola, Ethiopia, India, Kenya, Nigeria, Somalia, and South Sudan with a focus on community based Acute Flaccid Paralysis (AFP) surveillance, community-focused social mobilization for campaigns and routine immunization, independent campaign monitoring, cross-border planning, campaign micro-planning, vaccine registers and child tracking. CGPP solidified its reputation as a global leader in community focused civil society engagement in polio eradication through the quality of its work and increased profile at local, district, national, regional and global meetings.

Having been one of the first countries to initiate a CORE Group Polio Project in 2000, Angola celebrated five years without a case and graduated from the partnership as a polio free nation in 2016. While CGPP will no longer be working in Angola in FY2017, many of the innovations introduced in Angola by the CGPP such as the use of Community Health Workers to conduct social mobilization for Supplemental Immunization Activities (SIAs) and independent campaign monitoring will continue in other countries. A recent yellow fever outbreak in Angola does, however, cast some doubt on the strength of Angola's immunization system.

As will be elaborated in the country specific sections of this report, CGPP continues to contribute to polio eradication by working through more than 15,000 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, community based AFP surveillance, advocacy, and provides logistical support for both campaign and routine immunization.

Globally, the senior management of the project has greatly raised CORE's profile and credibility through active participation and representation at various global and regional meetings including the Independent Monitoring Board for Polio Eradication (IMB), the Polio Partners Group (PPG) 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). More than ever before, CGPP is known as a productive global partner in polio eradication and a reliable voice for civil society at the country, regional, and global levels. 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.

Acknowledgements

This report was developed with the contributions of many people, starting with the submission of annual reports from approximately 50 implementing partners in seven countries. The Secretariats consolidated the partner reports into country reports. The final global CGPP report was written by Lydia Bologna, the Polio Communications Senior Technical Advisor, and designed & formatted by Rina Dey, Communication Advisor, India with support and guidance from Lee Losey, the Deputy Project Director.

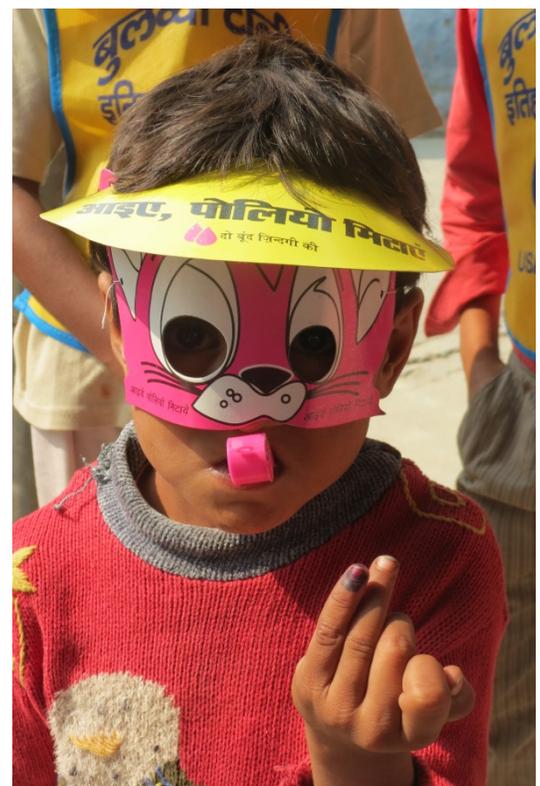


Acronyms & Abbreviations

ADI Addis Declaration of Immunization
ADRA Adventist Development and Relief Association
AFP Acute Flaccid Paralysis
APHA American Public Health Association
AVW African Vaccination Week
BMC Block Mobilization Coordinators
bOPV Bivalent oral polio vaccine
CBHC Cross Border Health Committees
CBI Cross Border Initiative
CBS Community Based Surveillance
CGPP Core Group Polio Project
CHV Community Health Volunteer
CI Community Informant
CMC Community Mobilization Coordinator
CRS Catholic Relief Services
CSIS Center for Strategic and International Studies
CV Community Volunteer
cVDPV Circulating vaccine-derived poliovirus
cVDPV2 Circulating vaccine-derived poliovirus type 2
DMC District Mobilization Coordinator
EOC Emergency Operating Committee
EPI Expanded Program for Immunization
ERC Expert Review Committee
GAVI Global Alliance for Vaccines and Immunization
GPEI Global Polio Eradication Initiative
HDA Health Development Armies
HEW Health Extension Worker
HOA Horn of Africa
IAG Immunization Action Group
IBR In Between Rounds
ICC Interagency Coordinating Committee
ICM Independent Campaign Monitoring
IDP Internally Displaced Person
IMB Independent Monitoring Board
IMC International Medical Corps



IRC International Rescue Committee
LGA Local Government Area
MOH Ministry of Health
NGO Non-Governmental Organizations
NID National Immunization Day
NPAFPR Non Polio Acute Flaccid Paralysis Rate
NPHCDA National Primary Health Care Development Agency
OBR Out Break Response
OPV Oral Polio Vaccine
PCI Project Concern International
PPG Polio Partners Group
RI Routine Immunization
SAGE Strategic Advisory Group of Experts on immunization
SIA Supplementary Immunization Activity
SNID Subnational Immunization Day
SPHCDA State Primary Health Care Development Agency
STC Save the Children
SVP Special Vaccination Post
TAG Technical Advisory Group
tOPV Trivalent oral polio vaccine
UNICEF United Nations Children's Fund
VCM Volunteer Community Mobilizers
VWS Volunteer Ward Supervisors
WHO World Health Organization
WPV Wild Polio Virus
WPV1 Wild poliovirus type 1



Our partners

Angola

1. Africare
2. Catholic Relief Services
3. World Vision
4. The Salvation Army

Local NGOs

1. CARITAS
2. ASSODER

Ethiopia

1. Amref Health Africa
2. CARE
3. Catholic Relief Services
4. International Rescue Committee
5. Save the Children International
6. World Vision
7. Ethiopian Evangelical Church Mekane Yesus
8. Ethiopian Orthodox Church
9. Pastoralist Concern
10. Wabishebele Development Association
11. Organization For Welfare Development In Action

Horn of Africa

Kenya

1. Adventist Development and Relief Association (ADRA)
2. International Rescue Committee (IRC)
3. Catholic Relief Services (CRS)
4. World Vision (WV)

Somalia

1. The American Refugee Committee
2. Somali Aid

South Sudan

1. Nile Hope
2. Community Aid for Development
3. Bio Aid
4. Universal Network for Empowerment Agency
5. Support for Peace and Education Development Program.

India

1. ADRA
2. PCI
3. CRS

Local NGOs

1. Innovative Approach for Social Development Society
2. Malik Social Welfare Society Rampur (MSWS)
3. ADRA India
4. Society for All Round Development (SARD)
5. Adarsh Seva Samiti (ASS)
6. Jan Kalyan Samiti (JKS)
7. Mahila Jagriti Sewa Samiti (MJSS)
8. Meerut Seva Samaj
9. Sarathi Development Foundation
10. Holy Cross Welfare Trust
11. Gorakhpur Environmental Action Group

Nigeria

1. Catholic Relief Services (CRS)
2. International Medical Corps (IMC)
3. Save the Children (STC)

Local NGOs

1. Health Care Education & Support Initiative (HES)
2. Family Health & Youth Empowerment (FAHYE)
3. Community Support & Development Initiative (CSADI)
4. Archdiocesan Catholic Healthcare Initiative (DACA)
5. WAKA Rural Development Initiative
6. Federation of Muslim Women Assn. of Nigeria
7. Network for Integration & Rural Advancement (NIRA)
8. African Healthcare Implementation & Facilitation Foundation (AHIFF)

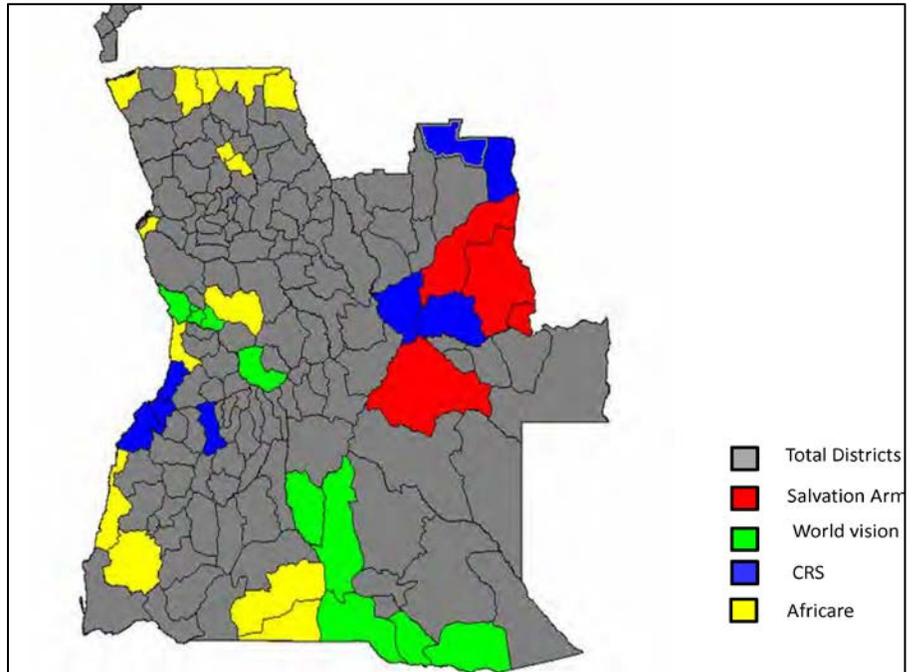
Objectives

1. Build effective partnerships with 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.



Angola

Angola celebrated polio free status during the 2016 project year with its graduation from the Core Group Polio Project. After five years without a case of wild polio virus, Angola received WHO certification in December 2015. In its final year with CGPP, the Angola project focused on legacy planning to transition its essential functions to the Ministry of Health and other partners and documented lessons learned since its inception in 1999. CGPP Angola inventoried critical project assets and



partnered with the Interagency Coordinating Committee (ICC) to train the Angolan military (FAA) to assume independent campaign monitoring. While Angola, has not reported a case of wild polio virus (WPV) since 2011, the major yellow fever outbreak in 2015 highlighted the low level of vaccination coverage in the country. Despite significant oil and diamond resources, the government has historically been reluctant to invest in the public health sector. The poor state of the health infrastructure has further been eroded by the departure of most international NGOs and weak oil prices.

Despite a history of re-importation and persistent challenges to the quality of routine immunization, Supplemental Immunization Activities (SIAs), and disease surveillance, the Angola project has much knowledge to impart. While CGPP will no longer be working in Angola in FY2017, many of the innovations introduced in Angola by the CGPP will continue in other countries; the critical contribution of Community Health Workers to conduct social mobilization for Supplemental Immunization Activities (SIAs) and independent campaign monitoring will be part of Angola's legacy.

Angola conducted its first national census since 1970 in 2014, documenting a population increase from 5.6 million to 24.3 million residents (with a continued upswing to an estimated 25.8 million inhabitants in 2016.) 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 or weakened health services for the poor. Following a decade's long civil war, Angola has been at peace since 2002, which makes access for vaccination campaigns and health services much easier. However, collapsing energy prices and high inflation have negatively impacted the Angolan economy and government spending on social services including education, health and immunization.

No cases of wild polio virus or circulating vaccine derived polio virus were recorded in 2016. However, during the last year of the polio project, Angola wrestled with a massive yellow fever outbreak that resulted in 400 deaths. In response, WHO worked with the MOH, UNICEF, CGPP and other partners to conduct emergency vaccination campaigns to cover 25 million Angolans. CGPP played an important role in supporting the national response to the yellow fever outbreak including planning, implementation and social mobilization by community volunteers who conducted home visits and organized meetings with community leaders to promote vaccination.

In 2016, CGPP Angola worked in 41 high-risk districts in 12 of the 18 provinces reaching 9,422,824 children under the age of fifteen. CGPP-Angola mobilized community volunteers, supported the implementation of high-quality vaccination campaigns and identified cases of acute flaccid paralysis (AFP). 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.

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 met on a monthly basis to coordinate and discuss strategies to strengthen polio eradication activities. These monthly meetings also provided the CGPP Secretariat an opportunity to communicate decisions, policies, and guidelines established by the ICC, MOH, and the Global Polio Eradication Initiative. Likewise, the presence of the Secretariat Director on the ICC and the Technical Working Group provided the NGOs and civil society a voice at the national decision making level among the MOH and implementing 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.

In FY16, the project coordinated 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 supported 2,710 community volunteers, 43 supervisors, and four project coordinators. To better coordinate and plan activities and build the capacity of project staff, CGPP Angola held two partner forums in 2016 which included the polio management staff and senior leadership of the entire 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 the entire partner NGOs which included the 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 planned and implemented cross border meetings with the Democratic Republic of the Congo to the north and Namibia to the south.

In FY 2016, CGPP Angola organized or participated in the following key meetings:

- eight Interagency Coordinating Committee meetings,
- 38 technical meetings, including discussions with the military to deliver polio vaccine to areas affected by insecurity or poor infrastructure, and
- 35 coordination and planning meetings with the municipal level health departments

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. MOH administrative data also shows a downward trend in routine OPV3 coverage rates nationally from 86 percent in 2012 to 75 percent in 2013. Various logistical challenges such as stock outs, poor administrative support to outreach vaccination teams, and vacancies in vaccination staff have all contributed to less than ideal access to vaccination services in many parts of the country.

Since Angola's economy and the vast majority of the government's income is dependent on oil revenues, record low oil prices in 2015 and 2016 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 2016 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.

In the 2016 project year, project staff held several technical meetings to plan partnerships with the Angolan Army. The CGPP Secretariat requested and received assistance from the Angolan Armed Force in Luanda to support numerous vaccination campaigns, particularly against polio, malaria and yellow fever. Project staff and MOH officials provided logistical support, trained soldiers on immunization and form completion and supervised military vaccinators. This partnership allowed support of campaigns in insecure and hard to reach zones, including Luanda, Belas and Viana municipalities and Kilamba Kiayi urban district. CORE group volunteers provided community education and mobilization in these areas as well.

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 2016, the project continued to build the capacity of vaccination staff through technical training in vaccination techniques, 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 visit their village or area. Discussions with health administrators have countered that mothers were too busy to bring their children for immunization and that family did not prioritize preventive 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. In replicating this approach, CGPP staff successfully conducted advocacy events with municipal administrators to increase support and coordination for malaria clean-up campaigns.

The project worked to increase routine immunization through the use of vaccination registries maintained by Community Health Workers (CHWs). This required CHWs to visit households under their supervision and record the vaccination status of all children under five, allowing CHWs to identify which children required follow up vaccinations. The CGPP had 2,710 trained CHWs covering approximately 25 to 50 households each in 41 districts of 12 provinces covering 430 health facilities offering vaccination services. CHWs visited health facilities to check whether the children referred for vaccination received the correct vaccinations for their age, conducted health education skits and talks, as well as visits to traditional healers, traditional birth attendants, community leaders, and houses.

During 2016, CGPP conducted a separate malaria program modeled after the polio eradication project. To prevent malaria and to respond to the yellow fever outbreak 1,800 community volunteers and 23 project supervisors coached families about the importance of using treated bed nets and anti-malaria drugs (as opposed to traditional herbs) with children under five years and pregnant women. For the first time in Angola's recent history, community volunteers also mobilized families to drain stagnant pools of water to control mosquito larva during 220 cleanup campaigns in 2016. Similar in design to the polio eradication initiative, volunteers conducted 187,466 household visits (an 18 percent increase from the initial planned number of visits) with the use of mobile phones that served as an added incentive for volunteers. In addition to addressing malaria and yellow fever prevention and treatment, volunteers also educated mothers on the need for HIV testing and the importance of childhood immunization. The novel effort of clean-up campaigns and the now established use of household visits point to a potential strengthening of commitment from both volunteers and beneficiary families.

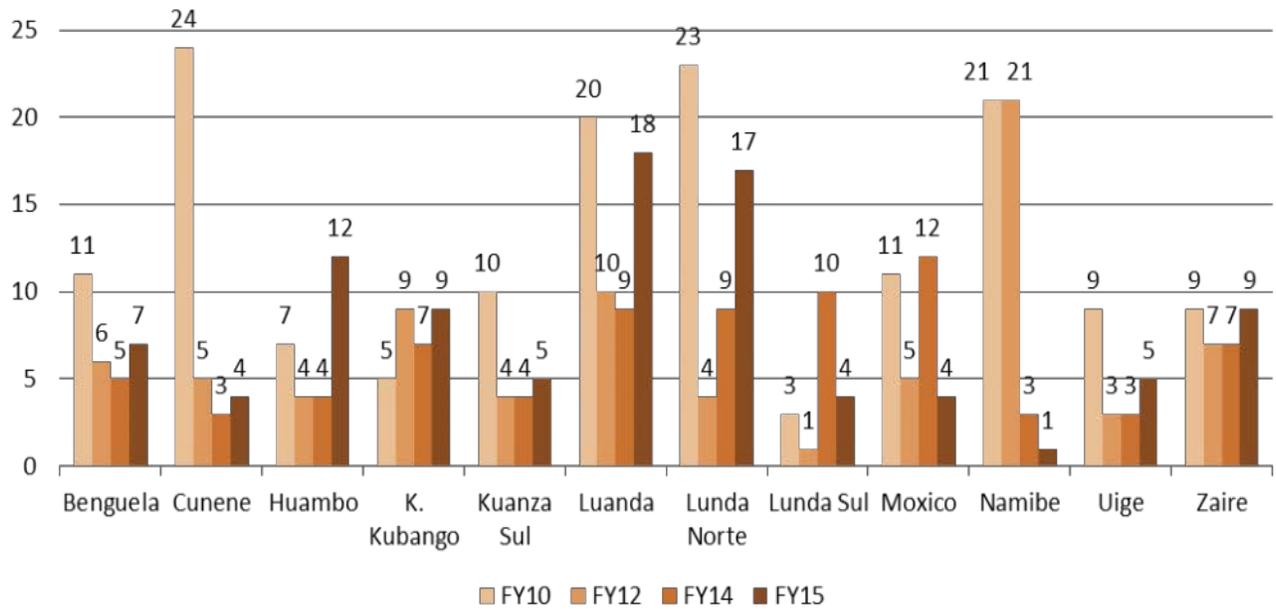
Post-war demographic shifts have significantly increased the population in the large urban areas of Luanda and Benguela without necessarily providing the increased capacity to meet the health needs of these populations. Based on the 2014 census, the population of Luanda is now over six million. Demographically, this means that the majority of unvaccinated children are concentrated in a small number of high-risk areas. In response to this, the project 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.

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

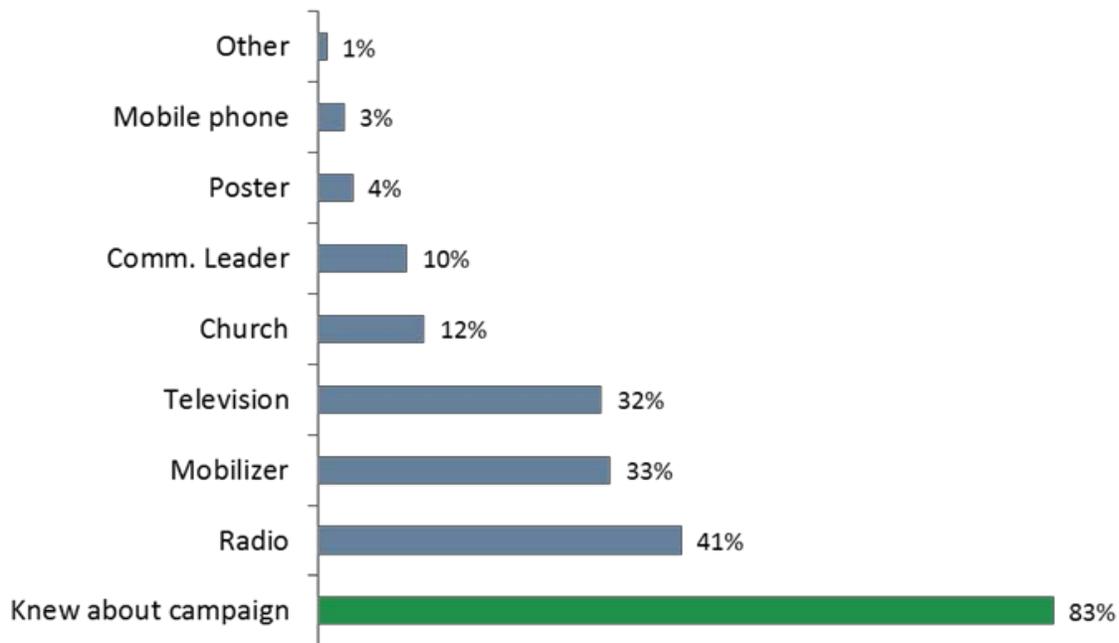
The CGPP has contributed a great deal of effort to both the implementation of immunization campaigns and the implementation and supervision of independent campaign monitoring using Angolan military personnel that were trained, transported, and supervised by CGPP staff. Each of the CGPP partner NGOs provided transportation, training, social mobilization, supervision and planning support for 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 to maintain 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 implementing partners and has now replaced the less reliable administrative data as the preferred method of evaluating and strengthening SIA performance. CGPP Angola 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 2016. 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 Magpie system to collect and record campaign monitoring data.

**Average % of 'Missed' children in SIAs in CGPP provinces:
Comparison of FY10, FY12, FY14, and FY15
(Source: Independent Monitoring Data)**



Source of Knowledge about Polio Campaign



Source: Independent Campaign Monitoring

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. There were no cases of wild polio virus reported in 2016. 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 NPAPF rate of 4.05 in 2016 and 95 percent stool adequacy rate. 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 supervision visits to community volunteers and CGPP staff participated in a national meeting to improve AFP surveillance. Now that Angola has been polio free for more than five years, the MOH 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.

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

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, conducted monitoring surveys which were 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.

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

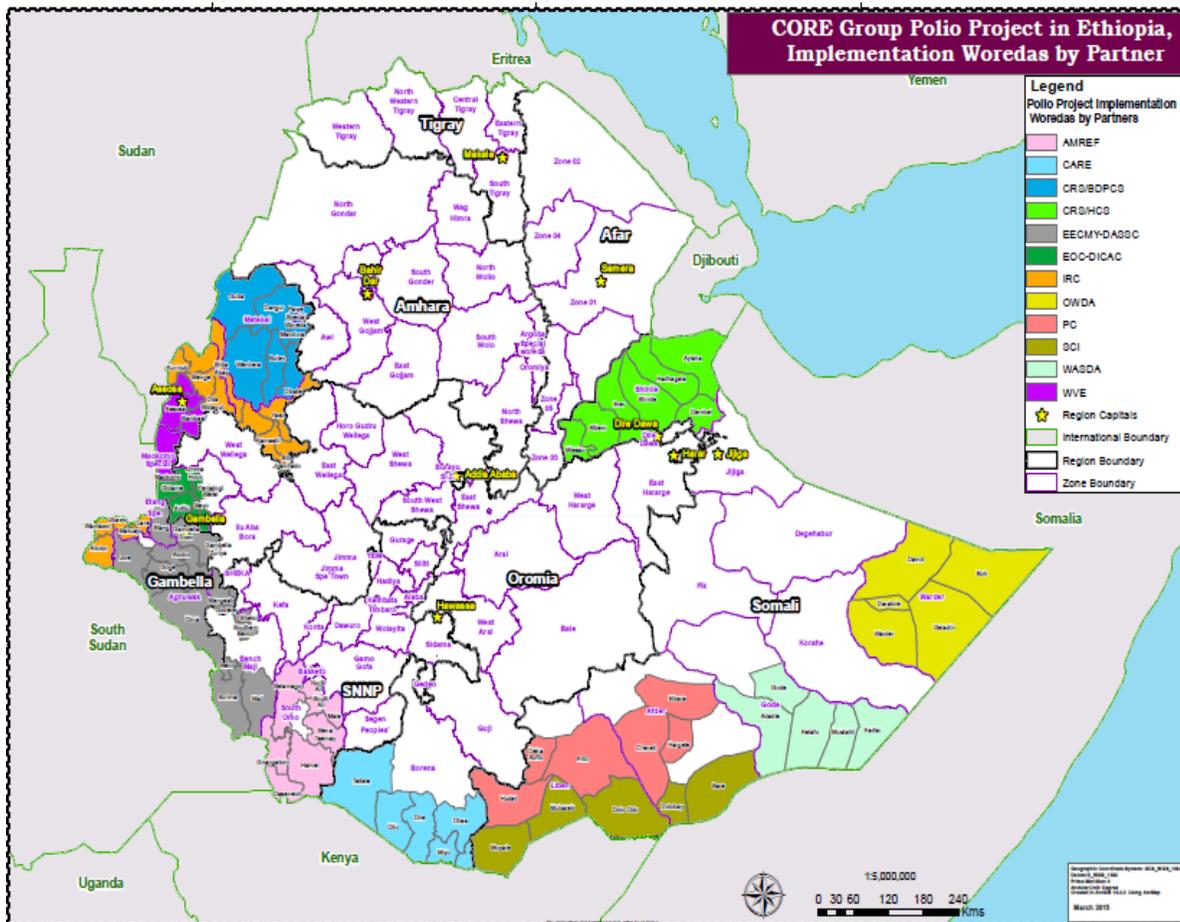
In preparation for closeout, CGPP Angola developed a transition plan detailing the steps needed to ensure a smooth transition of tasks and responsibilities from the NGO partners to the government, UN agencies, and communities. Partner NGOs met with local government officials at all levels to inform them that the project was closing and request that local governments assume responsibility for the supervision of the 2,710 volunteer community mobilizers. Despite these plans and clear information at the onset of the fiscal year, the transition and exit did not go as smoothly as hoped.

ETHIOPIA

CGPP Ethiopia continues to make impressive, measurable strides to protect Ethiopia from the re-importation of polio virus through an extensive network of NGO partners working on the critical hard-to-reach borders with the Sudan, South Sudan, Kenya and Somalia. It is a project comprised of experienced, well-respected leaders in a country tested by insecurity, harsh geography, strained health services and nomadic populations.

Ethiopia has been free of wild polio virus since its last case on January 5, 2014 in the Dollo zone of the Somali region. Nonetheless, the country remains at high risk for importation due to Nigeria's outbreak in 2016, a long history of outbreaks, numerous porous borders and nomadic populations. The Secretariat and eleven implementing partners have trained and placed about 12,000 community volunteers and health workers along the most vulnerable borders of South Sudan, Kenya and Somalia.

CGPP represents local perspectives to national players and builds the capacity of health workers within participating districts. The implementing partners and their community volunteers work closely with district health offices and Health Extension Workers (HEWs) to promote childhood immunization and AFP surveillance. In FY16, their efforts resulted in reaching 1.7 million people with routine and supplementary immunization, community based surveillance, and health education. Efforts in the new project year will focus on enhancing cross border activities, further fortifying district-level relationships and actively involving religious leaders in polio eradication efforts.



Build effective partnerships

The project serves children in 85 border districts, or woredas, in the difficult to reach and porous border regions of Gambella, SNNPRS, Oromiya, Somali and Benshangul Gumuz. The Secretariat works closely with eleven implementing partner organizations: Amref Health Africa, CARE, Catholic Relief Services, International Rescue Committee, Save the Children International, World Vision, Ethiopian Evangelical Church Mekane Yesus, Ethiopian Orthodox Church, Pastoralist Concern, Wabishebele Development Association and Organization For Welfare Development In Action. The partners and their community volunteers collaborate closely with district health offices and Health Extension Workers to improve AFP surveillance and promote childhood immunization. CGPP Ethiopia coordinates the work of partners through regular meetings and trainings. The Secretariat is a key immunization partner and member of the National EPI task force and the MOH's Communication Technical Working Group and attended several meetings organized by MOH and WHO.

Meetings

Ministerial Conference on Immunization in Africa and The Addis Declaration: At the invitation of WHO's Regional Offices for Africa and the Eastern Mediterranean, Ethiopia Secretariat Director Filomana Bisrat and CGPP Deputy Director Lee Losey attended the Ministerial Conference on Immunization from February 24-25, 2016 in Addis Ababa. This landmark meeting drew more than 1,000 vaccine experts and health professionals to focus on "providing universal access to immunization and strengthening of vaccine delivery systems." Dr. Bisrat and Mr. Losey staffed a display table at the meeting and participated in an NGO pre-conference planning meeting to develop an NGO statement that was recited at the conference.

All 41 African countries in attendance signed The Addis Declaration promoting the use of vaccines through 10 specific commitments, such as making universal access to vaccines critical to health and development efforts.

Global communications workshop: CGPP Ethiopia hosted a week-long communication workshop in April 2016 in Bahir Dar. Senior project staff from Angola, Kenya, Ethiopia, Somalia, Nigeria, India, and the US shared communications experiences, discussed polio legacy plans and presented global monitoring and evaluation efforts. Chris Mory of the Communications Initiative facilitated the workshop.

Partners meetings: The Ethiopia Secretariat conducted seven meetings with partners to review program implementation, associated challenges and budget utilization. The partners also reviewed new immunization data, shared ideas, and discussed transition plans.

Annual planning forum: More than 180 persons attended the Secretariat's annual meeting in July 2016 to share common strategies and to create budget objectives. The meeting was attended by government health officials from the regional, zonal and district levels, representatives from EPI, surveillance specialists, donors and implementing partners from field and head offices. MOH, WHO and UNICEF presented immunization and surveillance updates.

CGPP Ethiopia Secretariat Director and Deputy Director contributed to the following meetings:

- Three national Interagency Coordinating Committee (ICC) Meetings
- Technical Advisory Group (TAG) meeting in Kenya in September 2016
- Routine Immunization Technical Advisory Group and African Region Interagency Coordinating Committee meeting in Congo Brazzaville in July 2016
- Road Map Development meeting about Addis Declaration on Immunization (ADI) in Cairo in September 2016
- Additionally, the Secretariat's communication officer attended a UNICEF training in Kenya in June 2016, entitled "Communication for Development (C4D) in Emergencies and Disease Outbreaks"

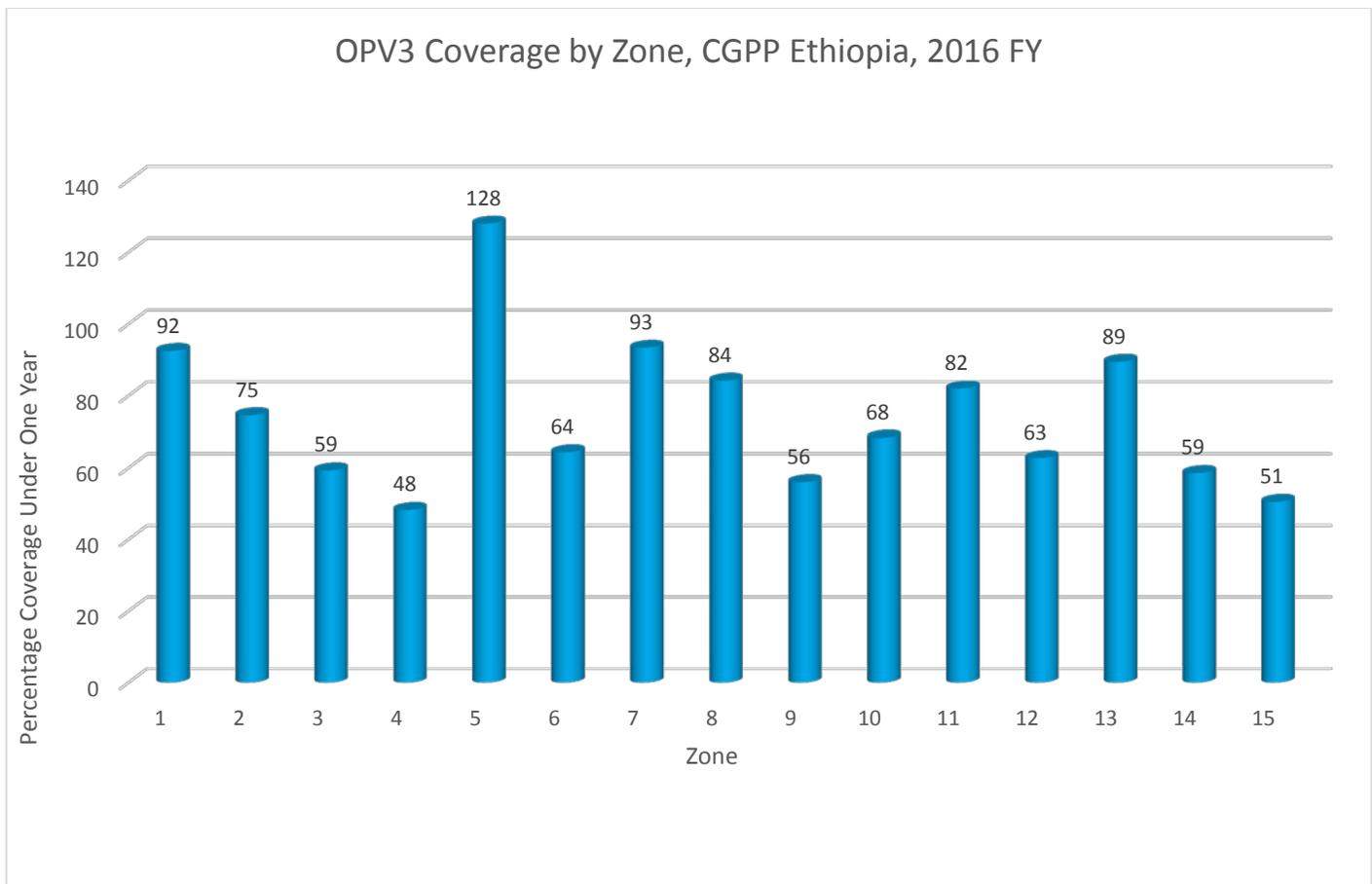
Confirmed Wild Polio and Vaccine Derived Polio Virus Cases

	2008	2009	2010	2011	2012	2013	2014	2015	2016	Total
WPV cases	3	0	0	0	0	9	1	0	0	13
VDPV cases	3	2	6	0	1	0	1	1	0	14

Source 2016 FY WHO AFP report week 37 and CGPP Ethiopia five-year summary report.

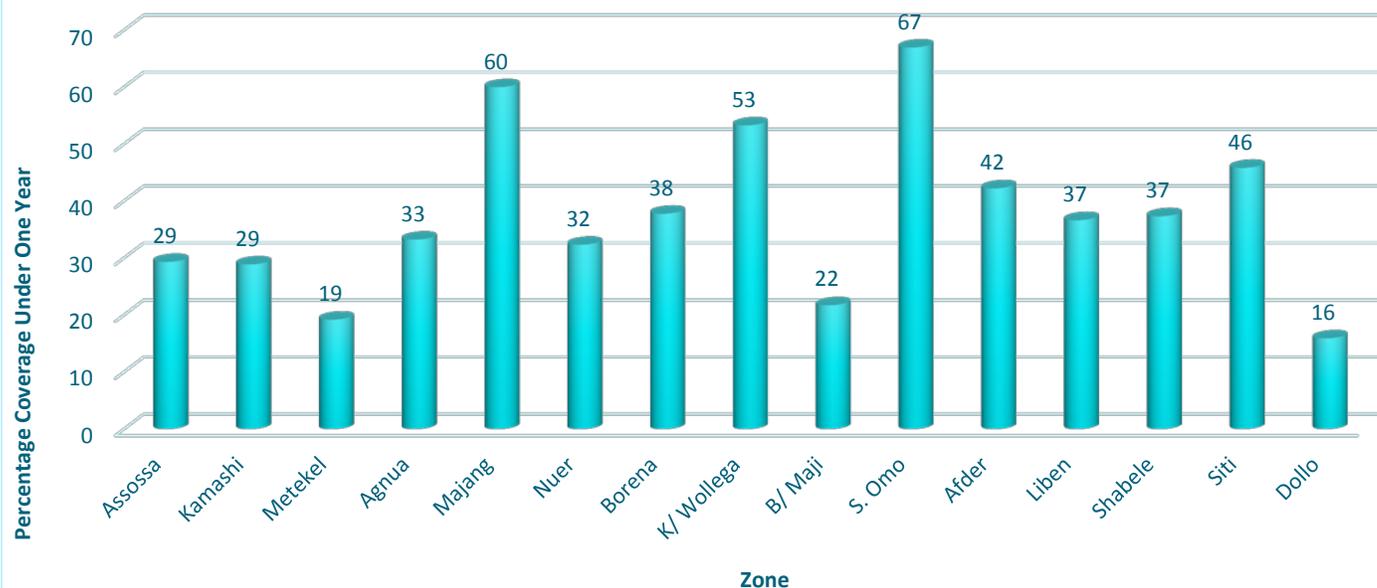
Support PVO/NGO efforts to strengthen national and regional immunizations systems

Coverage rates for OPV3 are still highly variable by region, ranging from 48 percent in Agnua to 93 percent in Borena. 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.



Birth dose coverage for children under one year varied significantly by region as well, from a low of 16 percent in Dollo to a high of 67 percent in S. Omo. More than 90 percent of deliveries occur at home with little chance of newborns receiving the birth dose.

OPV0 Coverage by Zone, CGPP Ethiopia, 2016 FY

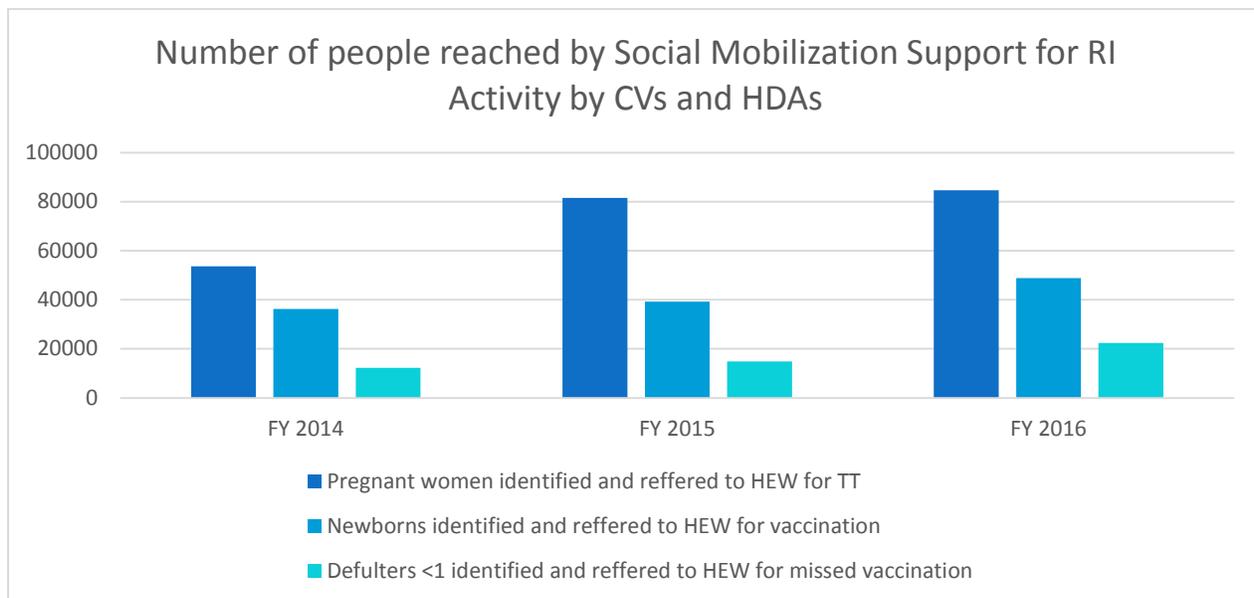


CGPP partners conduct training, provide logistical support, transport vaccines, supervise vaccinators and conduct social mobilization. The Secretariat and implementing partners conducted the following trainings in FY 2016:

- 77 training sessions for a total of 4,336 immunization service providers to improve quality in the areas of community based surveillance, newborn tracking, immunizations and cold chain
- theoretical and hands-on training for 17 participants during four days in May/June 2016 on QGIS, a free and open source global information
- communications skill trainings for 80 Muslim religious leaders in Siti with HCS and in Dollo with OWDA of Somali regions to incorporate immunization activities with the religious system; similar training for 34 Christian leaders was held in Gambella in 2015
- “sensitization workshop” for 282 religious and political leaders to increase community participation in immunization and surveillance activities

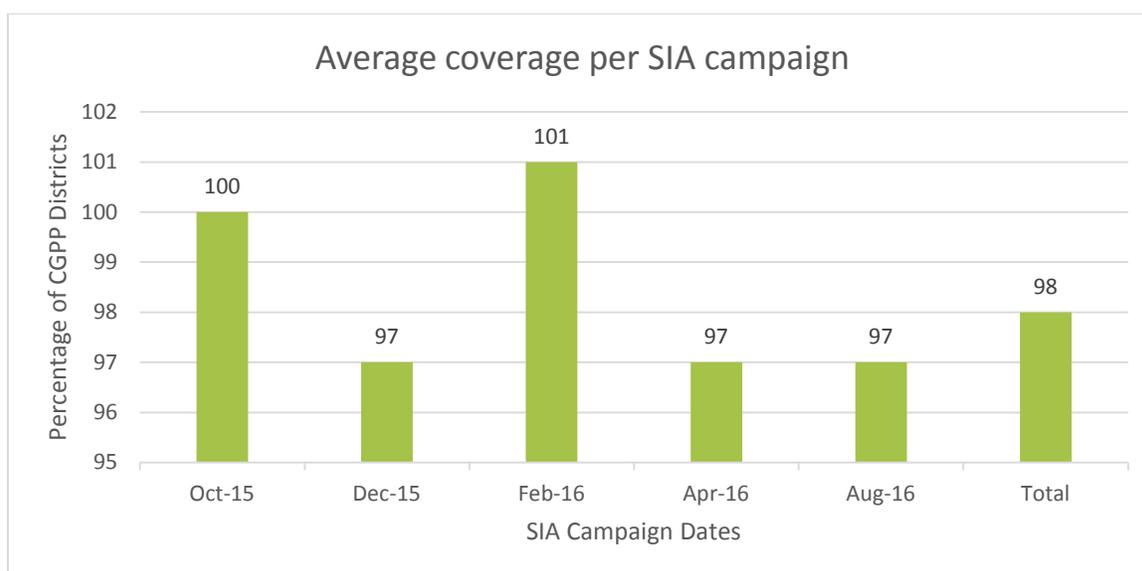
African Vaccination Week (AVW): The Secretariat provided lodging and meals for participants during the 6th AVW celebration in B/Gumz region, Assosa town from May 18-24, 2016. AVW’s main purpose is to bring political and community leaders together to mobilize the community to vaccinate more children.

Community participation: Community Volunteers (CVs), Health Development Armies (HDAs) and Health Extension Workers (HEWs) are the backbone of the Community Based Surveillance (CBS) and newborn tracking program. HDAs are based on a newer community level structure that includes a female supervisor or head for every five women and a command post leader for every thirty women. The Ethiopia project has trained, supervised and supported 11,650 CVs and HDAs who visited 700,991 households, reaching 1,719,986 people in the project year with health information. CVs and HDAs tracked 84,592 pregnant women, 48,842 newborns and 22,148 defaulters for missed vaccinations. This activity has increased significantly over the last couple years.



CGPP partners supplied 78,068 liters of fuel for 85 kerosene-operated vaccine refrigerators and 36 motorcycles, which are the main means of transportation for supervision, vaccine transportation and immunization outreach. CGPP partners also conducted one zonal level, 32 woreda level and 325 kebele (community) level review meetings and 35 joint supportive supervision visits. Additionally, 16 EPI taskforce teams supported routine immunization activities in the reporting period.

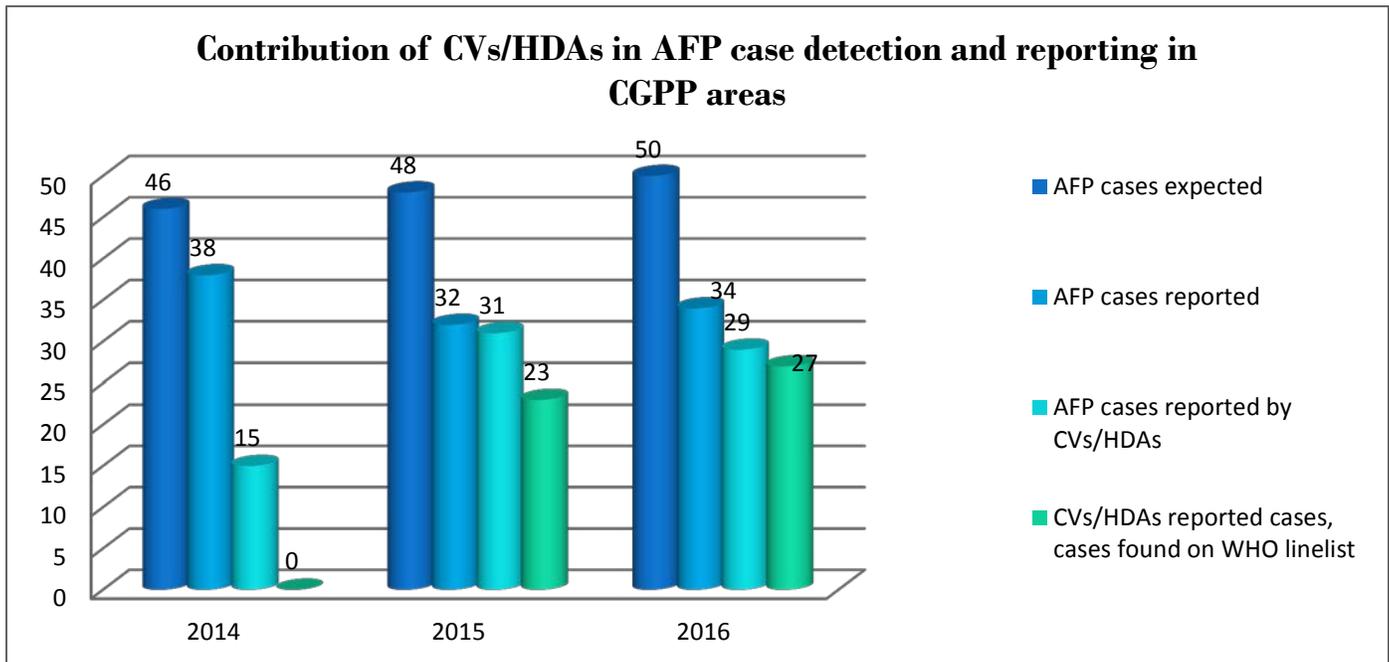
Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunization
 CGPP Ethiopia implemented five SIAs with an average of 98 percent coverage. More than 10,000 community volunteers served as social mobilizers or vaccinators and 518 central and field staff provided technical support during all phases of the campaigns. Partner NGOs provided 160 vehicles for transporting vaccination teams and vaccines; 17,474 liters of fuel; 1,138 social mobilization materials (megaphones, dry cells and banners); and 860 CBS training manuals in Amharic, English and Somali languages.



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

CGPP introduced the use of community based surveillance in Ethiopia, working with a strong force of 11,650 CVs and HDAs who are trained to conduct house-to-house disease surveillance for AFP, NNT, and measles while also tracking the vaccination status of pregnant women and newborns. CVs and HDAs conducted 700,991 household visits reaching 1,719,986 people through health education and reported 38 AFP cases and 259 measles cases. Partnering NGOs transported 20 stool samples. As of week 37, Ethiopia reported a total of 709 AFP cases. The non-polio AFP rate in the GCPP target districts was 2.4 per 100,000 children under 15 with a stool adequacy rate of 90 percent. Nure and Agnuwak zones from Gambella region and Maokomo special woreda from Assosa zone of B/Gumz region are silent zones, per the WHO AFP report from week 37.

Cross border meetings: The country remains at high risk for importation due to Nigeria's outbreak in 2016 with heightened surveillance at bordering areas of Ethiopia and Somali, Benishangul, Gumuz, Oromiya, Gambella and SNNPR regions. To strengthen surveillance, routine immunization and campaigns between border districts in Kenya and Ethiopia, CGPP Ethiopia conducted a local level cross border meeting in Marsabit, Kenya in November 2015 with follow up meetings in March 2016 at Moyale, Dire, Miyo, Dillo, Telltel woredas of Borena zone of Oromia region and Dollo Ado, Mubark and Moyale woredas of Liben zone of Somali region.



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

CGPP Ethiopia and implementing partners are working to establish recording, reporting and filing systems at target health facilities, woreda health offices and project field offices. CGPP distributed 17,969 reports and CBS training materials. During joint supportive supervision visits, CGPP headquarters and field staff provided coaching on documentation and use of local information for action.

The Secretariat prepared and distributed four quarterly newsletters to government offices and other partner organizations to share updates of immunization and surveillance activities.

CGPP Staff provided three presentations at the Ethiopian Public Health Association's annual conference in Addis Ababa.

CGPP Ethiopia Deputy Director Legesse Kidanne and Program Officer Kibrom Abraham presented two papers at the 143rd APHA's annual conference in Chicago.

Joint supportive supervision: The Secretariat's technical staff conducted supportive supervision visits jointly with partner staff at 58 woredas and 14 zones in five regions, a substantial increase from the 33 woredas visited in 2015. The visits included partner field offices, zonal health departments, woreda health offices, health posts, interviews with CVs and HDAs, and interviews with mothers with children under one year of age using a standardized checklist. The Secretariat office provided immediate feedback and follow up with target project woredas and partner offices. CGPP technical and financial staff also conducted supervisory and follow up visits to Charati (Afdar zone) and Filtu (Liben zone.)

Midyear review meeting: CGPP facilitated a midyear review meeting outside of Addis Ababa in May 2016 for 74 staff from the 11 partner NGOs to share six-month progress reports, plan for the remaining project year, and review quarterly reporting templates.

Staff retreat: CGPP Ethiopia organized and conducted a five-day meeting in Adama town beginning August 30 to review the project's 2016 performance and develop a plan for 2017.

Data collection: CGPP with implementing partners conducted a survey of 723 health facilities in 77 project woredas to collect information on the facilities' service readiness, the use of plastic bags by immunization card holders and the contributions of community volunteers. The data is being analysed.

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

National and international teams conducted external outbreak responses during FY16.

Polio legacy: CGPP Ethiopia is developing a comprehensive polio legacy plan to strengthen CBS and immunization activities and transition resources to an ongoing project.



Future plans

- Strengthen mobile device and web based data collection and reporting systems
- Strengthen Routine Immunization through supporting woreda level taskforce, EPI review meetings and tracing of immunization defaulters
- Strengthen work with the HDA system through collaboration with woreda health offices
- Strengthen cross border activities, particularly the notification of HOT cases and synchronization of SIAs
- Mainstream immunization education into Christian and Muslim school systems



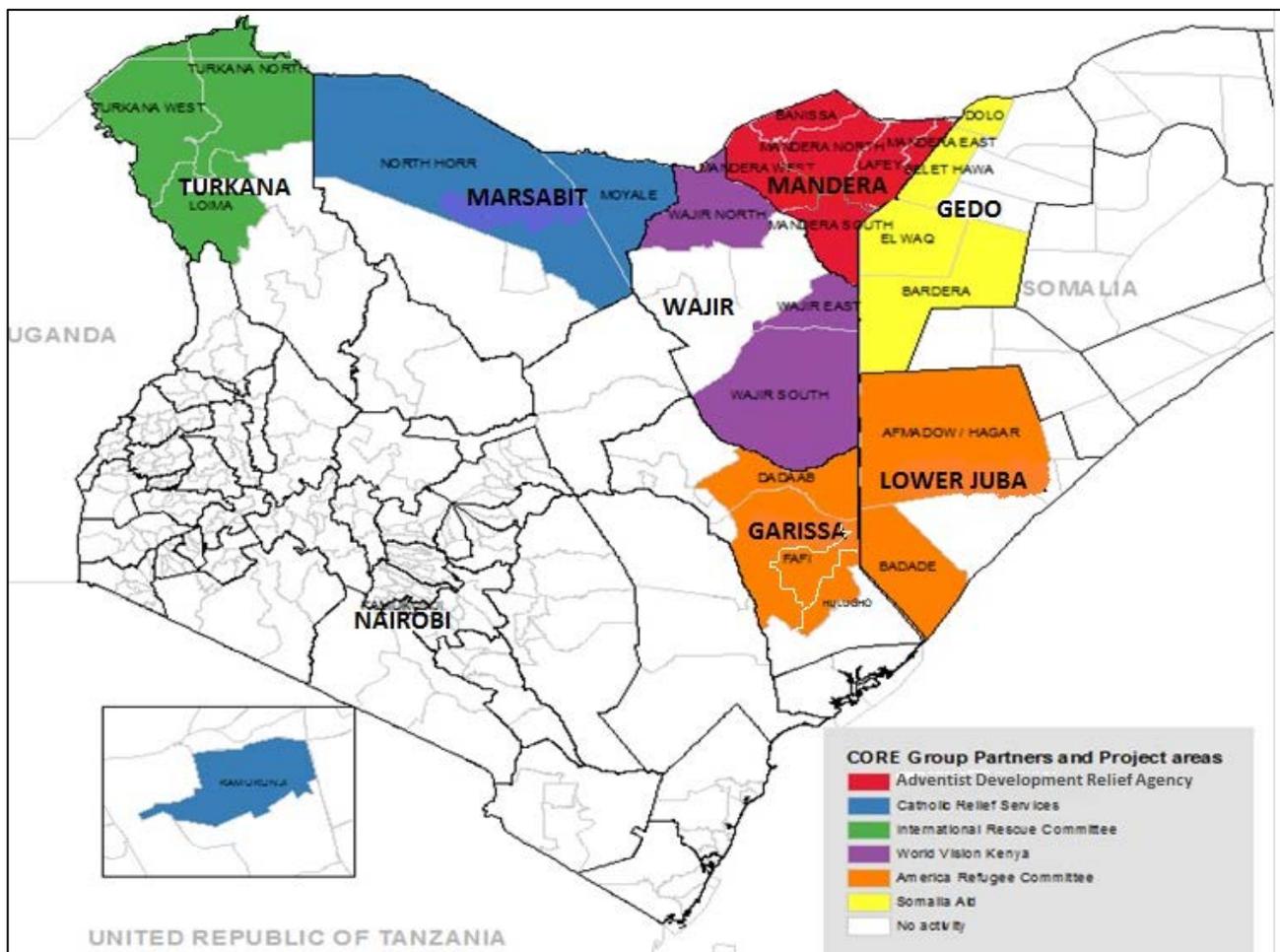
Horn of Africa

Established in response to the 2013 outbreak, the Kenya-Somalia program promotes essential high-quality immunization and surveillance activities in high-risk, hard-to-reach areas along five

northern border counties in Kenya and two southern border regions in Somalia as well as in Nairobi, Kenya's capital. Challenges in this region are complex due to the fluid movement of vulnerable and marginalized populations. The area is host to IDPs, refugees and nomadic herders affected by political instability, insecurity and fractured formal health systems in Somalia. The region continues to be vulnerable to importation of WPV due to vaccination gaps at border sites with Kenya and Somalia. The situation is further complicated by high staff turnover at border health facilities and bans on polio vaccination in parts of Southern Somalia by the Islamic insurgency group Al Shebab.

Despite numerous barriers, substantial progress is being made. CGPP HOA has emerged as a major, well-respected voice in the region in cross border polio eradication activities and community based surveillance. Five international agencies and one local organization now serve a total of 88 health facilities targeting transit populations (72 in Kenya and 16 in Somalia). CGPP Kenya-Somalia contributes to regional planning, monitoring and evaluation, and the creation, adaptation and dissemination of monitoring and evaluation and social mobilization tools that are used by CGPP partners, MOH and UN agencies.

In 2016, 1,300 Community Health Volunteers (CHVs) targeted more than a million children through participation in routine and supplementary immunization campaigns and AFP case detection.



Build Effective Partnerships

The HOA Secretariat is based in Nairobi (housed by CRS) and serves as the regional headquarters for the joint operation. Field activities are implemented by five International NGOs in Kenya: American Refugee Committee (ARC), Adventist Development and Relief Association (ADRA), International Rescue Committee (IRC), Catholic Relief Services (CRS) and World Vision (WV) covering Garissa, Mandera, Marsabit, Turkana, Wajir and parts of Nairobi counties. In Somalia, ARC and Somali Aid, a local NGO, work in the Lower Juba and Gedo regions. The Somalia districts are Dhobley, Diif, Waraq, Kulbio, Ras-Kamboni, Dollow, Elwak, Belet-Hawa and Bardhere.

In Kenya, the project targets about 900,000 children under 15; 314,000 children under 5 and 61,000 under 1. In Somalia, CGPP serves about 200,000 children under 15; 82,000 children under 5 and 19,000 children under 1. The NGO partners meet regularly to coordinate activities, learn about new policies and share ideas and concerns. CGPP Kenya-Somalia collaborates with MOH, WHO, UNICEF, and other key health leaders to build knowledge, address challenges, utilize best practices and plan with partnering groups. CGPP Kenya-Somalia and implementing partners also participate in numerous meetings organized by the governments, donors and spearheading partners:

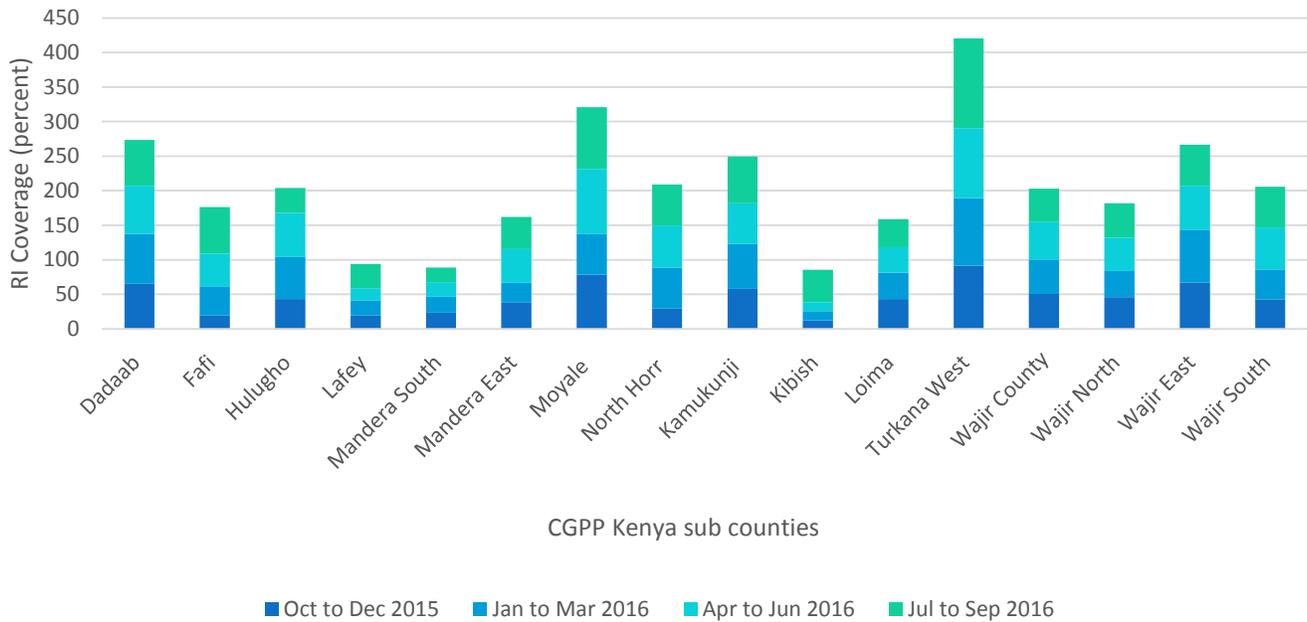
- The CGPP participated in the 15th HOA TAG meeting in September 2016 in Nairobi. TAG lauded the Secretariat's work in community-based AFP surveillance, cross-border coordination and social mobilization. To stay apprised of the project's progress, TAG extended an invitation to the CGPP to provide a stand-alone follow-up presentation at its April 2017 meeting. As evidence of the project's wide-reaching impact, tuberculosis coordinators also approached the project to be included in the cross-border health committees in Turkana and Marsabit.
- In Somalia, more than 60 coordination meetings were held between implementing partners and the MOH, WHO, UNICEF and other key partners;
- Three Secretariat staff members attended the **Third CGPP Summit in Ethiopia in April 2016** to present country-specific communications strategies, share best practices and develop the project's legacy plan.

Community health volunteers (CHVs) and health workers are the backbone of CGPP Kenya-Somalia. In FY16, technical experts from the Secretariat provided numerous trainings to CHVs and health facility staff in both countries to receive integrated training on community based AFP surveillance, supplementary immunization, routine immunization and early case detection and reporting.

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

In FY16, CGPP Kenya-Somalia collaborated with the MOH to support routine immunization (RI) outreach efforts through 69 health facilities – 63 in Kenya and six in Somalia. To boost population immunity, OPV was delivered to 2,418 children in Somalia and 1,200 in Kenya; a total of 9,468 children received different antigens. CGPP has been assisting the MOH in the development of routine immunization micro-planning tools and participating in national and sub-national immunization meetings. Partner NGOs have been recruiting and training community volunteers with outreach efforts. In Somalia, volunteers reached 297,270 people through community outreach activities; 122,627 through household visits; 13,724 mothers with children under one with immunization health talks and 2,892 people during community dialogue sessions.

FY 16 Quarterly RI Coverage



CGPP Kenya percentage of RI coverage rates

Location	Oct to Dec 2015	Jan to Mar 2016	Apr to Jun 2016	Jul to Sep 2016
KENYA	69	72.1	67.2	74.3
Garissa County	53.8	63.9	65.3	65.1
Mandera County	28.5	24.6	27	28.9
Marsabit County	63.6	73.4	77	76.7
Turkana County	65.4	67.1	67.8	75.2
Wajir County	50.5	49.8	54.3	48.3
Nairobi County	75.1	71.3	66	77.3



Somalia's political instability, frequent population movement and low immunity all point to a high risk of importation of polio virus into Somalia. ARC and Somali Aid participated in more than 60 meetings at the national, state, district and sub-district levels and worked with MOH, WHO, UNICEF, and IOM for the planning, coordination and management of routine immunization services.

Somalia Health Facility and Catchment Population	<1Yr Pop.	< 5Yr Pop	BC G	OPV O	OPV 1	OPV 2	OP V3	Pent a1	Pent a2	Pent a3	IPV	Measles	Total	
Dhobley MCH	28,347	1,418	5,669	374	352	377	297	295	348	325	274	169	651	3,462
Deg Elema-Mobile clinic	3,960	198	792	27	18	54	48	35	54	48	35	22	98	439
WRRS HPs	4,800	240	960	19	13	34	42	31	34	42	29	13	65	322
Diif HFs	23,800	1,190	4,760	58	47	65	42	31	63	41	29	11	87	474
RasKambooni HFs.	24,000	1,200	4,800	54	44	73	58	46	73	57	32	10	116	563
Elwak HF	69,978	2,798	13,996	112	87	98	68	34	45	34	21	8	87	594
Gerille HF	18,500	198	260	32	45	31	27	26	31	41	26	7	62	328
TOTAL	173,385	7,242	31,237	676	606	732	582	498	648	588	446	240	1,166	6,182

ARC/Somali Aid in Somalia provided routine immunizations in the hard-to-reach villages in Afmadow and Badhadhe districts. Under this program, four special immunization weeks were planned each month from April to August 2016. ARC and Somali Aid has identified 138 CHVs and 14 Community Mobilizers from mapped border villages to carryout extensive community awareness and mobilization. The Somalia partners actively participated in various forums and meetings at national, state, district and sub-district levels. ARC worked closely with district medical officers, WHO and IOM for the planning, coordination and management of RI services at the sub-district level. Somali Aid is working closely with district medical officers and active health partners in the region to support the outreach teams to reach more children in hard-to-reach areas.

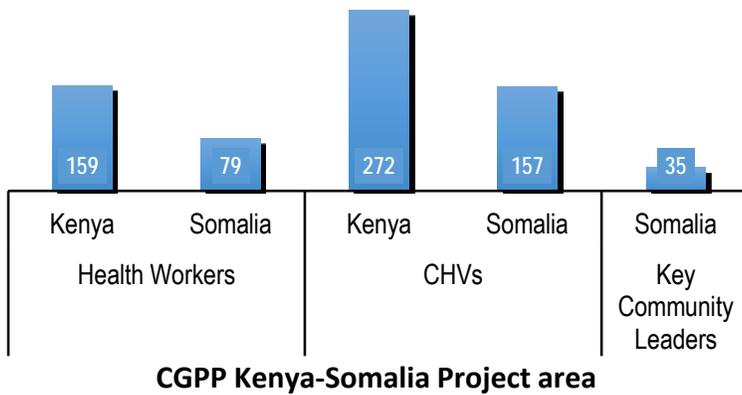
In partnership with the Kenya MOH Disease Surveillance and Response Unit (DRSU) and the Expanded Program for Immunization (EPI), implementing partners recruited community health volunteers (CHVs) for training in social mobilization efforts. Most CHVs are women who live near hard-to-reach areas and are linked to health facility staff to stay apprised of the comings and goings of nomads and pastoralists.



Routine immunization coverage can vary widely. In Manderia County, a vast, remote and isolated area in a semi-desert belt of Northern Kenya, routine immunization rates are less than 28 percent. CGPP-ADRA supports the project through outreach clinics for nomadic pastoralists at border crossing points. Immunization rates are very low in the CGPP-CRS supported project in urban Nairobi as only 62 percent of children are fully immunized as compared to Kenya’s national rate of 77 percent. Poor sanitary conditions contribute to the area’s vulnerability to the polio virus. CGPP Kenya-Somalia supports five health facilities in Nairobi. As of November 2015, 15 informal settlements in the area housed residents fleeing from areas of continuing strife.

In the project year, 1,300 CHVS reached more than 600,000 persons through house to house social mobilization and activities. In collaboration with the government’s expanded program for immunization (EPI) program, CGPP partners developed materials for immunization use by health workers and CHVs. More than 700 health workers, CHVs and key community leaders received special training in informational and educational materials to orient them to disease surveillance and immunization campaigns. Health workers and CHVs in both Kenya and Somalia as well as key community leaders in Somalia utilized these materials.

Groups trained on RI using CORE Group developed materials



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



Kenya conducted a national SIA in Garissa, Marsabit, Turkana, and Wajir and a sub-national campaign in Nairobi and Mandera counties. Somalia conducted four national campaigns targeting children living in hard-to-reach areas. Due to a collapsed formal health system, Somalia relies on supplementary immunization activities in lieu of routine immunization campaigns. Access is a key challenge in reaching children, especially those living in Somalia's southern and central zones. As of August 2016, 16 of a total of 115 districts in Somalia remained inaccessible; 235,000 children had not been reached by immunization campaigns since 2013. More than 350,000 children living in areas that are controlled by the Al-Shebab are inaccessible. CGPP and partners conducted four national SIAs and three Short Interval Vaccinations in the hard-to-reach Gedo and Lower Juba regions.

- Working with WHO, ARC provided ten teams during December 2015, February 2016 and April 2016 SIAs. Those teams were placed at major crossing points and special population areas to boost vaccination coverage. During these periods, 1,574 children were reached.
- Three short interval vaccinations meant for hard-to-reach areas were also supported with extra teams and a total of 2,096 children were reached.
- Somali Aid similarly supported five extra teams in the last two SIAs and reached 1,374 children in Belet-Hawa District.
- Somali Aid supported three teams during the campaign for hard-to-reach areas.

To promote the SIA efforts, CGPP-ARC printed banners, posters and stickers and GCPP-ARC provided five megaphones, 100 t-shirts and caps, 20 scarves and banners. In Kenya, social mobilization activities reached 3,034 people during both sub-national campaigns. Nine districts in Somalia benefitted from similar efforts, such as community dialogues, mother-to-mother support group discussions, and meetings with village administrators, community key influencers and religious leaders. Social mobilization activities in Somalia reached more than 70,000 people.

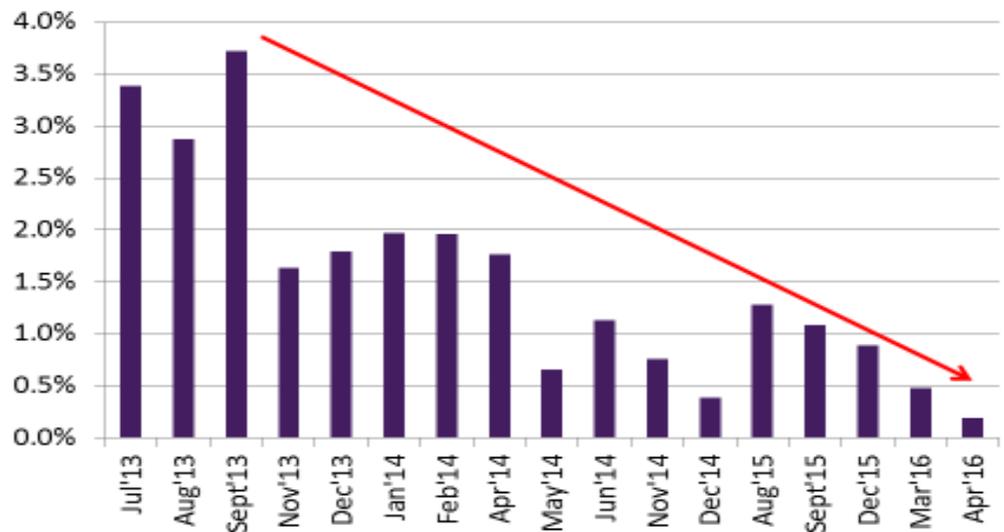
Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection (and reporting and detection of other infectious diseases).

The MOH's DRSU conducted integrated community-based surveillance (CBS) trainings for 332 CHVs between April and August 2016. CHVs, as important front-line workers, are provided with monetary allowances to encourage their work in the hardest to reach areas, such as pastoralist and nomadic settlements.

Project-trained CHVs reported 18 AFP cases - 10 in Kenya and 8 in Somalia. As of week 38, Kenya reported a national non-polio AFP rate of 2.86 per 100,000 children under age 15. The national stool adequacy rate in Kenya was 87 percent in week 38, and 99.59 percent in week 37 in Somalia.

The Polio Eradication Program in Somalia has established plans to ensure that immunization activities take place without delay in any areas that become newly accessible. The surveillance system continues to be strengthened through innovative strategies including sampling of healthy children in regions that have not reported cases, expanding the number of village polio volunteers, investigations of children who have never been immunized, contact sampling, and validation of acute flaccid paralysis cases.

Trend in % of Zero dose children vaccinated in Kenya Polio SIAs 2013-2016



In April 2016, cVDPV was detected in Kamukunji Sub County of Nairobi County in Kenya. As a result, the MOH requested CGPP assistance to conduct vigorous AFP surveillance in the slum area. The CGPP trained and deployed 226 CHVs to visit 6,912 households. As a part of the outbreak response, CHVs located two AFP cases.

To ensure timely stool collection and case investigation, the project provides transport allowance to disease surveillance coordinators in Turkana county in Kenya. Project support allowed timely sample collection and speedy transportation for six AFP suspected cases from Loima and Kibish sub counties to national laboratories in Kenya.

Support timely documentation and use of information to continuously improve the quality of polio eradication (and other health-related activities).

The Cross Border Initiative

CGPP facilitated the formation of Cross Border Health Committees (CBHC) to improve information sharing between bordering counties and districts in Kenya and Somalia in response to the history of cross border outbreaks. Border health administrators, health facility officials and other democratically selected representatives organized nine cross border meetings with health officials, WHO, UNICEF and NGO partners to map vaccination sites, share data, synchronize NIDS, map



Social mobilization session being conducted by CHVs in a bulla (pastoralist village) in Dhobley

population movements and cross border points and establish cross border vaccination points. At the border crossing points along the Kenya-Gedo region, 4,100 children were immunized.

Community interest is growing in strengthening the important work at border health facilities. In Wajir, county health officials purchased solar fridges to support four border health facilities. In Garissa, staff were assigned to border health facilities for additional support. In Somalia, CGPP-ARC collaborates with the neighboring Garissa County in Kenya to cover mobile populations on both sides of the border. The CBHC, in addition, has expanded its mission to include other pressing health needs, including cholera and measles outbreaks in Wajir and Mandera counties in Kenya.

IDSR Acute Flaccid Paralysis (AFP for Poliomyelitis)_ Oct 2015 to Sept 2016					AFP cases reported by CGPP-HOA CHVs after Community Based trainings in April 2016		
Sub county	Oct to Dec 2015	Jan to Mar 2016	Apr to Jun 2016	Jul to Sep 2016	Sub county	Apr to Jun 2016	Jul to Sep 2016
Dadaab					Dadaab		
Fafi					Fafi		
Hulugho					Hulugho		
Lafey					Lafey		1
Moyale					Moyale		
North Horr					North Horr		
Kamukunji				1	Kamukunji	2	
Kibish				5	Kibish		5
Loima				1	Loima		1
Turkana West					Turkana West		
Wajir East					Wajir East		
Wajir North					Wajir North		
Wajir South					Wajir South		1
Data Source DHIS2					Data Source: CGPP CHVs report		

During FY16, one journal article on CGPP's contribution was published and 11 presentations were made at regional and international conferences.

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

The CGPP Kenya/Somalia Secretariat plays an active role in legacy and transition planning in the HOA TAG meetings and in National platforms.

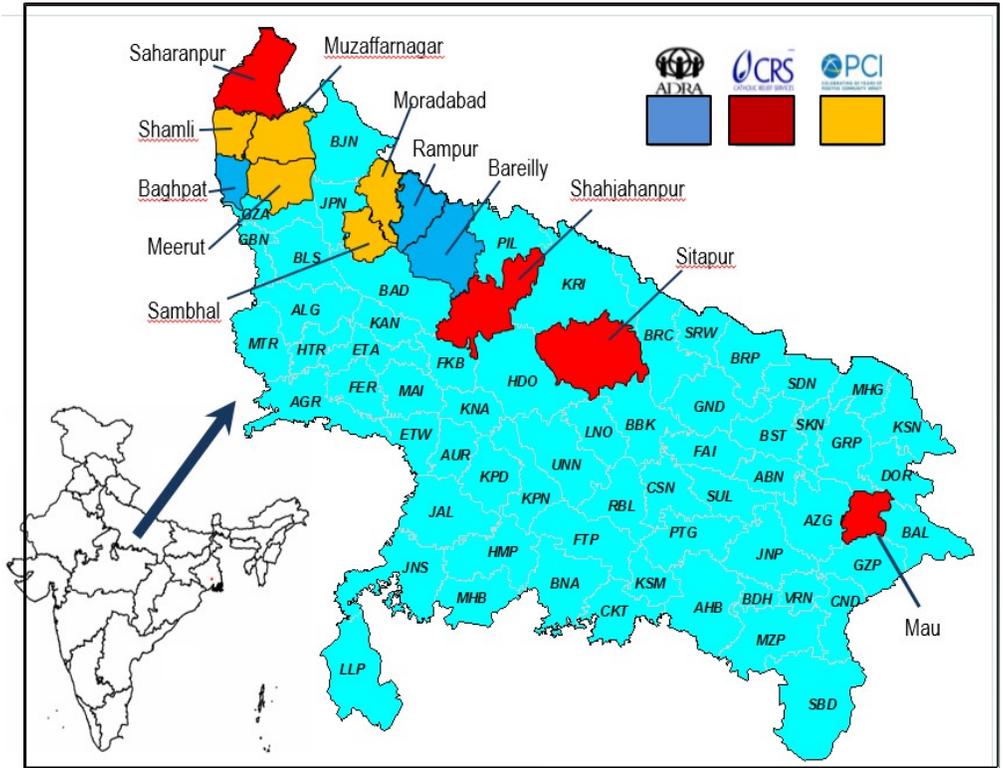
CGPP was a very active participant in all polio eradication planning meetings at the national and regional levels including the HOA TAG meetings in Nairobi.



**CHV conducting SIA social mobilization in
Kambiu slum, Kamukunji sub county Nairobi.**

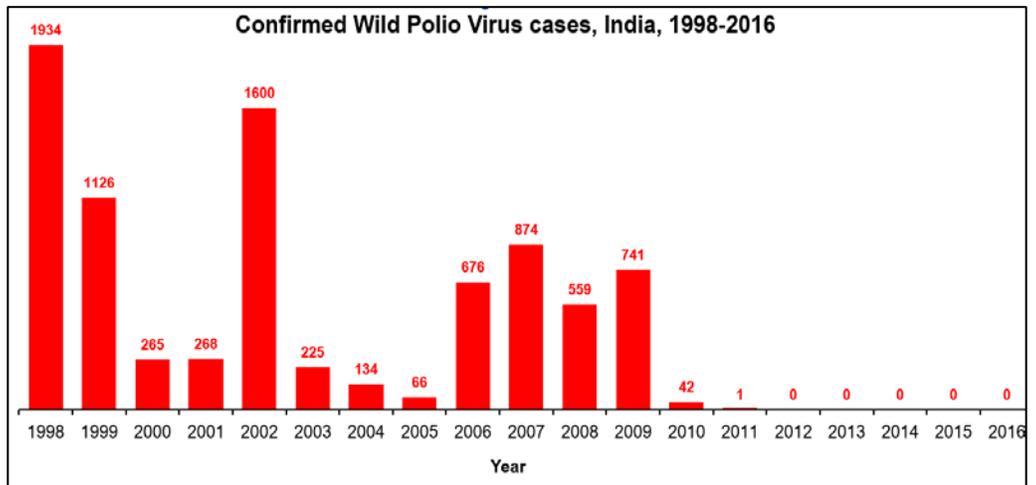
India

Certified polio free in March 2014, India continues its uninterrupted march to stay ahead of a threatened re-importation of the virus. The country maintains strong levels of population immunity through high-quality campaigns, improved routine immunization and aggressive disease surveillance. The country continues to benefit from strong political will, deep community engagement and local commitment. In turn, India's lessons learned are actively shared with other CGPP



country partners such as Nigeria, Kenya, Somalia and South Sudan and Senior CGPP India staff contributes their knowledge and expertise in various national, regional and global meetings.

Despite successes, challenges exist to India's well-fought war against polio. Pockets of low routine immunization coverage, gaps in surveillance in migrant populations and the circulation of the virus in Pakistan threaten India's polio-free status. India will continue to be the gold standard in polio eradication due to the sustained, creative work



done by teams at all levels – from government officials to mothers. In this project year, community workers detected 89 AFP cases. Serving as the eyes and the ears of the project, community mobilizers will need to stay vigilant and remain unwavering in their commitment to keep polio far away from their children. To do so, CGPP-India will need to maintain the quality of supplementary immunization activities, strengthen routine immunization to ensure high coverage of zero dose and OPV3 and increase or maintain a higher coverage of the new inactivated polio vaccine.

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

Build effective partnerships with PVOs, NGOs, and international, national and regional agencies involved in polio eradication

CGPP India is working with three well-established international NGOs – Adventist Development and Relief Association (ADRA), Catholic Relief Services (CRS) and Project Concern International (PCI) – and ten local NGOs in 58 blocks of 12 districts of Uttar Pradesh (U.P.) Community Mobilization Coordinators, or CMCs, are the cornerstone of the polio eradication effort. During the reporting year, an experienced team of 1,107 CMCs conducted social mobilization activities to 497,926 households located in areas of high density and poor sanitation. The CMCs, who are typically women from the community, provide a range of services from health education to tracking pregnant women, newborns and defaulters.

PVO Partner	NGO Partner	
ADRA	Innovative Approach for Social Development Society (IASDS)	
	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
PCI	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

The Secretariat and partners have developed strong working relationships with WHO, UNICEF, Rotary and the MOH and they meet regularly to discuss and plan implementation strategies. CGPP conducted numerous 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, such as meetings with the Immunization Action Group (IAG) to address immediate areas of need. The IAG acts as the ICC equivalent in other countries. Other key meetings and trainings are listed here:

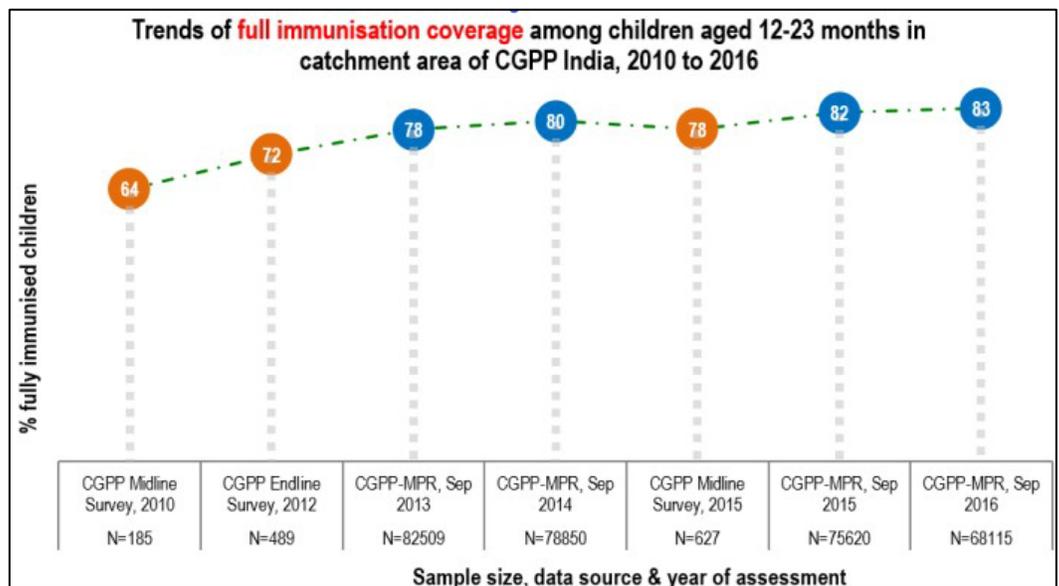
1. Strategic Advisory Group of Experts (SAGE) on immunization, Geneva, 12-14 April 2016. Attended by Secretariat Director Dr. Roma Solomon to discuss, in part, ultimate removal of OPVs, April 2016 switch from tOPV to bOPV and the introduction of IPV.
2. Third CGPP Summit, Addis Ababa, Ethiopia, 18-23 April 2016. Attended by Dr. Roma and Communications Specialist Rina Dey. The group found that current communication and social mobilizations strategies to promote sustainable health behavior change should be expanded to include other indicators, such as nutrition and sanitation. A holistic, comprehensive communications package would provide more support for CMCs' outreach efforts.
3. GAVI CSO SC and OAG meetings in Geneva, 15- 21 June 2016. Attended by Dr. Roma.
4. Semi-Annual Meeting of Polio Partners Group (PPG) in Geneva, 24 June 2016, convened at the World Health Organization (WHO) headquarters and attended by Dr. Roma.
5. Dr. Roma and Frank Conlon participated in a webinar entitled "Implementing the Polio Project in India" in June 2016.
6. Dr. Roma met with CEO GAVI Seth Berkeley 8 Jan. 2016 to increase coverage and equity in the national immunization program.

7. Meeting on immunization attended by Rina Dey and Dr. Roma 18 Feb. 2016.
8. *CRS India Review* meeting, Kausani, 2-5 March 2016.
9. *PCI India Review* meeting, Shimla, 15-19 March 2016.
10. *CGPP Program Review Meeting*, Gurgaon, 30 March-1 April 2016.
11. Dr. Roma and Rina Dey attended a meeting convened by USAID, 18 May 2016.
12. Rina Dey and Manojkumar Choudhary attended a Barber's Involvement meeting, Lucknow, 29 June 2016, organized by CRS.
13. Dr. Roma participated in a panel discussion, 13 July 2016, "National Consultation on World Vision India's Experience on MCHN"
14. Rina Dey and Dr. Roma attended the Immunization Partners meeting at MOHFW, 19 August 2016.
15. Rina Dey participated in CRS India Review meeting, Haldwani, 5-7 September 2016.
16. Rina Dey and Manojkumar Choudhary attended the PCI India program review meeting, Jaipur, 16-18 September 2016, to demonstrate processes to implement mobilization activities.
17. CGPP-India held its staff retreat in Coorg, 25-29 September 2016.
18. CGPP Secretariat conducted two trainings in Mumbai: Training of Master Trainers in July 2016 for 31 participants from all 12 districts and training for 82 DMCs, BMCs, and MIS Coordinators in July and August 2016.

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

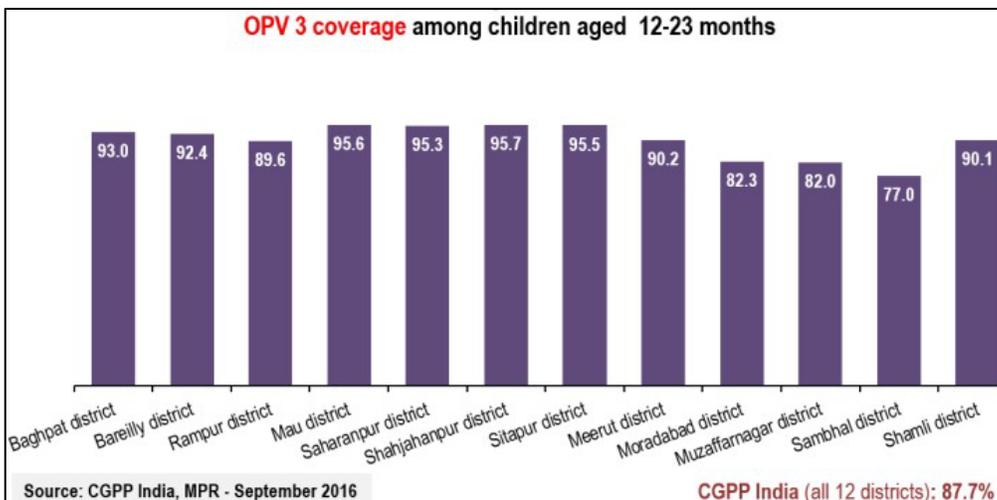
The project continues to mark substantial success in routine immunization thanks to a strong cadre of community volunteers and partners. Their combined efforts reached nearly half a million households. OPV3 rates among children 12-23 months old increased to near 88 percent in 2016 (ranging from 77 percent in Sambhal district to 96 percent in Shahjahanpur district.) Since September 2012, OPV3 coverage has consistently remained above 80 percent. Starting in November 2015, IPV was added to OPV3 to fight VDPVs. District-wide coverage averaged 55 percent, ranging from 37 percent in Muzaffarnagar district to 76 percent in Saharanpur district. IPV shortages accounted for the 6 percent difference between IPV and OPV3 coverage. Districts with higher OPV3 immunization rates reported higher IPV coverage rates.

Birth dose vaccination has significantly improved by 25 percent from 53 percent in September 2013 to 78 percent in September 2016, with a notable jump of 2 percent from 2015. A



mid-term evaluation conducted in June 2015 showed that all children aged 12-23 months in the project area received at least one dose of vaccine either during a SIA or RI. The percentage of fully immunized children moved upwards to almost 83 percent, an increase from 82 percent in the previous year. Only 2 percent of children were missed due to resistance to OPV.

CGPP's primary impact on routine immunization is through CMCs, or community mobilizers. 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 India has



participated at RI-focused forums, task force meetings and conferences at the national, state, district and sub-district levels. Block Mobilization Coordinators (BMCs) and District Mobilization Coordinators (DMCs) also have assisted government medical officers to improve micro plans by regularly updating data for high-risk groups such as nomads, slum dwellers and hard to reach areas.

CGPP has launched many creative programs to reach families. To boost RI coverage in 201 districts, the government launched 'Mission Indradhanush' (MI) during two phases in U.P. CGPP India supported both immunization campaigns by preparing lists of birth dose children and defaulters, or children who began but did not complete RI.

Additional RI efforts during the project year are highlighted here:

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 Nataks* (street plays/shows) teams. This activity reached 135,000 community members.

Barbers' initiative: Men continue to be the main decision makers in most families. The project is tapping the influence of male barbers to encourage discussion of immunization with their clients as barber shops typically serve as hubs for men to talk about current or community events. The project selected 415 barbers to receive orientation about polio and routine immunizations. These men are then empowered to share information with their clients.

CMC friend (sakhis): A *sakhi*, or friend, is a person who assists CMCs in mobilization activities. CMCs identified *sakhis* who could disburse health information to other community members. Field officers provided orientation on mobilization activities to 144 *Sakhis* from Manota blocks of Sambhal district.

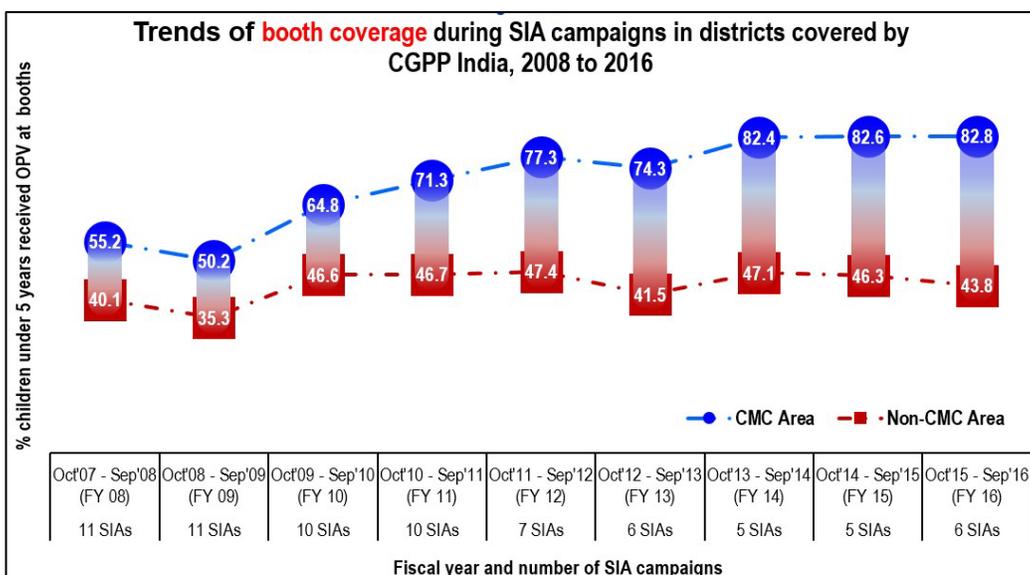
ASHA training on communication skills: CGPP initiated a plan to improve the communication skills of Accredited Social Health Activists (ASHAs.) As part of legacy planning and transition, CGPP trained 60 ASHAs from Manota blocks of Sambhal district. The activity will be increased during the 2017 project year.



ASHA participating in training - District Sambhal

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

CGPP India supported seven supplementary immunization campaigns (SIAs), six of which began with 1,500 polio booths, or fixed vaccination sites. CMCs mobilized vaccinations at all 12 project districts during the months of November, January, February, June and September. A December SIA was limited to the districts of Baghpat, Meerut, Muzaffarnagar and Shamli. (Vaccination teams



conducted house-to-house visits during a special April SIA. The April campaign was scheduled before the switch to the bivalent vaccine.) The influence of CMCs continues to be strong during these efforts. CMCs reached 83 percent of children under 5 years in project areas, compared to only 44 percent in areas not covered by CMCs. Likewise, the proportion of children missed in campaigns in CMC areas (4.9 percent) was slightly lower than in non-CMC areas (5.4 percent).

Excluding the special April campaign, which was limited to only house visits, total SIA coverage was 99.6 percent. Vaccinators visited about 500,000 households in the CMC area, including 380,000 children under five years in each SIA. The biggest reason for missed children was long-term or short-term migration (89 percent.) The proportion of children missed due to OPV resistance was negligible.

Key social mobilization activities in India, FY2016

IPC visits		Number of group meetings								Number of coordination meetings*		# of Govt. RI sessions monitored by CGPP team	
		Mothers/ Adolescent girls meetings		Fathers/ Adolescent boys meetings		Interface/ Influencers/ Religious leaders		Total					
Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done
369791	345225	24486	23451	733	721	5402	5558	30621	29730	746	632	6840	11308

*Coordination meeting with CMCs, Accredited Social Health Activists and Auxillary Nurse Midwives.

Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection (and reporting and detection of other infectious diseases)

CGPP-India has a robust surveillance system that also includes environmental surveillance. AFP surveillance is based on facility-based reporting. In addition, CMCs are trained to search for AFP cases and report cases expediently to the nearest health facility. During the reporting period, CGPP staff reported 89 AFP cases. The non-polio AFP rate in the 12 CGPP districts was 19.7 per 100,000 children under 15 with a stool adequacy rate of 88.3 percent as of October 2016. Adequate stool collection rates varied by districts, from 93.9 percent in Mau district to 82.8 percent in Baghpat district.

Support timely documentation and use of information to continuously improve the quality of polio eradication (and other health-related activities)

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 at various meetings in FY2016.

- 'The Logic of Hope & Trust,' a book collection of mobilisers' personal expressions about the project, was published in December 2015 and launched in Lucknow by the Director NHM, U.P.
- Prince Mahidol Award Conference, Bangkok 26-31 Jan. 2016: Rina Dey and Manojkumar Choudhary presented two posters: 'Immunization card holders boost immunization coverage in Uttar Pradesh, India' by Rina Dey and 'Principal Approaches to Improve Immunization Coverage: CORE Group Polio Project (CGPP) India Strategies for Addressing Barriers to Routine Immunization' by Manojkumar November 2016
- CGPP- Community Based Health Volunteers: An Important Stakeholder in Eradicating Polio from India. By Adesh Chaturvedi, Jitendra Awale, Manojkumar Choudhary.
- CORE Group Polio Project India: Child Survival: A success story of Polio Eradication Program in India. By Adesh Chaturvedi, Jitendra Awale, Manojkumar Choudhary

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

The Independent Monitoring Board (IMB) for Post-Polio Eradication Transition appointed Dr. Roma to The Polio Transition IMB (TIMB.) The 11-member board consists of international experts who will work to “independently monitor and guide the process of transition planning, assessing the quality, sufficiency and impact of work being undertaken to achieve transition planning aims stated in the Polio Eradication and Endgame Strategic Plan 2013-18.” Dr. Roma and her colleagues will work to ensure that “the investments made to eradicate poliomyelitis help sustain a polio-free world, and contribute to future health goals, through a program of work to systematically document and transition the knowledge, lessons learned and assets of the Global Polio Eradication Initiative.” TIMB will focus on 16 designated priority countries that currently contain GPEI’s current infrastructure and staff. An initial preparatory meeting of the Polio Transition IMB was held in November 2016, with the first formal meeting to be held in early 2017.

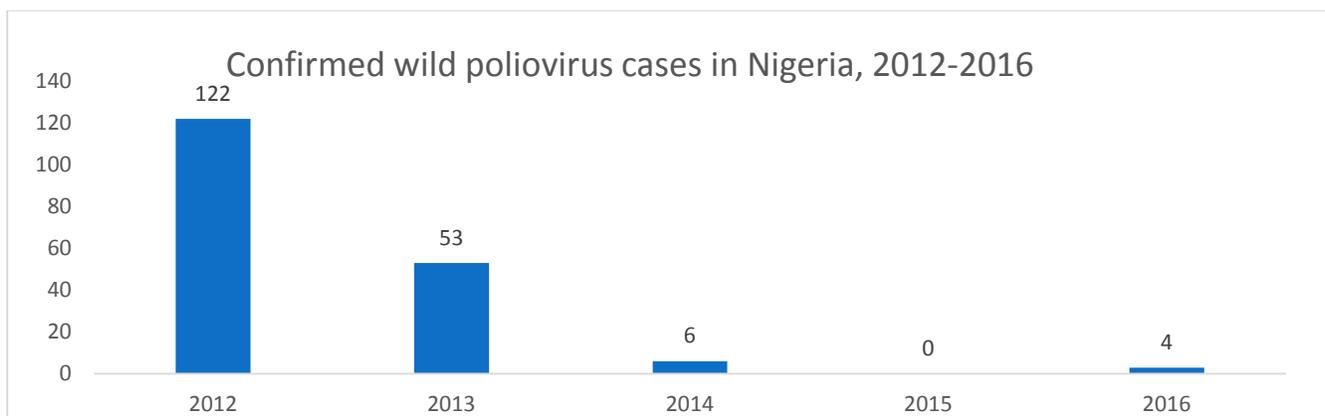
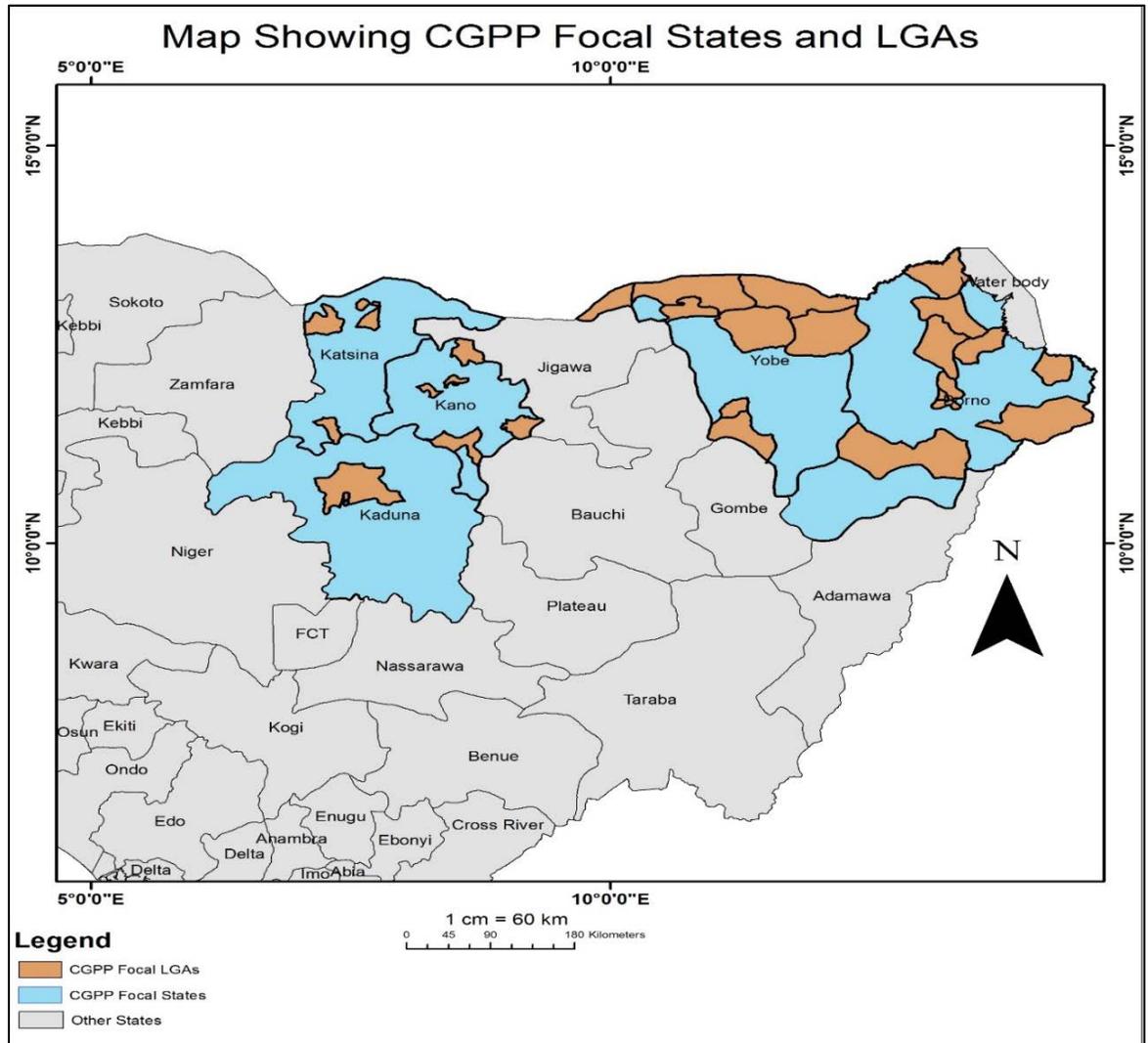


Nigeria

Nigeria suffered a serious setback when four cases of wild polio virus were recorded in July and August 2016. This was a disappointing reversal in the country's 24-month triumph against the virus.

The epicenter of the 2016 outbreak was an Internally Displaced Persons (IDP) camp located in the state of Borno, the site of malnourishment, measles outbreaks, low immunization coverage and continued violence by the terrorist group Boko Haram. Nigeria's outbreak response to these negative developments was swift and effective. To stop the outbreak, CGPP

supported five supplementary immunization campaigns to reach more than 400,000 children under age five in the affected areas. More than 2,000 community volunteers continue to be at the center of polio eradication efforts. Additionally, USAID provided additional funding to boost routine immunization. This organized response pushed RI coverage to 95 percent in 2016 from 49 percent in 2015 in targeted LGAs.



Build effective partnerships

CGPP continued to work with three International NGOs: Catholic Relief Services (CRS), International Medical Corps (IMC), and Save the Children (STC,) and eight local NGOs in 30 LGAs. The implementing partners work in five states of Kano, Katsina, Kaduna, Borno and Yobe within 30 Local Government Areas (LGAs/ districts,) to target 500,000 children under five and 1.5 million children under 15.

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

The project depends on the important contributions of 1,995 Volunteer Community Mobilizers (VCMs) and 243 Volunteer Ward Supervisors (VWSs) who work to promote participation in campaigns, routine immunization and AFP case detection. VCMs track pregnant mothers, newborns and defaulters and provide referrals for immunization services. VCMs also conduct community dialogues to create demand for immunizations, pay house-to-house visits to reduce the drop-out rate and attend compound meetings to address non-compliance. CGPP VCMs and VWSs, who provide supervision and support to VCMS, are critical to reaching previously inaccessible populations with health services and to reducing the drop-out rate by reaching missed children and non-compliant families.

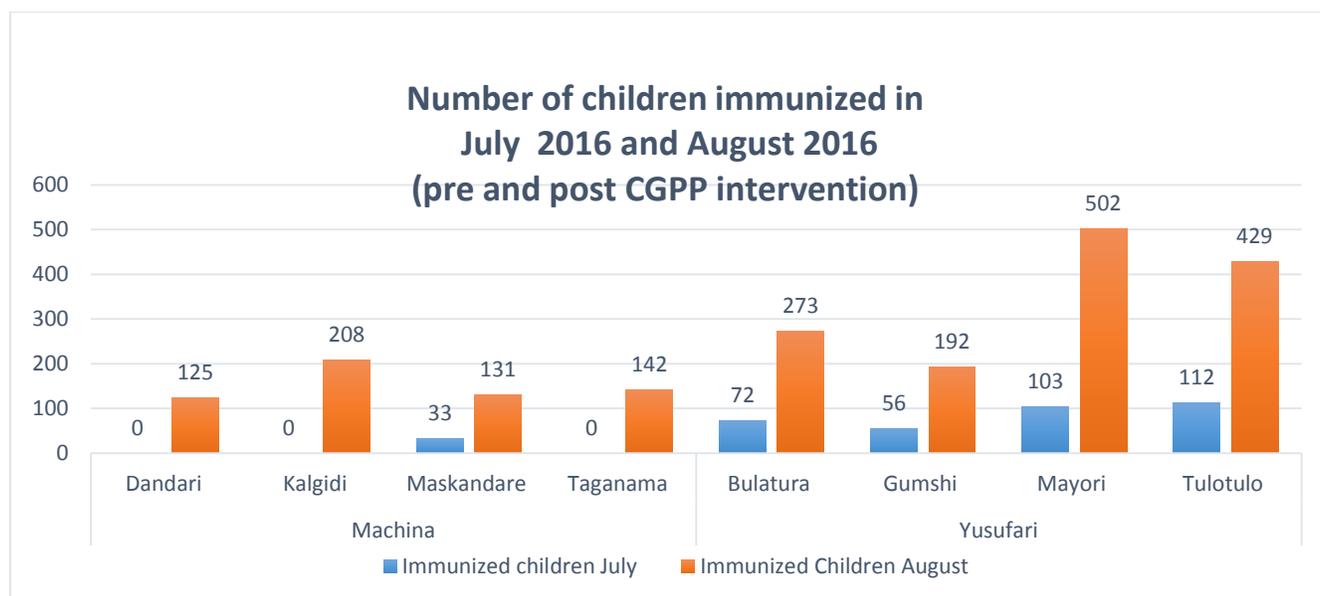
Support PVO/NGO efforts to strengthen national and regional immunization systems

The 2015 midterm survey found OPV0 coverage of 61.2 percent, OPV3 coverage of 49.6 percent, Penta 3 coverage of 46.7 percent, measles coverage of 62 percent and fully immunized coverage of 41.2 percent in children 12 to 23 months of age. According to administrative data in the project target areas, CGPP Nigeria made remarkable progress towards accelerated immunization coverage during the reporting period:

- OPV3 rates in children 12 to 23 months increased from 49 percent in 2015 to 95 percent in 2016.
- The percentage of children under five years with seven or more doses increased from 65 percent in 2015 to 96 percent in 2016
- The percentage of fully immunized children 12 to 23 months of age increased from 41percent in 2015 to 59 percent in 2016

These exceptional results are attributable to several factors: CGPP trained, monitored and supervised nearly 2,250 community volunteers to reach a greater number of children for vaccination; CGPP improved data collection and analyses across the five program states and CGPP conducted intensive routine immunization interventions in Katsina, Borno and Yobe states including a regular system of outreach vaccination.

Indicator	Sept. 2014	Sept. 2015	Sept. 2016
percent of children 0 to 23 months with OPV3	47	49.6	95
percent of children one year and older with 7 or more doses of OPV	52	65	96.5
percent of children 0 to 23 months fully immunized	33	41	59



These activities were made possible by additional USAID funding to expand RI coverage in Borno, Yobe and Katsina states through 66 health facilities in September 2016 (from 36 health facilities in July 2016) in nine LGAs, or districts. Stepped-up interventions began in July and August 2016. The implementing partners - CRS in Yobe, IMC in Borno and STC in Katsina - collaborate with the State Primary Health Care Development Agency (SPHCDA), the National Polio Emergency Operating Center (EOC) and the State Technical Working Group on Routine Immunization (RIWG.)

The aim of the routine immunization intervention is to support each health facility to conduct one outreach session per week. CGPP strengthens the capacity of providers through the development of micro-plans and supportive supervision. CGPP also recruited one RI Officer in each state to coordinate the project and assist each state's Program Manager and M&E Officer to generate data. The use of CGPP community volunteers reduced the dropout rate and improved community buy-in and participation in the sessions.

Several old and new challenges threaten the project's progress. IDPs face malnutrition as they are unable to farm their lands due to insecurity. A measles outbreak is further straining resources as Boko Haram insurgents continue to destroy RI facilities. Much needed maintenance of cold chain equipment, including broken solar fridges, also interrupts the project's progress. The project will pay special attention to vulnerable IDPs: integrate nutrition services with immunization campaigns, especially in conflict-affected areas, with Community Management of Acute Malnutrition (CMAM) sites; utilize security forces to deliver immunizations to protect health workers; merge polio awareness into broader health and wellness messages; conduct RI in security-compromised and hard to reach areas to raise population immunity and boost training, social mobilization, and advocacy.

Project staff provides RI services for children who reside both inside and outside of the IDP camps through five health facilities situated in IDP camps within Maiduguri and Jere districts of Borno. Yobe supports a total of 11 health facilities in three districts – four each in Yusufari and Machina and three in Yunusari. Most of these facilities are in hard to reach areas with previously very low coverage of all antigens and a high drop-out rate. At the end of FY16, Katsina was providing RI through 40 health facilities in Funtua and Katsina districts. Support for 10 additional health facilities in Batsari and Rimi districts is scheduled to begin in FY17.

Annual Vaccination Week: Additionally, CGPP supported the Annual Vaccination Week (AVW) 2016 in Borno. The event encourages countries to strengthen immunization services and systems through advocacy, education, tools and activities. The theme of the event was “Close the immunization gap. Stay polio free!” and celebrated the switch from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV.) The Deputy Governor of Borno and the State Commissioner of Health attended the bivalent switch on April 18, 2016.



CGPP VCM in Katsina vaccinating a baby at meeting

During the project year, the EOC requested that CGPP collect data on zero dose children in the five CGPP states. Initial results show the strong response to the newborn vaccination is linked directly to the social mobilization efforts of health workers.

The project conducted various trainings to strengthen the capacity of VCMs and VWSs. Across the project states, GPP conducted numerous trainings ranging from smartphone and data tool instruction to case detection.

Type of Training by CGPP Nigeria, FY16	Number of Participants
M&E Training on Smartphone (ODK)	112
Training on BCC Tools	173
Community AFP Case Detection	318
Sensitization Training for Religious leaders	857
Training on Polio campaign/PEI	323
RI training	144
Sensitization training on hit and run	40
Training on VCMs register and data entry	100
Total	2,067

Social mobilization tools deployed by CGPP Nigeria, FY16

States	M&E Tools		BCC Tools					T-shirts	Hijabs	Wrist Bands
	VCM Register	Smart phones	Streamers	Danglers	Flip book	Bags	Leaflets			
Kaduna	101	10	150	325	100	100	1200	28	110	146
Kano	301	30	200	450	300	300	2500	41	310	374
Katsina	181	22	305	480	255	100	1200	58	335	147
Yobe	501	60	350	550	600	250	2600	48	530	598
Borno	581	77	350	550	600	250	2500	33	544	589

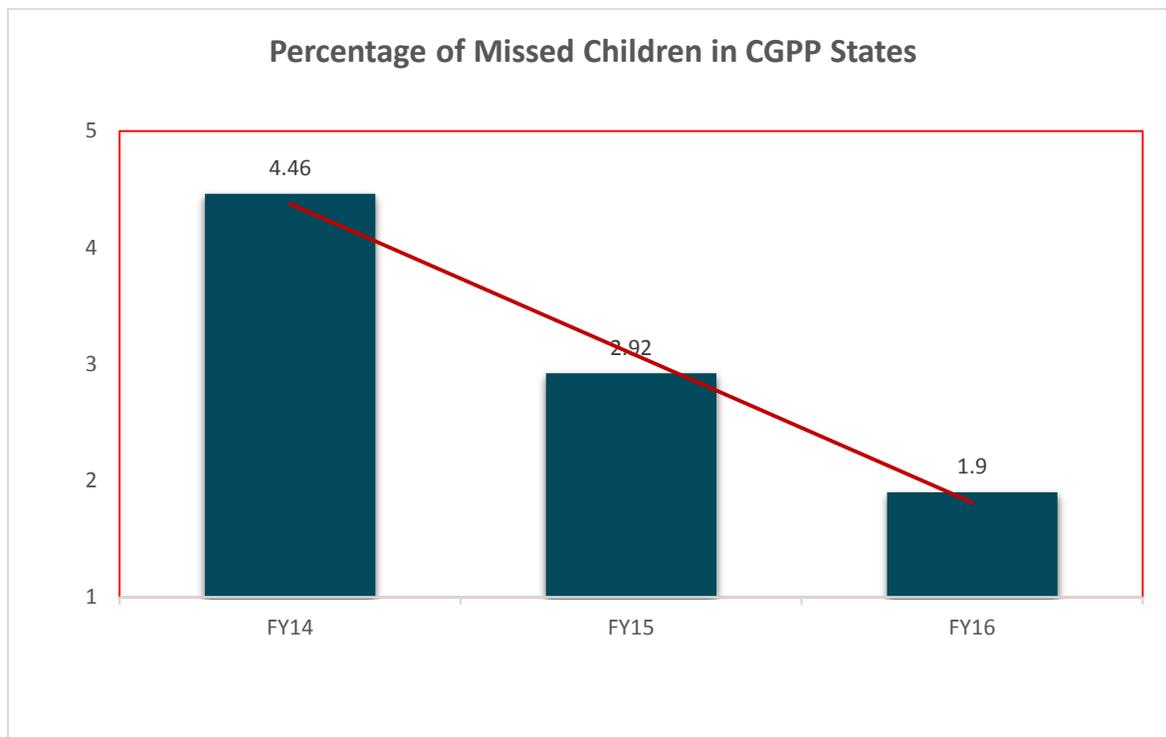
Hygiene and polio: CRS-Nigeria and local NGO FOMWAN initiated a privately funded Water, Sanitation and Hygiene (WASH) project to reduce the spread of waterborne diseases. From January to July 2016, FOMWAN utilized the cadre of polio eradication community mobilizers to promote the need for good hygiene. Mobilizers were well-received in their dual role and worked to successfully change the behavior of non-complying households

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

Outbreak Response: The identification of four cases of WPV1 and two circulating vaccine derived poliovirus cases (cVDPV2) was a major setback for CGPP Nigeria in 2016. All four cases were found among children in previously inaccessible portions of Borno. Two of the four infected children had received multiple doses (10 and 6 doses) of oral polio vaccine according to mother self-report but may have had a poor immune response due to malnutrition.

In coordination with the government and other partners, CGPP contributed to a comprehensive outbreak response, which included five campaigns targeting 400,000 children under five in Borno, Yobe, Kaduna, Kano, and Katsina. During the August 2016 OBR, vaccinators vaccinated 219,446 children, achieving 105 percent administrative coverage. VCMs conducted intensive newborn tracking, house-to-house social mobilization, and in-between round (IBR) activities to encourage vaccination. CGPP community volunteers used behavior change communication tools to reduce resistance to vaccination and increase awareness of the program.

The percentage of children missed in 2016 SIAs in CGPP target areas, (except Katsina) dropped from an already low 3 percent to a striking 2 percent. In Kaduna, less than 1 percent of children were missed in 2016 compared to 7 percent of children missed just two years earlier. This significant decrease is attributable to CGPP-supported VCMs' intensive newborn tracking, house to house immunization and in-between round (IBR) activities. The project has contributed significantly to campaign quality through logistical support, supervision, and social mobilization at the community level achieving less than 2 percent missed children.



CGPP employed multiple strategies to reduce non-compliance in Katsina, a stronghold of opposition to the oral polio vaccine. VCMs conducted compound meetings, held community dialogues, and visited naming ceremonies, Majalisa sensitization meetings with religious groups and Islamiyah schools for married women to reach unvaccinated children under five. Due to these efforts, the number of children in non-compliant households dropped from 5,855 in October 2015 to 4,719 in September 2016, a 19 percent reduction.

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

Community Based Surveillance: The ability to identify and rapidly respond to any future outbreak is critically important. To support community based case surveillance, CGPP has enlisted and trained Community Informants (CIs) to assist VCMs in their work across CGPP's five target states. Traditional Birth Attendants (TBAs), Herbalists, Patent Medicine Vendors (PMVs) and Traditional Bone Setters serve as first-line informants when a child is suffering paralysis. This effort has resulted in an increase in the Non-polio AFP rate (NPAFPR) from 17.3 in September 2015 to 20 in December 2016. The stool adequacy rate also remained high at 99 percent. In FY16, trained CIs and VCMs helped identify 449 suspected AFP cases in the CGPP areas; Yobe reported 233 AFP cases in 2016; Borno, 83; Katsina, 64; Kano, 38; and Kaduna, 31. Nevertheless, there are still silent portions of some LGAs with significant security related access restrictions.

WHO evaluated Nigeria's surveillance program in August 2016 and found strong use of open data source (ODK, ONA,) verification of cases of near 100 percent in accessible areas in Borno, appropriate record keeping on verified AFP cases and proper collection of stools. The WHO-led external surveillance found that all CGPP volunteers and staff are trained on surveillance and actively search for potential AFP cases.

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

CGPP Nigeria has developed a comprehensive project monitoring and evaluation system, coordinated by a Secretariat M&E Officer based in Abuja and supported by state M&E officers working within each partner NGO. The foundation of the health information system (HIS) is data collected by VCMs in registers of all of the children under five in their target households. The data from these registers is used primarily to identify vaccine defaulters and encourage mothers to take children in for scheduled vaccinations but the data is also compiled to provide the project with comprehensive vaccine coverage data for project beneficiaries. Volunteer supervisors review the registers and compile the data into reports that are then collated and combined to produce partner reports that can guide project planning.

In FY16, CGPP Nigeria published or co-authored five abstracts in peer reviewed journals and attended three conferences.

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 mapping all government and partner assets working on polio eradication. CGPP represents the voice of civil society in the implementation of the legacy planning for the Nigeria polio program. Through the Polio Legacy Technical Task Team, CGPP has mapped and estimated the cost of all its polio assets at one million dollars, including human resources, physical assets, intellectual assets and other resources deployed by CGPP to support Nigeria's polio eradication initiative.



CGPP and health officials reviewing AFP case detection in Limanti community of MMC during state-wide case search in May 2016.

South Sudan

South Sudan ranks high on the list of countries with the potential for a wild polio virus outbreak. The ongoing conflict appears to be worsening and spreading to the southern states as well creating security access issues for

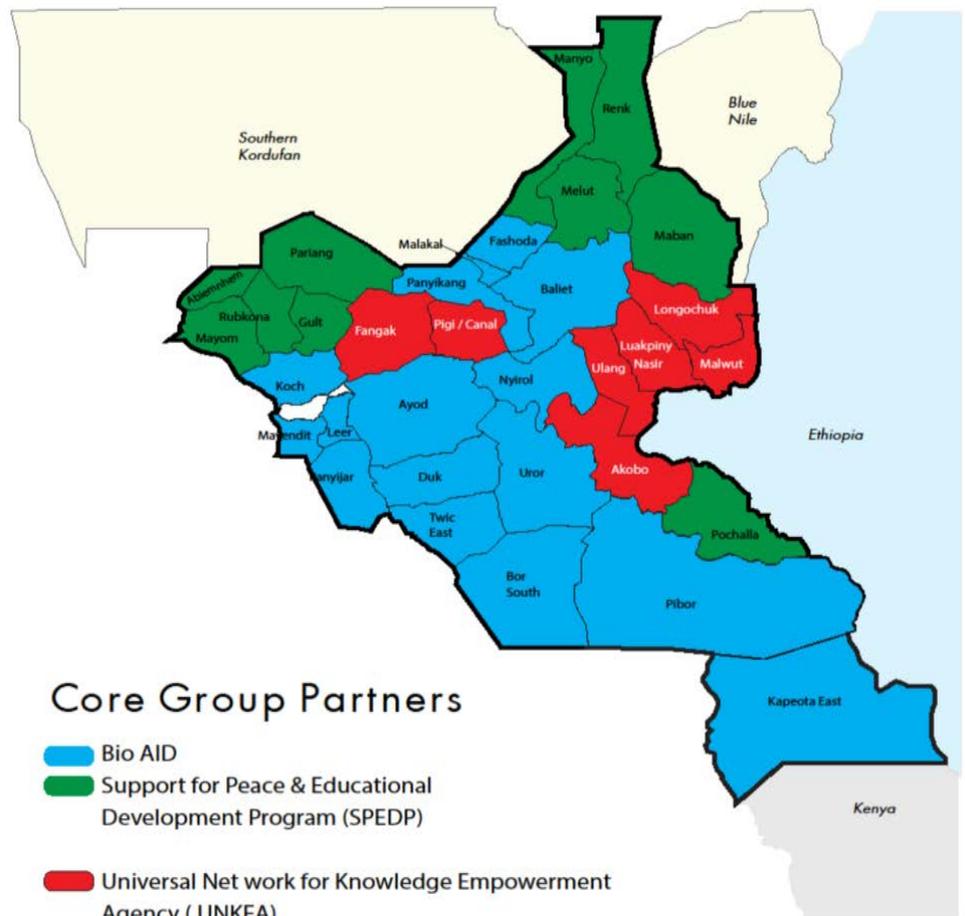
campaigns, surveillance and routine immunization. The government health infrastructure remains extremely weak and heavily reliant on outside help from NGOs and UN agencies but many of the international organizations have reduced their presence and expatriate staff due to poor security and attacks on international staff by government soldiers. The CGPP strategy of working with and through local NGOs has made CGPP one of the only partners able to maintain surveillance and social mobilization activities fairly uninterrupted

throughout this difficult period and therefore more of an asset than ever in South Sudan's polio eradication efforts. At present CGPP receives funding for our work in South Sudan from the BMGF, USAID and UNICEF. USAID funds were primarily used to support independent campaign monitoring for the whole country in 2016 and a portion of the Secretariat costs. UNICEF funded social mobilization through community mobilizers and BMGF funded community based AFP surveillance in 29 targeted counties out of a total of 70 counties in the country.

The ongoing conflict has resulted in the displacement of at least 400,000 unimmunized children under five years of age, the destruction of health facilities and an extreme shortage of health workers. Further exposing the

country's vulnerability is the circulating vaccine-derived poliovirus (cVDPV) confirmed in 2015 in a camp for internally displaced persons (IDPs.) In response to these challenges and at the request of the Polio Technical team (WHO, UNICEF, MOH, and CGPP), CGPP shifted from working with three international NGOs in eight southern border counties to working with five local NGOs in 29 counties in the three conflict effected northern states of Jonglei, Unity and Upper Nile. CGPP continued Independent Campaign Monitoring (ICM) throughout the country in every county accessible for NIDs and SNIDs. This strategy has been very effective and has allowed the polio eradication program to continue in areas that would have been otherwise inaccessible.

Core Group South Sudan Operation Areas



Build effective partnerships

The CGPP South Sudan Secretariat recruited five national organizations in FY16: Nile Hope, Community Aid for Development (CAD), Bio Aid, Universal Network for Empowerment Agency (UNKEA) and Support for Peace and Education Development Program (SPEDP). The Secretariat and its implementing partners initially targeted the conflict-affected states of Jonglei and Upper Nile with community-based surveillance and independent campaign monitoring in the whole country. In July 2016, CGPP South Sudan expanded its project area to include Unity state and hired three state surveillance supervisors to support implementation in Upper Nile, Jonglei, Kapoeta East and Unity states. The Secretariat organized monthly meetings to update progress and challenges in the field during implementation. Although working with local NGOs gives the project greater access to security challenged areas and at a much more reasonable cost than working with international NGOs, there have been some challenges. One of the local NGO partners, CAD, stole BMGF and UNICEF project funds in 2015 and were removed from the project. They did not steal any USAID funds and CGPP partner, World Vision, has taken legal action against CAD and frozen their bank accounts.

CGPP South Sudan is a critical voice at meetings with national, state, county and community level organizations and collaborates regularly with WHO, UNICEF and MOH. The Secretariat Director and Surveillance Project Manager attended weekly meetings of the Expanded Program on Immunization (EPI) Technical Working Group to discuss and evaluate monthly performance and planning for NIDS and outbreak emergency responses. The CGPP supported two national Interagency Coordination Committee (ICC) meetings in January 2016 and August 2016. 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. To build on this relationship, the South Sudan Secretariat attended the 14th and 15th HOA TAG meetings in Nairobi to discuss ways to increase the sensitivity of surveillance both within the conflict-affected states and along heavily traveled routes at cross border sites.

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

Due to the Horn of Africa's WPV outbreak in 2014 and ongoing violence in the states of Upper Nile, Jonglei and Unity, CGPP established Special Vaccination Posts (SVPs) to reach mobile populations that are typically unvaccinated or under-vaccinated. Population movements due to conflict and instability create the ideal environment to spread the virus. In FY16, CGPP expanded the number of permanent vaccination posts from three to fifteen in 2015. Nine posts are located at the international borders of the Democratic Republic of Congo, Uganda, Kenya, Ethiopia and the Sudan. Six posts are located within the country. Vaccinators reached a total of 54,120 children under 5 years with oral polio vaccine; only 2.5 percent of the children received OPV for the first time. The highest proportion of zero-dose children were located at Kilikili vaccination border posts in Morobo county in Central Equatoria state bordering DR Congo (16 percent) and Malwal in Longechuk County in Upper Nile State bordering Ethiopia (18 percent.)

Children reached at Special Vaccination Posts in FY16

Time Period	# at least 1 dose	# zero dose	percent zero dose
Oct. -Dec. 2015	8,075	215	2.7
Jan.-March 2016	19,997	404	2.0
April-June 2016	19,889	557	2.8
July-Sept. 2016	6,159	192	3.1
Total	54,120	1,368	2.5

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

Boosting population immunity through Supplemental Immunization Activities in South Sudan is a top priority. More than 1.8 million internally displaced persons are living within Sudan, including 204,370 in the UN protected sites of Unity, Upper Nile, Jonglei and Juba states. An estimated 120,000 zero-dose children remain isolated in these conflict-affected areas. Huge movements of IDPs and refugees, the presence of circulating vaccine-derived poliovirus in IDP camps in Unity, and the potential re-importation of the virus across borders all point to the urgent need for SIAs.

At the request of the EPI Technical Working Group, the CORE Group Polio Project has been conducting independent campaign monitoring in South Sudan since 2013. CGPP South Sudan conducted independent campaign monitoring throughout accessible areas in 2016 and provided logistical support and supervision to three rounds of National Immunization Days and one Sub-National Immunization Day. SIAs were held in November, December, February and April as well as two short interval additional doses in Unity, Upper Nile and Jonglei in May and August 2016. The project provided trained vaccinators, fuel to freeze ice packs, transported and distributed vaccine to counties and villages using boats, motorbikes, cars and bicycles and mobilized communities to participate in the campaigns. The national campaigns targeted 3.5 children under 5 years. Despite ongoing violence, the November 2016 NID reached 300,00 children, including 40,000 internally displaced children, with oral polio, vitamin A supplements and deworming tablets.

Independent Campaign Monitoring Strategy

The CGPP has contributed a great deal of effort to both the implementation of immunization campaigns and the implementation and supervision of independent campaign monitoring using Angolan military personnel that were trained, transported, and supervised by CGPP staff. Each of the CGPP partner NGOs provided transportation, training, social mobilization, supervision and planning support for 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 to maintain adequate protection against re-importation of the wild polio virus.

CGPP trained and deployed a local supervisor to each state and identified and trained local teachers to serve as data collectors at the county level. More than 300 teachers collected both in-house and community data within a payam, visiting four bomas per payam and 10 households per boma following WHO campaign monitoring guidelines. The data was entered and analyzed, with independent monitoring results within 14 days of the campaign completion. CGPP advocates for the uses of ICM results in central, county and payam levels. In 2015, CGPP pilot-tested the use of mobile technology to transmit data in real-time, reducing the wait time for ICM results from five weeks to three days. In 2016, the project expanded the use of mobile technology country wide.

Based on CGPP Independent Campaign Monitoring data, the majority of project counties met the 90 percent benchmark or pass rating for the quality of the campaign. During the first two NIDS in FY 2016, 32 of 40 project counties in November and 34 of 40 project counties in December met the threshold. During the February 2016 SNID, 19 of 22 counties met the pass rate of 90 percent coverage. During the April 2016 campaign, 33 of 41 counties received a pass rating while eight counties failed. The primary reasons for missed children during the campaigns included vaccination teams not visiting the household or the child not being home during the visit.

14th HOA TAG Meeting February 2016

Due to the large numbers of inaccessible children, massive population movements and persistent immunity gaps, TAG members encouraged South Sudan to maintain high quality surveillance, fill remaining immunity gaps, and address subnational surveillance gaps. TAG officials suggested the development of an Immunization Operational Support Cell (OSC) to lead and drive all public health activities related to immunization, improve surveillance in the conflict-affected states, and improve quality of SIA activities. Led by a senior MOH official, the OSC would collaborate with partnering NGOs to implement an accountability framework and one implementation plan for immunization activities; improve surveillance in the three conflict-affected states by fully engaging NGOs on the ground, conducting healthy children stool sampling, and carrying out contact/community sampling.

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

In FY16, the project expanded community-based surveillance by broadening its network of community volunteers to the grass-roots level. The project recruited 1,977 “key informants,” such as healers, church leaders or birth attendants, across 20 counties to undergo training to identify potential cases of AFP. These well-respected community mobilizers serve as the eyes and ears of the project by alerting their supervising payam (district) assistants to the signs and symptoms of active AFP cases in the village. In turn, payam assistants visit key informants daily, conduct social mapping and ensure follow up of any AFP cases with county supervisors, who are managed by state officers.

PARTNER	# OF COUNTIES	# OF KEY INFORMANTS
NILE HOPE	3	357
BIO AID	8	521
SPEDP	5	858
UNKEA	4	241
TOTAL	20	1,977



During the project year, project staff recruited three State Surveillance Officers; 26 of 34 County Supervisors and 157 of 230 payam assistants. The vacant positions were to be filled by late 2016. State surveillance officers spent about 75 percent of their time in the field to improve the quality of CBS and are expected to visit half of their counties quarterly, depending on logistical constraints due to fighting. In December 2015, the Secretariat provided a broad orientation on the goals of the community based surveillance project to its implementing partners. Seventeen participants met in Juba to review AFP case detection, reporting and investigation.

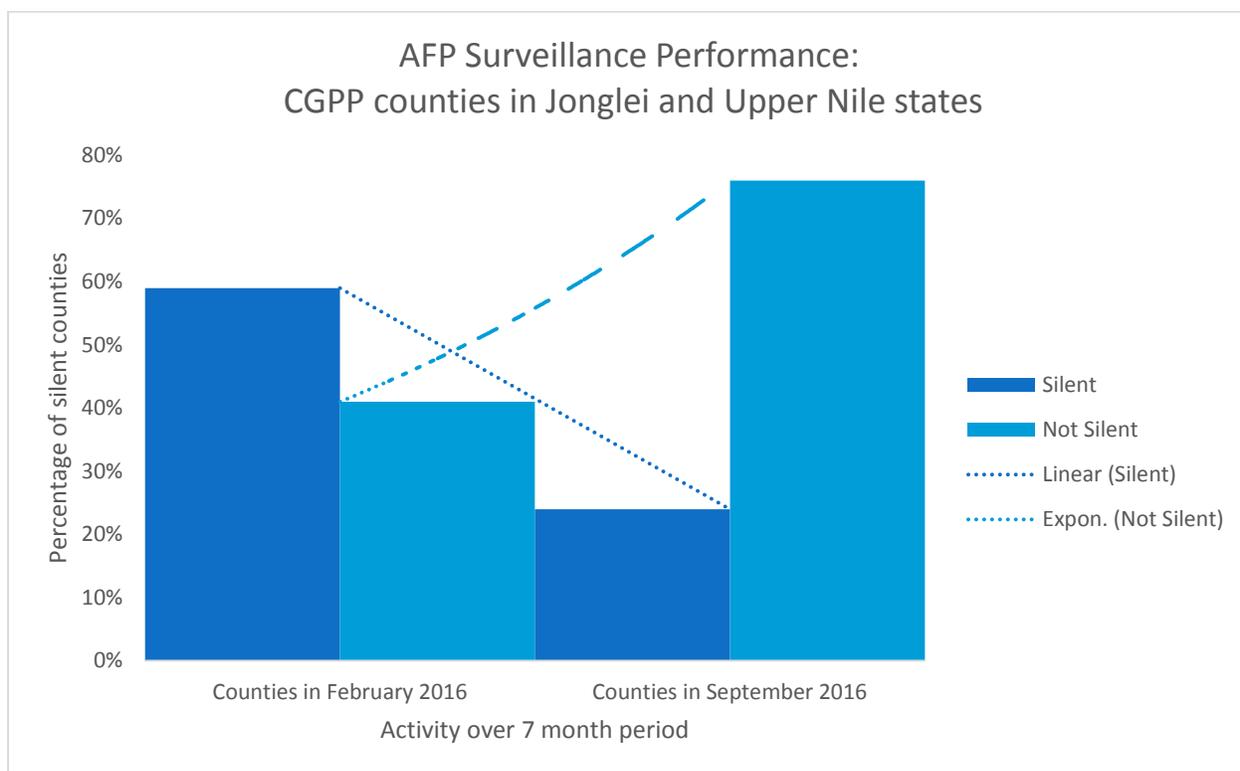
CGPP, WHO and UNICEF provided a three-day training to 20 county supervisors in June 2016 in Juba to review AFP surveillance priority sites, understand roles and responsibilities of the various team members, handle stool specimen collection, and learn from case studies. The Secretariat conducted an additional training for 26 county supervisors and monitoring and evaluation officers in September 2016 in Juba. Strengthening report writing skills, mapping locations of payam assistants and key informants, and developing work plans served as the primary goals of the meeting.



Pochalla County Supervisor Candiga Moses works on social mapping

Community-based surveillance efforts have resulted in the vast improvement and maintenance of key surveillance indicators in CGPP-supported counties. In FY16, a total of 96 cases was reported within 38 CGPP-supported and non-CGPP counties in the four states of Upper Nile, Jonglei, Eastern Equatoria and Central Equatoria. Of the 96 reported cases, key informants, or village mobilizers, reported 29 confirmed cases, or 30 percent of all confirmed cases.

Despite insecurity and flooding, CGPP attained a remarkable reduction in the number of silent counties. During a seven-month period from February to September 2016, CGPP South Sudan reduced the number of silent counties from 17 to 4 in the Jonglei and Upper Nile states. The project hopes to reduce the proportion of silent counties to less than 15 percent by the end of June 2017.



Stool Adequacy Rates and Non-Polio AFP Rates

All stools arrived at Juba’s national laboratory for testing and identification in good condition, with more than 80 percent arriving within seven days. All states achieved the national target for non-polio AFP rates-2 cases per 100,000 children under age 15. Eight of 11 counties in Jonglei attained the target while 8 of 12 counties in Upper Nile attained the national and international target by Sept 2016.

AFP contact sample indicators (Epidemiological Week 39/2016)

States	Population <15	Stool Adequacy	Samples collected within 7 days of case notification	NP-AFP Rate
Upper Nile	895,541	100 percent	87 percent	3
Jonglei	982,693	100 percent	91 percent	4.1
Eastern Equatoria	674,008	100 percent	97 percent	6.3
Central Equatoria	737,148	100 percent	100 percent	2.2

Source: WHO South Sudan weekly updates 2016

Expansion of community based surveillance to Unity State

An expansion of the project to Unity State was delayed until September 2016 due to fighting that erupted within Juba during July and August. Two partner organizations assist Unity: SPEDP provides support to Rubkona, Guit, Pariang, Abiemnhem and Mayom counties while Bio Aid supports Mayendit, Koch, Leer and Panyijar counties. With assistance from state health officials, CGPP was eventually able to recruit six county supervisors, 25 district assistants and 50 village mobilizers in Rubkona, Guit, Pariang, Abiemnhem, Mayom and Mayiendit. By the conclusion of FY16, Mayendit County was the sole functioning area; the security situation is still unstable in Leer, Koch and Panyijar with recruitment on hold.

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 organized a meeting in May 2016 in Kaya with 21 health experts from Uganda and the Democratic Republic of Congo. Participants concluded that lack of funds for DR Congo and Uganda and insecure borders in South Sudan prevented any significant progress since the last meeting in 2015 in Uganda. The group resolved the need for continued funding for the cross-border initiative and development of standard indicators and targets to boost cross border vaccination.

Due to the decline in security and increased movement along the border between Upper Nile and Gambella, CGPP organized another cross-border meeting in August 2016 at the Burbie border point in Nasir county, located between South Sudan and Ethiopia. Sixty-one participants resolved that the CBI should immediately coordinate AFP surveillance activities as South Sudan's formal health system is not functioning.

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

The use of ODK technology in FY16 accelerated the collection of data and survey responses to improve campaign effectiveness. The use of mHealth and real-time data reduced the wait time for independent monitoring results from five weeks to three days. This allows counties with poor ICM outcomes to identify issues and implement corrective actions expediently.



Activities at a Glance



KENYA: Turkana county CGPP project officer take history of illness of a suspected AFP case at Natete village, Kokuro Sub Location, Kibish Sub County. Accompanying him is Mr Edward Kaatho (in green cap) - CHV for Kokuro health center, and Mr. Gregory Kiyonga (in white cap - PA for Kokuro health center)



2nd Summit –CGPP team in Ethiopia



A VCM conducting group meeting in Nigeria

Nigeria campaign in action



CMC & Vaccination team visiting a house during Polio campaign in Moradabad, India



Health Camp at Sambhal District, India