CORE GROUP POLIO PROJECT

Fiscal Year 2014

Annual Program Report

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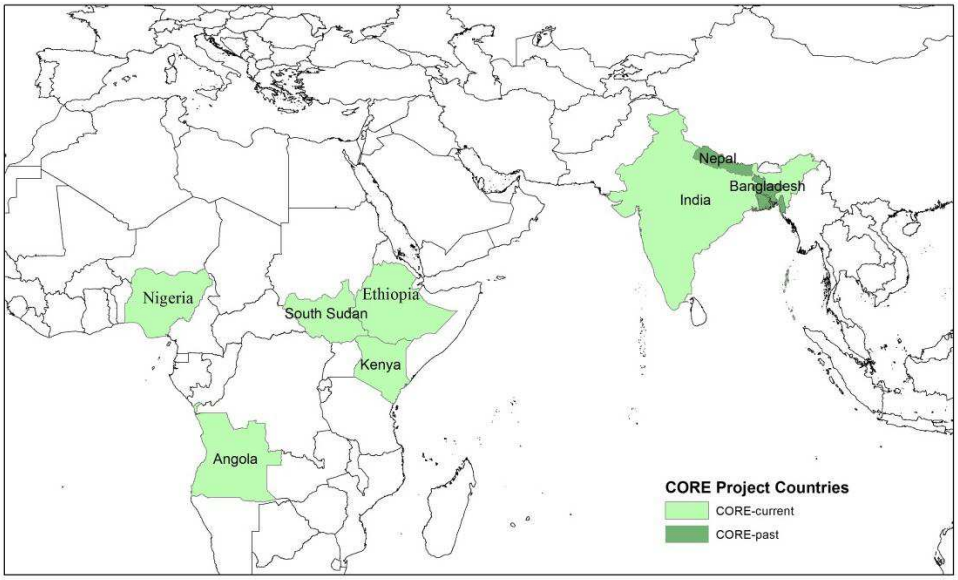
Executive Summary

Fiscal Year 2014 has been a remarkable year of programmatic expansion and virus reduction for CGPP and should prove to be a pivotal year in global polio eradication. CGPP doubled the number of countries covered with USAID funds from three in FY 2013 to six in FY 2014 with the launching of new programs in Nigeria and the Horn of Africa covering Kenya and Somalia. The project is now present in seven countries counting South Sudan partnering with over ten international NGOs and 20 local organizations, allocating approximately 40 sub-grants and posting over ten thousand community volunteers. India and Angola both celebrated three year anniversaries with no new cases of wild poliovirus; remarkable considering they both registered cases in the thousands when CGPP began. Ethiopia successfully stopped a 2013 wild poliovirus outbreak imported from Somalia, and the massive 2013 outbreak in Somalia (194 cases) seems to have been interrupted with only five cases reported in 2014 and the last case reported in August 2014.

Nigeria is the greatest global success story. After years as the worst offender in Africa, exporting cases to numerous other countries, Nigeria has only reported five cases in 2014, down from 50 in 2013 and 101 in 2012. With the last case reported in August 2014 there is a very real chance that Nigeria has at long last interrupted transmission of wild poliovirus. If true, this could signal the achievement of a once nearly unthinkable end of wild poliovirus on the continent of Africa.

The CORE Group Polio Project in 2014



Pakistan, a non CGPP country, is the one truly dark cloud on the horizon, reporting 276 cases year to date in 2014, up from 93 total cases in 2013. Added to the 24 cases in Afghanistan, the Pakistan/Afghanistan block accounts for 300 of the 325 cases reported in 2014 and all but five of the cases in endemic countries. There seems to be little good news on the Pakistan eradication front except that the surveillance system seems to be finding the cases and success in Africa will allow the world to focus more attention and effort on finishing the job in Pakistan.

CGPP has a strong track record of interrupting transmission in their target countries through the introduction and meticulous implementation of innovations many of which have now become standard procedure in the global polio eradication initiative. The CGPP India program has continued to improve

while sharing their years of experience with Nigeria and other countries through short-term assignments experience sharing. The CGPP global program also saw the return of the former Nepal Secretariat Director as the Team Leader for the new Horn of Africa program. The Ethiopia and India Secretariat Directors both continued to share their expertise as valued members of two GAVI boards and the Angola program and Secretariat continued to play significant leadership roles in Angola eradication and immunization. In 2014 CGPP is both a mature program with years of experience in key countries and a young expanding program in Nigeria and the Horn of Africa. The program is strong and getting stronger and well poised to contribute to the final push to eradicate polio from the world.

List of Acronyms and Abbreviations

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

SNID	Sub-national Immunization Day
SMO	Surveillance Medical Officer
TAG	Technical Advisory Group
TCG	Technical Consultative Group
TFI	Task Force on Immunization
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization
WPV	Wild Poliovirus
WV	World Vision
WV-US	World Vision United States

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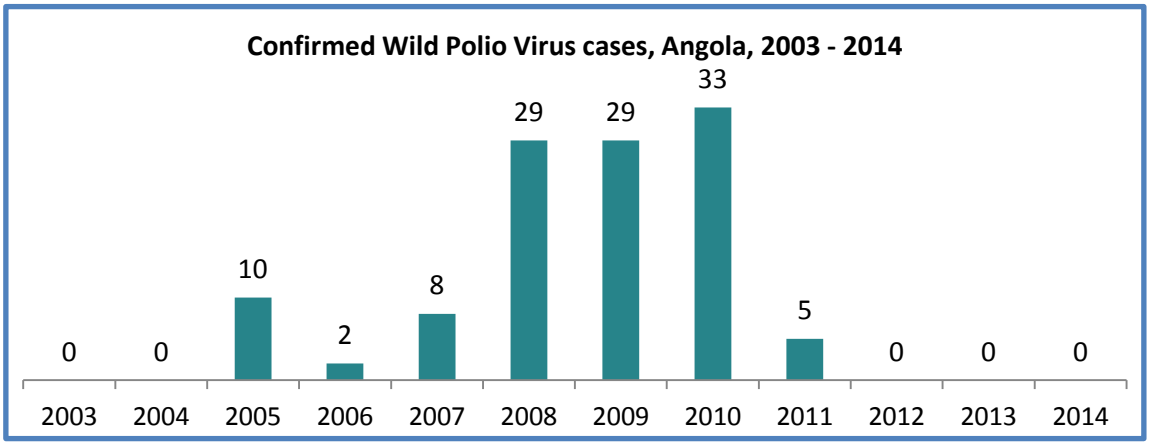
CGPP Angola

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



Angola conducted its first national census since 1970 in 2014, documenting a popoulation increase from 5.6 million to 24.3 million inhabintants. The capital, Luanda, now has 6.5 million residents which poses a major risk for virus importation and spread due to population density, poor sanitation, and inconsistent health services for the poor. Following a decades long civil war, Angola has been at peace since 2002, which makes access for vaccination campaigns and health services much easier, while also making it easier for diseases to spread should the country face a new importation.

CGPP-Angola is currently working in 41 high-risk districts in 13 of the 18 provinces reaching 9,422,824 children under the age of fifteen each year. CGPP-Angola continues to mobilize community volunteers, support the implementation of high-quality vaccination campaigns and identify cases of acute flaccid paralysis (AFP). This year, the project focused on several key areas including: 1) active case detection targeting community leaders and urban health facilities, 2) support to strengthen SIAs, 3) campaign monitoring, and 4) local level advocacy meetings to more effectively mobilize leaders at district (*municipio*) and sub-distrcit (*communa*) levels.

Objective 1: Build effective partnerships between agencies

CGPP-Angola has established a strong working relationship with the MOH and spearheading partners in Angola, playing an important role in the national ICC meetings and working closely with the MOH, UNICEF, CDC, Rotary, and WHO to plan, implement and monitor all aspects of polio eradication in Angola. The CGPP partner NGOs meet on a monthly basis to coordinate and discuss strategies to strengthen polio eradication activities. These monthly meetings also provide the CGPP Secretariat an opportunity to communicate decisions, policies, and guidelines established by the ICC, MOH, and the Global Polio Eradication Initiative. In a similar fashion, the presence of the Secretariat Director on the ICC and the Technical Working Group gives the NGOs and civil society a voice at the national decision making level among the MOH and spearheading partners. In qualitative interviews conducted as a part of the baseline project evaluation in 2012, 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.

The current project coordinates the participation of four international NGOs; Africare, Catholic Relief Services, World Vision, and the Salvation Army, and two local NGOs; CARITAS and ASSODER. The partners support 2,710 community volunteers, 43 supervisers, and 4 project coordinators. To better coordinate and plan activities and build the capacity of project staff, CGPP Angola held two partner forums in 2014 which included the polio management staff and senior leadership of all of the partner NGOs. These meetings provided an opportunity for project staff from different NGOs working in varied regions to learn from, interact with and share best practices with their counterparts throughout the country.

CGPP Partners in Angola

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

Africare is one of the key partners of the ministry of health working with WHO and UNICEF to improve health care and disease prevention. Africare participates in weekly meetings with the Luanda and Uige Provincial Directors of Health in which they review routine vaccination coverage and AFP surveillance and plan campaigns. They are actively working with the MOH to identify causes for low immunizatin coverage and to create strategies to improve coverage. They promote outreach vaccination teams and action plans. They are also active in AFP surveillance supporting both facility based active case searches and community based surveillance. In FY 2014, Africare participated in 138 technical planning meetings at the provincial and district levels. They are also working with local radio stations to promote vaccination.

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

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

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

CGPP continued to play an integral role in the national Interagency Coordinating Committee (ICC), working together with the MOH, WHO, UNICEF, Rotary, and the Red Cross to develop various national plans for campaigns, the introduction of new vaccines, GAVI reports, environmental sampling, external reviews, and presentation of independent campaign monitoring results. In addition to sitting on the overall ICC, CGPP is a key contributer to the technical committee and the social mobilization committee. CGPP played an active role in meetings to evaluate the national surveillance system and national immunization.

CGPP planned and implemented two cross border meetings with the Democratic Repbulic Congo to the North and Namibia to the south in FY 2014.

Objective 2: Strengthen routine immunization systems

Based on data from a 30 cluster baseline, mid-term and a final evaluation survey, OPV3 coverage rates in project areas based on card only were 32 percent in 2008, 40 percent in 2010 and 37 percent in 2012. OPV3 coverage by card plus mother recall actually declined from 59 percent at mid-term in 2010 to 49 percent at the final evaluation in July 2012. Ministry of Health (MOH) administrative data shows a decrease 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. A mid-term evaluation survey is planned for 2015.

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.

GAVI visited Angola in 2014 to review Angola's plans to introduce IPV and identified various weaknesses in human resources, data quality, surveillance, social mobilization, finance, cold chain and logistics. The MOH also conducted national capacity building for immunization workers at all levels in 2014. CGPP worked together with district health officials, WHO, and UNICEF to train approximately 5,144 technicians in 1,286 health facilities.

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 2014 the project continued to build the capacity of vaccination staff through technical training in vaccination techniques and cold chain management and on the job supervision. Responses on the 30 cluster survey identified various access related issues as important factors in the low immunization coverage. Mothers responded that they did not know where or when to go for immunizations, the vaccination site was too far, there was no vaccine at the vaccination site, and that the vaccination teams did not come to their village or area. Discussions with health administrators have countered that mothers were too busy working to bring their children for immunizations and that families did not prioritize preventative services such as immunization. Based on these responses, the project has engaged both the health workers and the communities in creative ways such as outreach campaigns and social mobilization to increase vaccination coverage.

One of the ways in which the project is working to increase routine immunization is through the use of vaccination registries maintained by community health workers (CHWs). This strategy requires the CHWs to visit households under their supervision and record the vaccination status of all children under five. By tracking the individual vaccination status of these children, the CHWs are able to identify which children need to go for follow up vaccinations and to verify their compliance. Project coordinators and supervisors held 1,052 meetings with the MOH and partners. The CGPP has 2,710 trained CHWs covering approximately 25 to 50 households each in 41 districts of 13 provinces covering 430 health facilities offering vaccination services. The community volunteers conducted 6,972 visits to health facilities to check whether the 10,913 children referred for vaccination received the correct vaccinations for their age. They also conducted 1,668 health education skits, 21,744 health education talks, 13,229 visits to traditional healers, 11,560 visits to traditional birth attendants, 12,777 visits to community leaders, and 411,863 house visits.

CGPP Angola community volunteer manual and registry

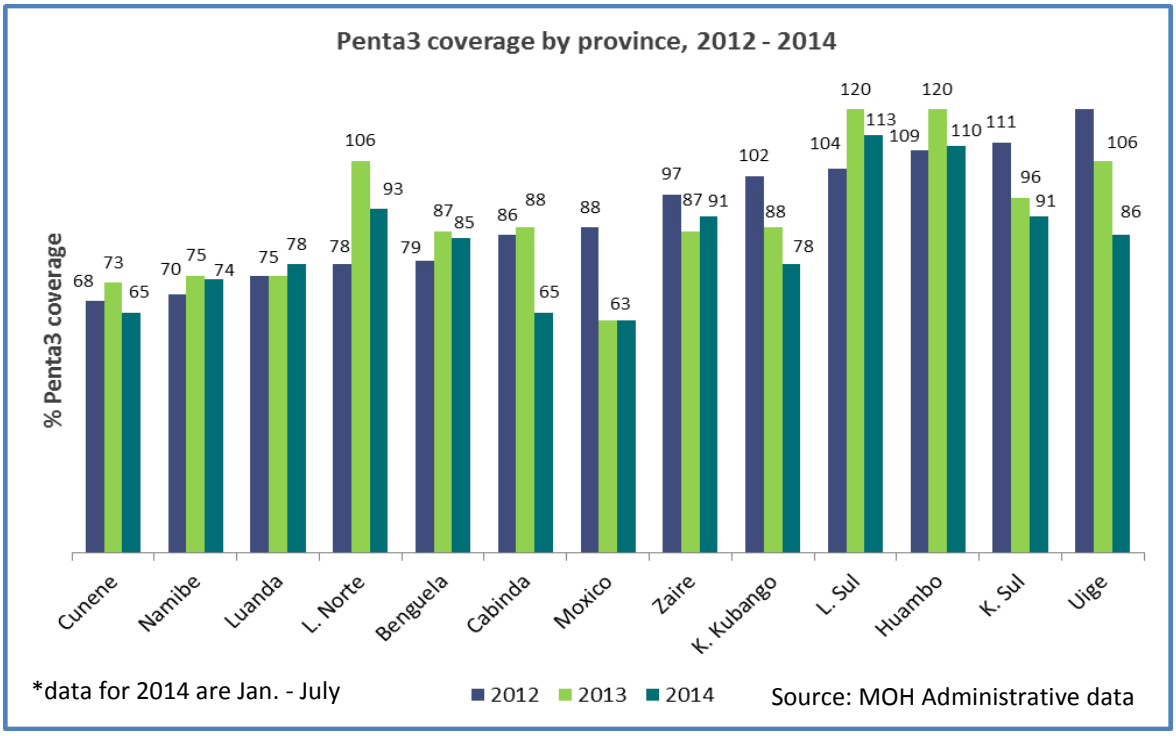
Volunteer and Health Worker Training in FY 2014

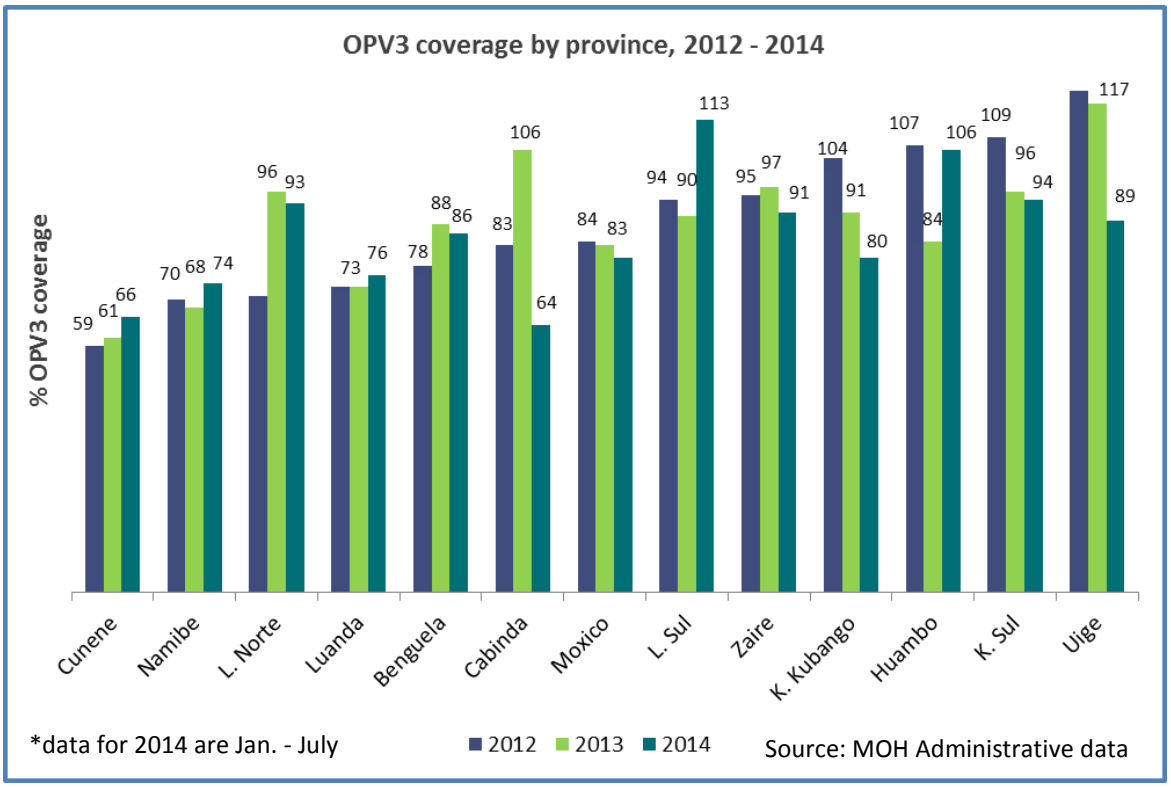
Province	Nº of volunteers	Nº of volunteer trainings	Nº of volunteers trained	Nº of health worker trainings	Nº of health workers trained
Benguela	490	24	490	7	184
Cabinda	60	4	60	3	61
Cunene	100	5	100	0	0
Huambo	80	3	80	2	46
K. Kubango	230	10	230	8	84
K. Sul	360	11	360	5	85
Luanda	450	21	390	27	457
L. Norte	100	4	100	0	0
L. Sul	240	14	240	7	130
Moxico	150	16	150	8	152
Namibe	100	4	100	3	55
Uige	190	8	190	4	68
Zaire	170	8	170	7	75
TOTAL	2,770	132	2,660	81	1,397

Social Mobilization Activities in FY2014

Province	Nº of meetings with MOH & partners	Nº of theater performances	N° of health talks	N° of house visits	N° of visits with traditional healers	N° of visits with TBAs	N° of visits with community leaders
Benguela	76	139	4,578	40,918	2,364	1,996	2,664
Cabinda	63	65	226	10,284	50	55	175
Cunene	23	40	452	10,084	54	92	230
Huambo	45	50	884	10,540	772	833	500
K. Kubango	64	36	2,215	107,228	1,718	1,714	1,368
K. Sul	36	219	7,135	70,851	4,198	4,597	4,237
Luanda	309	566	1,582	43,389	974	385	901
L. Norte	3	0	567	8,502	571	288	366
L. Sul	217	385	1,059	21,523	515	152	394
Moxico	161	117	1,823	29,720	770	382	719
Namibe	9	6	281	13,362	349	251	265
Uige	36	38	573	26,139	635	543	589
Zaire	10	7	369	19,323	259	272	369
TOTAL	1,052	1,668	21,744	411,863	13,229	11,560	12,777

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



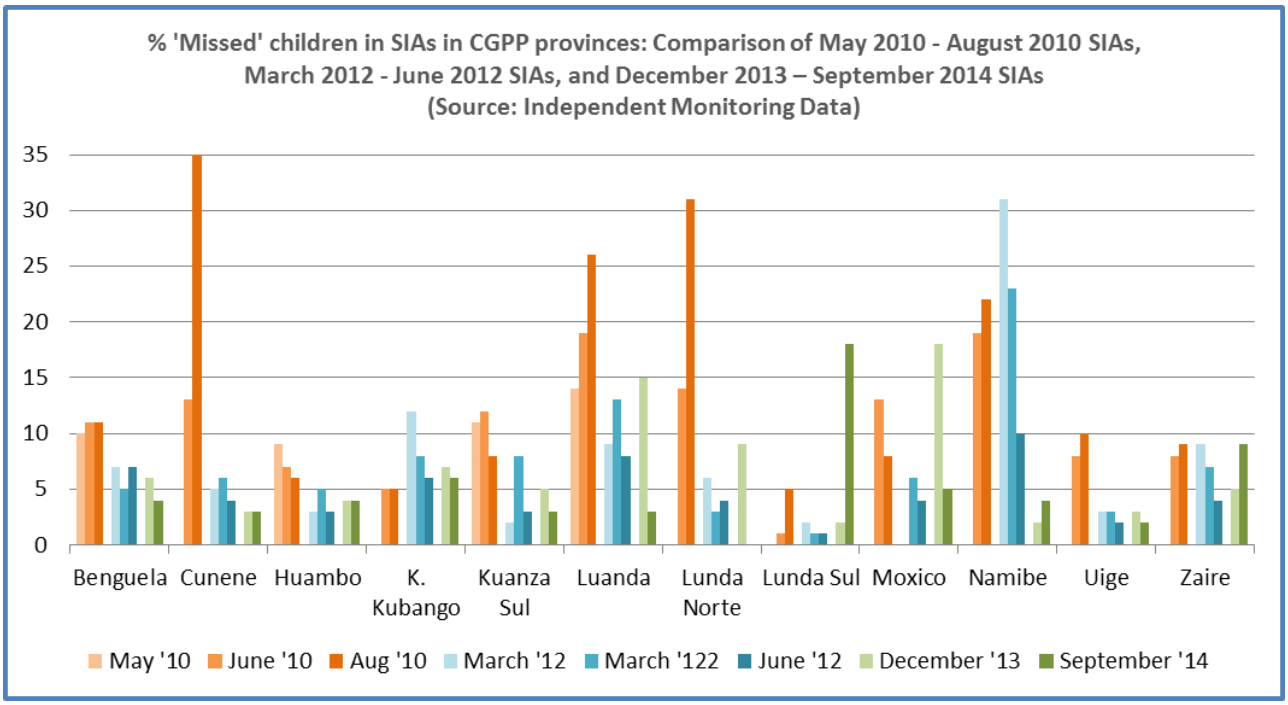


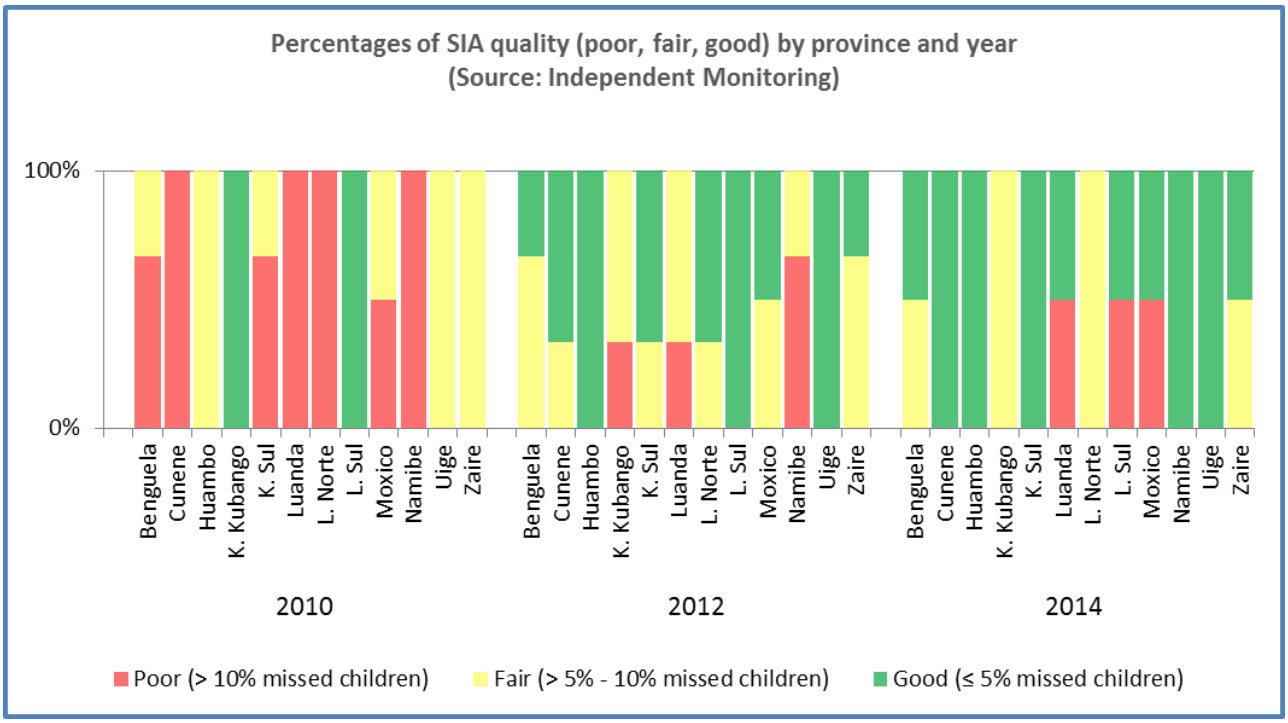
Objective 3: Support supplemental polio immunization activities

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

The quality of the independent monitoring data has been recognized by both the MOH and the spearheading partners and has now replaced the less reliable administrative data as the preferred method of evaluating and strengthening SIA performance. CGPP funded and collaborated with the MOH and WHO to conduct a nationwide training for the monitoring coordinators. Based on the independent monitoring data, approximately 2.36 percent of houses were missed during NIDS in 2013. In an effort to

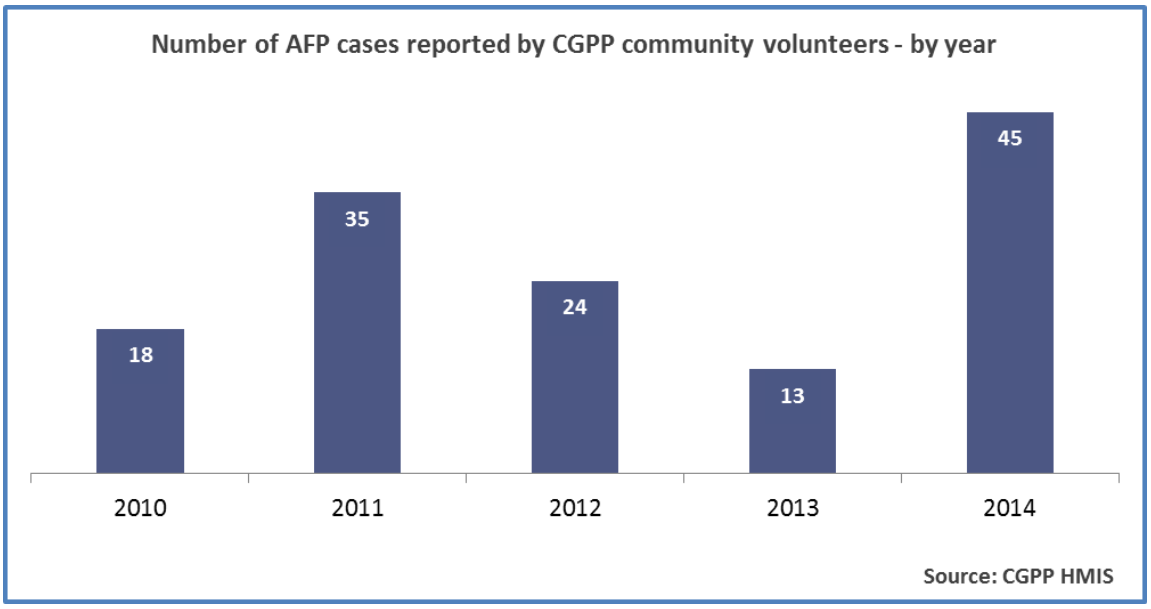
improve vaccination as well as other health services, the MOH appointed new Provincial Health Directors in Luanda and Benguela and the National EPI office sent national support staff out to the provinces with the greatest number of missed children. CGPP used smart phones using the MagPi system to collect and record campaign monitoring data.





Objective 4: Support efforts to strengthen AFP surveillance

The CGPP contributed to Non polio AFP rates of above 2 per 100,000 in children under the age of 15 and Stool adequacy rates above 80 percent in the majority of project areas. CGPP partner staff have worked hard to improve AFP surveillance by supporting active case surveillance in coordination with the WHO and MOH surveillance personnel, providing transportation to surveillance officers, and visiting health facilities according to a calendar based on the level of priority. Additionally, CGPP partners use their extensive network of 2,710 Community Health Workers (CHWs) to promote community level case detection to ensure that no cases are missed and to identify cases earlier. The project distributed bicycles to all of the CHWs to motivate and enable them to conduct community based active case detection. Community based case detection is particularly important since some cases have previously been identified late due to community reliance on traditional healers outside the official health system. To improve the quality of CBS, project coordinators conducted 6,992 supervision visits to community volunteers. 15 CGPP staff participated in a national meeting to improve AFP surveillance in 2014. Now that Angola has been polio free for more than three years, the project will need to continue to maintain a high level of vigilance to ensure that any new importation is rapidly detected and stopped through a mop-up response.



AFP Surveillance Performance by Province, 2010 – 2014 (Source: WHO Weekly Polio Updates)

	10/15/10 – 10/14/11		10/21/11 – 10/20/12		10/21/12 – 10/21/13		10/20/13 – 4/19/14		4/20/14 – 10/19/14	
	NPAFP Rate	Stool Adequacy	NPAFP Rate	Stool Adequacy	NPAFP Rate	Stool Adequacy	NPAFP Rate	Stool Adequacy	NPAFP Rate	Stool Adequacy
Benguela	2.7	92%	2.0	80%	3.0	93%	1.8	77%	2.6	96%
Cabinda	2.3	62%	3.4	100%	3.2	100%	2.3	100%	3.9	100%
Cunene	2.0	75%	1.7	100%	1.7	100%	3.3	80%	4.1	100%
Huambo	2.3	100%	2.1	94%	3.0	84%	2.9	90%	2.9	94%
K. Kubango	7.0	95%	3.8	89%	2.6	100%	3.4	100%	1.7	67%
K. Sul	1.4	89%	3.0	88%	3.2	95%	1.6	100%	2.5	100%
Luanda	1.9	77%	2.6	81%	2.2	86%	2.1	90%	1.1	75%
L. Norte	4.0	100%	4.9	88%	5.9	90%	2.9	100%	5.2	89%
L. Sul	5.5	100%	4.6	88%	1.7	100%	3.3	100%	4.4	100%
Moxico	2.3	91%	2.2	100%	1.5	100%	2.9	57%	5.2	81%
Namibe	6.0	100%	11.5	100%	6.7	100%	6.6	100%	NA	NA
Uige	3.7	70%	4.3	87%	3.1	76%	5.3	100%	2.1	100%
Zaire	6.0	88%	2.3	100%	3.5	100%	1.4	100%	4.1	100%
	NPAFP Rate: 0 – 0.99 1 – 2.99 ≥ 3.0					Stool Adequacy: < 80% ≥ 80%				

Objective 5: Support timely documentation and use of information

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

As members of the national EPI technical team, the CGPP participated in the preparation of 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.

Objective 6: Certification

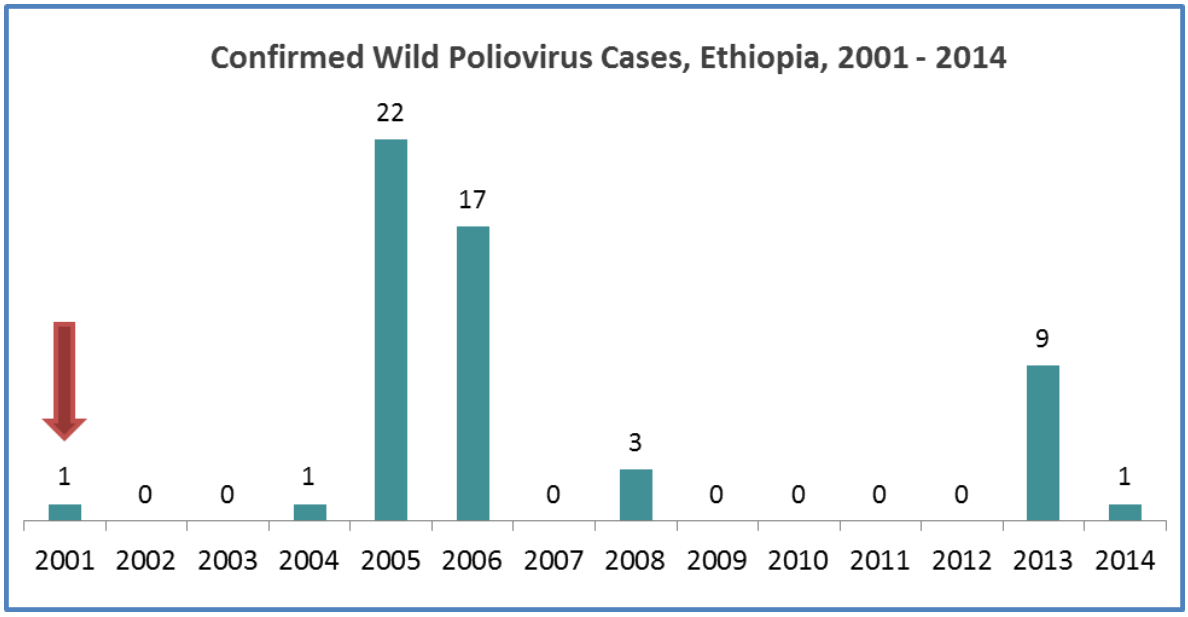
CGPP participated in the following meetings in support of certification:

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

CGPP Ethiopia

The massive outbreak of wild polio virus in the Horn of Africa in 2013 is now under control and hopefully interrupted with a reduction in cases from 217 in 2013 (194 in Somalia, 14 in Kenya and 9 in Ethiopia) to only six in 2014 (five in Somalia and one in Ethiopia). Ethiopia mounted a country-wide response with particular focus on the border areas of the Somali Region. The national ICC, of which CORE is a member, planed and conducted immunization campaigns in five refugee camps in Dolo Ado as well as the host community of the Woreda targeting children under 15 years of age. Ethiopia also conducted repeated rounds of outbreak response campaigns in 17 selected zones from five regions including Somali, Oromia, SNNPR, Hareri, and five refugee camps in Dolo Ado Woreda of Somali Region. In addition, a command post was established at the national level to monitor and coordinate the current outbreak response.

The last indigenous wild poliovirus in Ethiopia was reported in Alaba special woreda in the SNNPR in 2001. Between Dec 2004 and Nov 2006, Ethiopia reported four different importations from Somalia and



Sudan which resulted in forty wild poliovirus cases (1 in 2004; 22 in 2005, 17 in 2006) affecting four of the eleven regions of the country (Tigray, Amhara, Oromiya and Somali).

Following the interruption of these importations, the country reported no cases for 17 months, until April 2008 when three cases of WPV1 were confirmed in Gambella region. Ethiopia was again free of polio until the outbreak in 2013.

CORE Group Ethiopia, in conjunction with the Ethiopian government and spearheading agencies, has made substantial contributions to the country's polio eradication effort, supporting community-based surveillance, supplementary immunization activities, and routine immunization. CGPP represents local

perspectives to national players and builds the capacity of health workers within participating woredas. Project activities at the local level are implemented in pastoralist, semi-pastoralist, and particularly hard-to-reach agrarian areas. The CGPP maximizes impact by using the existing government health structure and international and local NGOs with demonstrated capacity in target areas.

Large-scale population movements persist across the Horn of Africa (HoA), due to seasonal and nomadic movements, and also insecurity. This puts all areas within Somalia and countries across the Horn of Africa at high-risk. To boost population immunity levels in accessible, polio-free areas of Somalia, vaccination posts are being set up in areas bordering inaccessible areas to immunize all populations entering/leaving such areas (including targeting older age groups). Assessments of high-risk areas and populations continue to be conducted, including mapping chronic conflict-areas and major population movement routes. Local-level access negotiations have intensified to increase access to populations in inaccessible areas.

Objective 1: Build effective partnerships between agencies

CGPP Ethiopia served approximately 800,000 children under five years of age in 81 hard to reach and porous border woredas of five regions, namely: Gambella, SNNPRS, Oromia, Somali and Benshangul Gumuz. CGPP partners (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, and Wabishebele Development Association) collaborate closely with their respective woreda health offices and Health Extension Workers to enhance AFP surveillance and promote childhood immunization. The table below details each partner's catchment area, the numbers of children they serve, and the number of community volunteers serving the project.

Partner PVOs and NGOs	Regional State(s)	No. Woredas	No. <5 children	No. <1 children	No. CVs
African Medical and Research Foundation (AMREF)	SNNPR	9	100,744	23,461	383
Catholic Relief Services (CRS)	B. Gumuz, Somali	14	127,391	11,102	460
CARE	Oromiya	6	64,851	15,102	188
Ethiopian Evangelical Church Mekane Yesus (EECMY)	Gambella, SNNPR	14	75,025	17,472	577
Ethiopian Orthodox Church (EOC)	Oromiya	5	65,937	15,355	353
International Rescue Committee (IRC)	B. Gumuz, Gambella	13	65,651	14,272	853
Pastoralist Concern (PC)	Somali	6	59,045	16,101	455
Save the Children	Somali	5	93,886	21,864	326
Wabishebele Development Association	Somali	5	50,045	11,654	188
World Vision	B. Gumuz	4	33,499	7,801	513
TOTAL	5	81	736,074	154,184	4296

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

- Four CGPP partner meetings held to discuss new ideas, program implementation, challenges, and budget review

- A meeting with government officials in Somali region to discuss the annual plan, implementation modalities, resource utilization, and coordination to address immunization gaps in the target woredas covered by Save the Children, CRS, PC and WASDA

- Ethiopia National ICC meetings

- GAVI Steering Committee Meeting in Geneva in June 2014.

- Annual planning forum held at CCRDA from August 4-7, 2014. 143 participants from the Ministry of Health (MOH), WHO, UNICEF, CHAI, CGPP partners attended the meeting. Each partner presented 2013/14 fiscal year achievements and 2015 fiscal year work plans and budgets. The meeting also covered updates on campaigns, surveillance and the RIIP (Routine immunization improvement plan of the MOH) for 2015.

Participants attend a workshop at the annual planning forum in August

- The National EPI quarterly review meeting in Addis Ababa which provided National and regional updates from the MOH and WHO on immunization and surveillance

- Membership on the National EPI task force and Communication Working Group at the Ministry of Health Ethiopia

- CGPP Secretariat Deputy Director made a key note speech at the 4th African Vaccination Week (AVW) in Gondar town, Amhara Regional State from April 23 – 29, 2014

Objective 2: Strengthen routine immunization systems

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

Community volunteers travel to support immunization outreach activities in hard-to-reach areas of Gambella

Training

To improve the knowledge and skills of the immunization service providers and to enhance the quality of services provided to the community the project trained 208 Health workers and health extension workers on Immunization in Practice (IIP) and cold chain. CGPP and IRC facilitated LQAS training in Gambella Town for 22 participants.

CGPP facilitated training on EPI mainstreaming and social mobilization for religious leaders in Gambella region and Community Based Surveillance (CBS) and newborn tracking for new community volunteers in Shebelle zone of Somali region. 884 community leaders participated in workshops on the importance of immunization and the prevention and control of vaccine preventable diseases. CGPP also provided training on immunization and vaccine preventable diseases to religious leaders.

Identifying and tracking pregnant women and newborns

Community Volunteers increased immunization by tracking and registering newborn children and pregnant women and conducting house to house health education including referrals to the nearest health facilities for antenatal care. 53,668 pregnant women and 36,333 newborns were identified and referred to the health facilities for antenatal care and immunization, representing a two fold increase over the previous year.

Social Mobilization Support for Routine Immunization		
	FY 2013	FY 2014
Pregnant women identified and referred to HEW for TT	22,623	53,668
Newborns identified and referred to HEW for vaccination	14,384	36,333
Defaulters <1 identified and referred to HEW for missed vaccinations	1,648	12,294

Immunization defaulter tracking

In pastoralist and hard-to-reach areas it is common for children to begin but not complete the routine immunization schedule. To address the high drop-out rates, CHWs tracked the immunization status of 12,294 children under the age of one and referred defaulters for further immunizations.

Health Education

The CGPP Secretariat developed and distributed a CBS training manual and IEC materials in three local languages. CVs provided health education to approximately 1,350,071 people in FY2014.

Immunization documentation

To improve retention of immunization cards, CGPP purchased and distributed 30,000 plastic bags for mothers of children under one year of age in the target woredas of Gambella and Benshangul Regional States.

Community Health Workers

Tea/coffee ceremony and mother-to-mother forum

83 percent of the population of Ethiopia lives in rural communities where CGPP community volunteers provide interpersonal health education and conduct AFP case detection in hard to reach, pastoralist and Semi pastoralist communities. The partners in collaboration with government health officers trained a total of 2,616 CHWs and Health Education Workers (Health Education Workers) on community based AFP case detection and newborn tracking. CHWs visited a total of 105,205 households in FY 2014 reaching an estimated 1,070,837 people. At every level the trainings were interactive supported by presentations, role play, group work and daily recaps.

Logistics Support

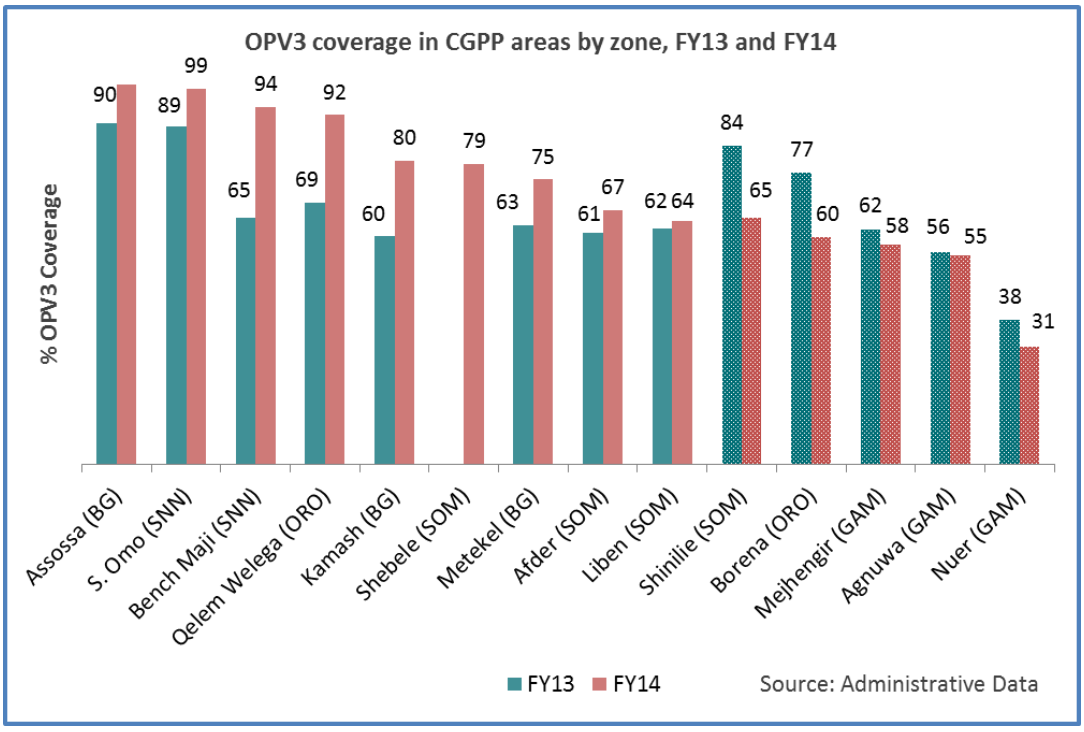
CGPP implementing partners provided logistics support to health posts and health centers whenever a shortage or gap was identified to ensure the continuation of immunization services. Logistics support included the provision of 62,018 liters of fuel (38,988 lt. kerosene, 21,480lt benzene, 1,550lt diesel and 15lt of motor oil) for the refrigerators, benzene for motor bikes used for outreach services and diesel fuel for vehicles used for outreach services or to transport vaccines to health posts. Project staff repaired and maintained vaccine refrigerators to ensure uninterrupted immunization service delivery. Similarly, implementing partners coordinated the repair of motor bikes.

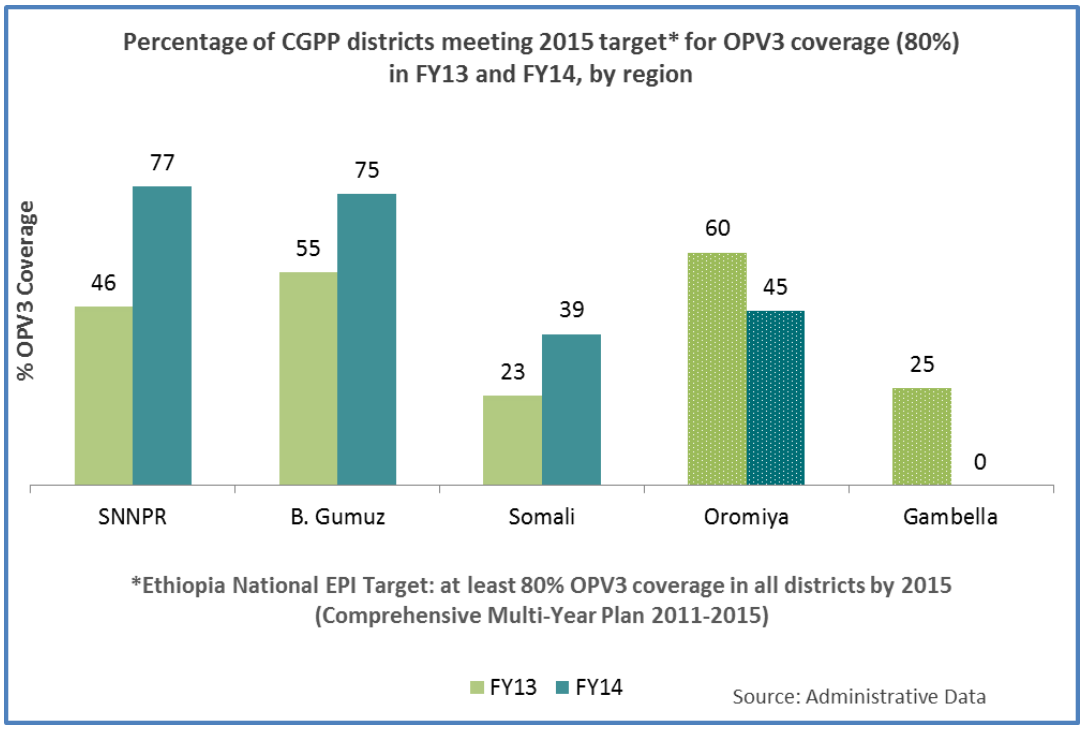
In project areas where the routine vaccination program has particular difficulty in reaching target infants, woreda health offices, in collaboration with CGPP field offices, conducted enhanced routine immunization activities (ERIAs) to ensure as many children as possible were reached.

Cold Chain Users Training, Benchimaji Zone, SNNPR

Advocacy visits to influential people (religious & community leaders and administrators)

CGPP carried out numerous advocacy visits to leaders at all levels of local, regional and national governments in FY2013 providing education and promoting immunization.





Objective 3: Support supplemental polio immunization activities

Ethiopia responded to the polio outbreak in Somalia, Ethiopia and Kenya with multiple rounds of SIAs starting in June, 2013 in Dollo Ado woreda, Somali region in the five refugee camps and host communities for children under 15 years of age. During this campaign 59,758 children (98.2 percent) out of a target of 60,826 children were vaccinated and 399 (zero dose) children were vaccinated for the first time. Ethiopia conducted seven rounds in Somali, five rounds in Gambella, B/Gumz and three rounds in Oromia and SNNP regions in high risk and bordering areas of the country. CGPP provided technical support and transportation for all of the polio campaigns including 205 supervisory staff, 7,908 Community volunteers, 46,239 liters fuel, and 205 vehicles providing mobilization and vaccination services.

Social Mobilization

Launching Ceremonies: CGPP carried out launching ceremonies at the regional and zonal levels in Gambella , Oromia, B/Gumz and Somali regions (Assossa, Borena, Hargella, filtu and Gambella town)

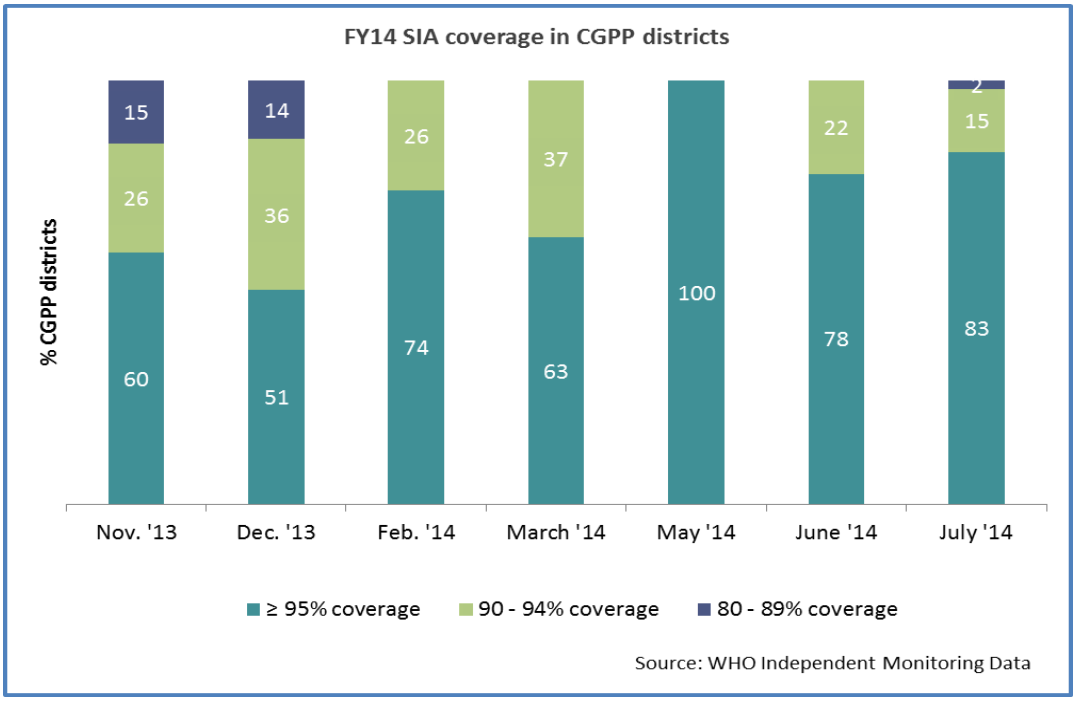
Community mobilizers and team guides: 7,908 Community volunteers mobilized the communities by announcing the campaign dates house to house and serving as a team guides

Banner distribution: CGPP posted two banners per woreda in local languages

Cross-border Meetings

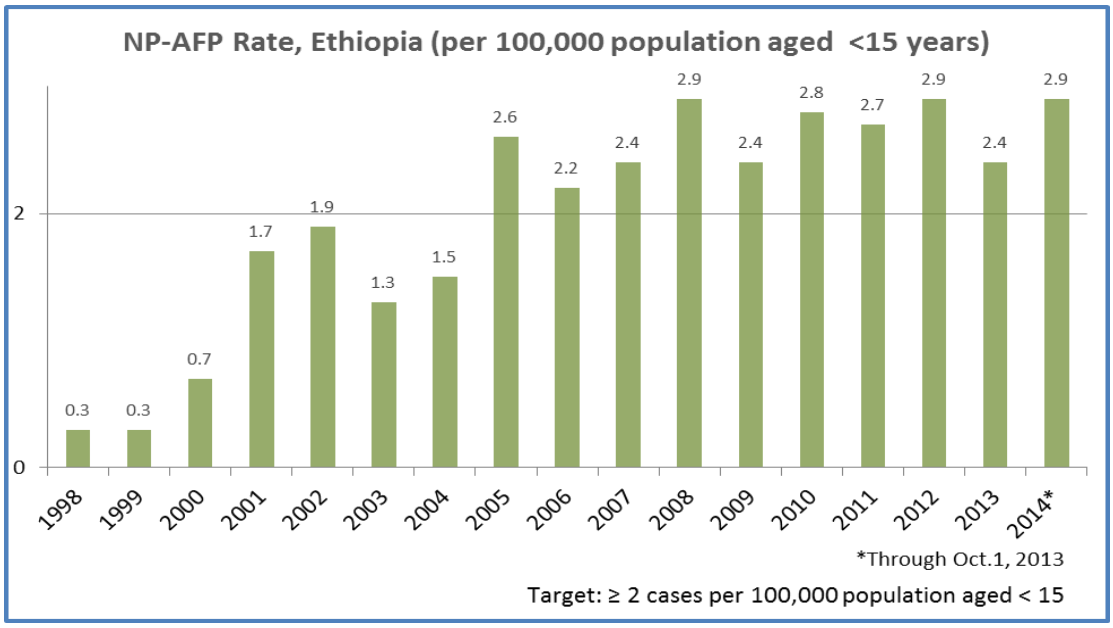
CGPP organized a cross border polio eradication collaboration meeting between Djibouti, Kenya, Somalia and Ethiopia at Jijiga on May 21-23, 2014.

All CGPP districts registered at least 80 percent coverage in all of their respective SIAs this fiscal year. The greatest percentage of CGPP districts registering at least 95 percent coverage occurred during the November 2013 at 15 percent.



Objective 4: Support efforts to strengthen AFP surveillance

CGPP plays a lead role in community based surveillance in Ethiopia. The national Non-Polio AFP rate has remained above two per 100,000 for children under 15 years of age for the last 10 years and in woredas covered by CGPP volunteers a large number of those cases were reported by project volunteers.



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

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

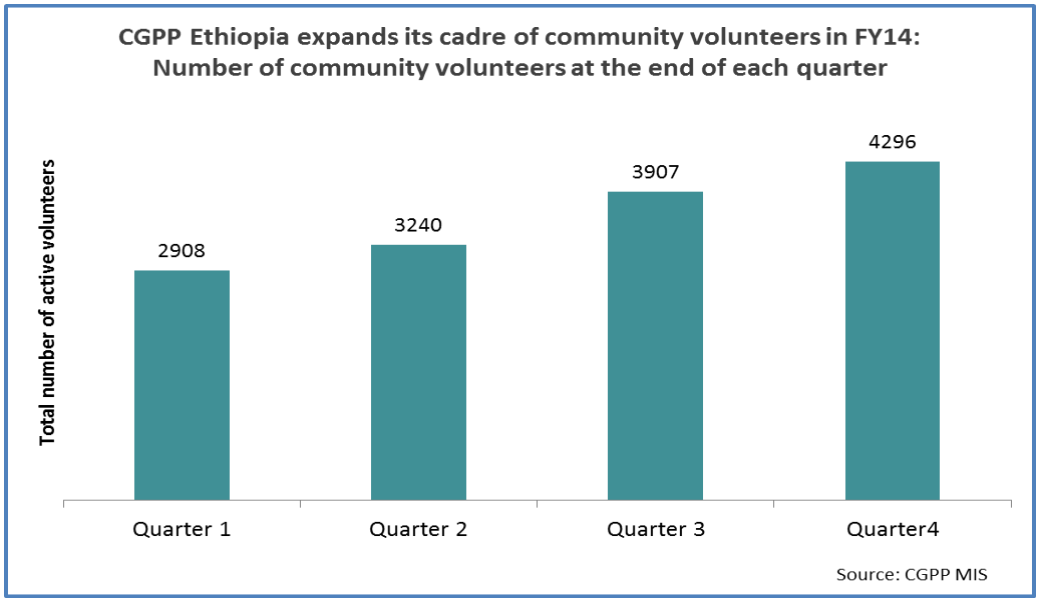
Community volunteers during CBS training

Volunteers conduct active case searches for acute flaccid paralysis and other diseases through house-to-house visits, health education sessions, discussions at community events, and meetings with key community stakeholders (religious leaders, traditional healers, etc.). Volunteers also discuss the signs, symptoms,

and consequences of polio and other diseases, disease prevention including routine immunization, and where to report suspected cases.

CGPP Ethiopia trained and deployed more than 4,000 community volunteers this year. There are three to five CVs per kebele, and the number of CVs continues to increase each year. CGPP conducted a four day training of trainers course for 49 field level staff on CBS and NBT. A total of 875 health workers received cascade training on CBS and New Born Tracking (NBT) by the implementing partners during the reporting period.

The partners in collaboration with government health offices trained CVs and Health Extension Workers (HEWs) to detect and report Acute Flaccid Paralysis, Measles & Neonatal Tetanus in joint sessions to strengthen the connection between the HEWs and CVs. A total of 2536 CVs and HEWs were trained on CBS and NBT (AMREF= 501, EECMY DASSC=286, EOC=330, WVE=164, IRC=239, SCI=242, CRS=170, CARE=224, WASDA=110, and 270, in PC intervention areas).



Picture 2:- CBS and NBT training for CVs by

Community volunteers conducted 495,793 house-to-house visits and organized community gatherings to educate their communities on the signs and symptoms of AFP, Measles and NNT and how to report and refer suspected cases, reporting 62 new AFP cases. CGPP partners also facilitated AFP case sample transportation from the district to the national laboratory (Bare and Dollo Ado woredas).

Silent areas for AFP surveillance

Maokomo special woreda in Benshangul Gumz region was the only silent woreda/District in the reporting period.

2014 AFP indicators - CGPP zones

	Zone	NP-AFP Rate (annualized)	Stool Adequacy (%)
Gambella	Agnuak	2.0	100
	Mejenger	2.0	50
	Nure	2.0	100
B. Gumuz	Assosa	8.9	100
	Kemashi	2.0	100
	Metekel	1.6	67
Oromia	Borena	3.6	100
	Q. Wolega	4.3	92
SNNPR	Bench Maji	4.0	89
	S. Omo	3.1	86
Somali	Afder	2.0	83
	Liben	4.7	43
	Shebelle	4.3	88
	Shinile	3.1	100
	NATIONAL	2.9	87

Source: WHO

AFP indicators by region (2013 - 2014)

	NP-AFP Rate (annualized)		Stool Adequacy (%)	
	2013	2014	2013	2014
Beneshangul Gumuz	2.6	4.4	50	93
Gambella	2.1	2.0	100	60
Oromia	2.5	2.7	89	88
SNNPR	2.6	2.9	93	94
Somali	2.8	5.7	65	69
NATIONAL	2.4	2.9	88	87

Source: WHO

Objective 5: Support timely documentation and use of information

CGPP Ethiopia contributed to a number of publications and presented at various venues in FY2014.

American Public Health Association (APHA) presentation: CORE Group Ethiopia presented at the 2013 and 2014 APHA meetings in Boston and New Orleans.

Training Manuals, Documents and IEC materials

CGPP prepared a best practices report and a five year CGPP summary report. Quarterly news letters were prepared and disseminated to update partners and share EPI related information to key partners during the reporting period. CGPP prepared and disseminated 1500 Broachers in Amharic, Somali and Oromifa languages during the polio SIAs and 500 copies of Secretariat calendars with pictures of the CGPP Secretariat and implementing partner. 4500 copies of Community Based Surveillance (CBS) training manuals, 3000 in Amharic and 1500 in Oromifa language were prepared and distributed to implementing partners.

LQAS Training and application

CORE Group Ethiopia conducted an annual project monitoring survey using LQAS. Before conducting the data collection, the secretariat provided Lot Quality Assurance Sampling (LQAS) training all 10 implementing partners.

Annual review meeting

The secretariat hosted its CGPP Annual Review Meeting in July with participants from partner country and field offices, woreda health offices, zonal health offices, and some regional health bureaus. The primary objective of the meeting was for partners and their respective government health officials to collaboratively plan the project's woreda-level activities for the coming year using administrative, monitoring, and evaluation data, and current EPI and surveillance information presented by representatives from the MOH, WHO, and UNICEF.

Quarterly supportive supervision and review meetings

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

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

Objective 6: Support PVO/NGO participation in certification activities

CGPP participated in the external outbreak response assessment in seven regions and eleven target clusters of the country from January 21 to 29, 2014. The team reviewed SIA coverage, communications, surveillance, routine immunization, health Facilities, case verification and coordination among immunization stakeholders.

Future CGPP plans

Expansion to new areas

CGPP Ethiopia is adding one new partner, OWDA) to expand to five woredas of Dollo zone in Somali region with a focus on Community-Based AFP Surveillance.

Mobile devices and web-based data collection and reporting

CGPP plans to introduce the use of Android Mobile devices using an Open Data Kit (ODK) platform to monitor project activities.

Focus on Routine Immunization

Based on the findings of a national coverage survey conducted in May 2013, CGPP is committed to working with the government to reduce the number of unimmunized children in Ethiopia. CGPP will focus on service delivery strategies, human resources, supply chain management and logistics, data quality, monitoring and supervision.

Using the new community structure

The Government of Ethiopia developed a new community structure called Health Development Army /HDA/ which is a network of one to five structures. The CGPP will work with this network in close collaboration with woreda health offices.

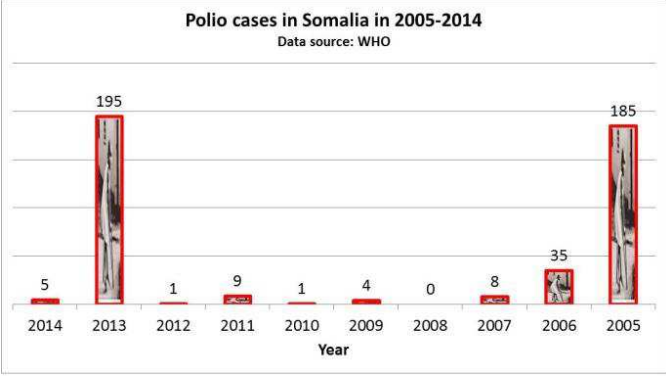
Cross border activities

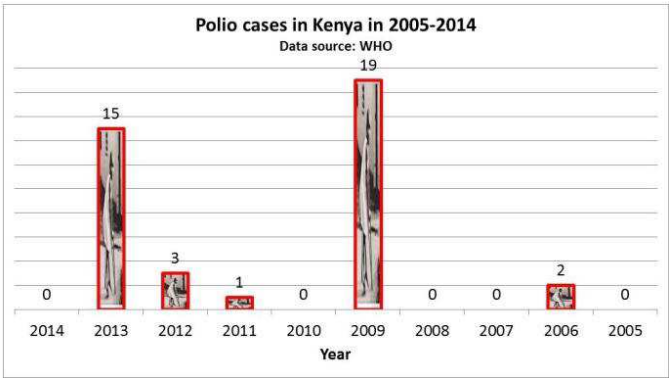
The TAG strongly recommends cross-border coordination among countries for immunization, communication and surveillance. The TAG recommendation on sharing of information on activities, particularly cross notification of polio HOT cases and synchronization of SIAs, with the neighboring countries should be continued and further strengthened. The objective of the cross border meetings is to hold discussions on the mechanisms for strengthening surveillance and addressing population immunity gaps to contain the current polio outbreaks through identification of ways of collaboration in border districts of Ethiopia and neighboring countries. CGPP Ethiopia is leading the organization of national and local level cross border meetings.

Horn of Africa Regional Office covering Kenya and Somalia

More than half of the 362 global wild polio virus (WPV) cases in 2013 were reported in the Horn of Africa due to the outbreak in Somalia (186), Kenya (14), and Ethiopia (6) with a total of 206 confirmed cases. There have been numerous smaller outbreaks in the Horn of Africa over the last ten years, the most recent in 2013. These outbreaks highlight the continued vulnerability of the region to importations and subsequent epidemic outbreaks due to the ongoing transmission in Nigeria, political instability in some regions of the Horn and weak or insufficient routine immunization systems. The recent political problems in South Sudan emphasized the tenuous nature of working in Africa's youngest nation. The CORE Group Polio Project made significant contributions to outbreak response in Ethiopia and South Sudan providing technical support, transportation, social mobilization, micro-planning, logistics, training, community based surveillance, and other support. 2014 saw a dramatic decline in wild polio virus cases in the HOA with no new cases reported in Kenya, only one case in Ethiopia and six cases in Somalia.

Polio incidence in Kenya and Somalia





As evidenced by the 2013 outbreak, Kenya's northern borders with Somalia, Ethiopia, and South Sudan place Kenya at great risk of virus importation. The lack of a stable national government in Somalia coupled with a ban on polio vaccination campaigns by Al Shabaab who are active in large portions of the country make Somalia a particularly challenging environment to work in and therefore a likely source of virus importation for Kenya. CGPP is working to promote a greater contribution to Polio eradication by NGOs and CBOs working in health and other sectors in Northern Kenya through tailored approaches that tap into NGO strengths. Small grants to NGOs to conduct cross border meetings, community based surveillance, demand creation, and support to routine and campaign immunization could help to protect Kenya from importation and ensure that any new outbreak is rapidly identified and contained.

Objective 1: Build effective partnerships between agencies

In order to contribute to the ongoing outbreak response and to lay the foundation for outbreak prevention, CGPP has established a three person team in Nairobi, consisting of a Team Leader, a monitoring and evaluation officer and a social mobilization officer. These three project officers are housed in Catholic Relief Services regional office in Nairobi where they are well situated to contribute to regional planning, monitoring and evaluation, and the creation, adaptation, and dissemination of M&E and social mobilization materials for use by NGOs, PVOs, ministries of health, UN agencies, and others active in polio eradication in the region. This small regional technical support team represents the CGPP at regional meetings, forums, and planning discussions giving voice to the NGO/PVO and community perspectives.

CGPP HOA has undertaken a number of consultations with the Kenyan and Somalia Ministries of Health and polio eradication spearheading partners to identify the areas most in need of NGO contributions. In addition, it has studied the recommendations of various assessments such as UNICEF's desk review on mobile populations in the HOA, Technical Advisory Group's (TAG) meeting recommendations and WHO outbreak response assessment reports. This process has shown that the greatest challenge to HOA polio eradication is the potential for cross border transmission of wild poliovirus through mobile populations. CGPP has accordingly chosen to focus on improving polio eradication efforts among cross border communities and mobile populations. This focus is supported by the Ministry of health and spearheading partners. CGPP has defined the project geographic and programmatic focus through a number of coordination meetings, and the development of concept notes. CGPP also conducted workshops to introduce partners to the project and engage them in the planning process.

CGPP HOA has established a cooperative relationship with all of the key polio eradication stakeholders, including WHO, UNICEF, CDC, and the Red Cross and is a member of the HOA Polio Eradication Team led by the WHO HOA coordinator. CGPP also participates in the weekly Somalia ICC meeting which is organized by WHO and UNICEF Somalia.

The CGPP met with the Head of the Division of Disease Surveillance and Response and hosted a 20 person meeting with the health officials of six counties in Northern Kenya and representatives from CDC and WHO to introduce CGPP and discuss the county assistance needs. This provided an ample opportunity for CGPP and county health officials to share and discuss ideas to support county polio eradication challenges. County health officials expressed their need for support to address cross border and mobile population challenges. CGPP also met a number of times with the USAID EA office and the USAID Kenya Mission who contributed significantly to the establishment of the CGPP HOA program. The CGPP HOA intervention is also working closely with the CGPP Ethiopia and South Sudan programs especially in cross border collaboration.

The HOA CORE Group Polio Project issued a Call for Proposal to CORE Group NGOs existing in Kenya and Somalia to support polio eradication in six counties of Kenya and 4 regions of Somalia (Table 1). Grants to NGOs will focus on cross border communities and mobile populations with interventions such as 1) support to polio campaigns, 2) community based surveillance, 3) cross border initiatives and 4) support to routine immunization. It will also address cross cutting areas such as social mobilization and communication, and documentation and use of information for decision making. The review of proposals is underway.

Counties and regions in Kenya and Somalia selected for CGPP support

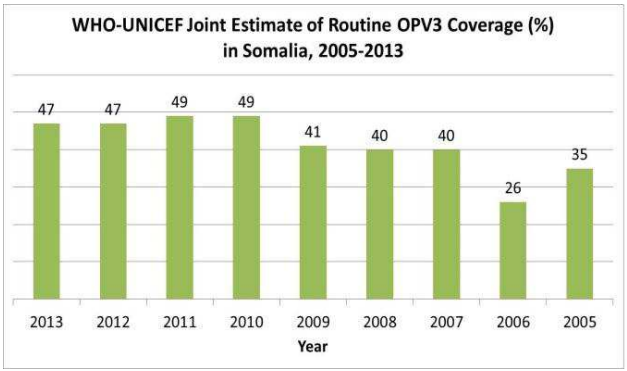
KENYA	Estimated < 5 children population	**SOMALIA**	Estimated < 5 children population
Garissa	239,982	Mudug region	181,526
Mandera	109,169	Gedo region	80,906
Marsabit	59,144	Middle Juba region	50,000
Nairobi-Kamukunji	65,000	Lower Juba region	62,842
Turkana	218,854	**TOTAL**	**375,274**
Wajir	142,586		
TOTAL	**834,735**		

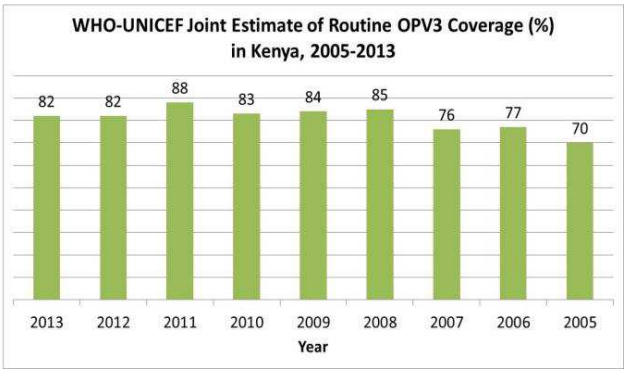
Objective 2: Strengthen routine immunization systems

The 2013 OPV3 routine vaccination coverage rate for Kenya was 82% according to WHO and UNICEF estimates and 47% in Somalia where significant portions of the country have little or no access to routine immunization services. While the Kenya numbers are encouraging they are not entirely consistent leaving pockets of low coverage among mobile populations and refugees along Kenya's Northern border with Somalia.

Under sub-grants to NGO partners the project will provide logistical and training support to routine immunization services to ensure that vaccines, cold chain, and routine immunization services are available. This may include bicycles to support outreach vaccination services and the transport of vaccines and vaccination supplies. This will be done based on a review of the routine immunization services in project areas to ensure that service demand activities performed by the health promoters are not wasted due to a lack of reliable vaccine services. A great deal of the project's support to routine immunization will be integrated into cross border interventions supporting routine immunization, campaigns, and community based surveillance.

Routine immunization coverage estimates of Kenya and Somalia



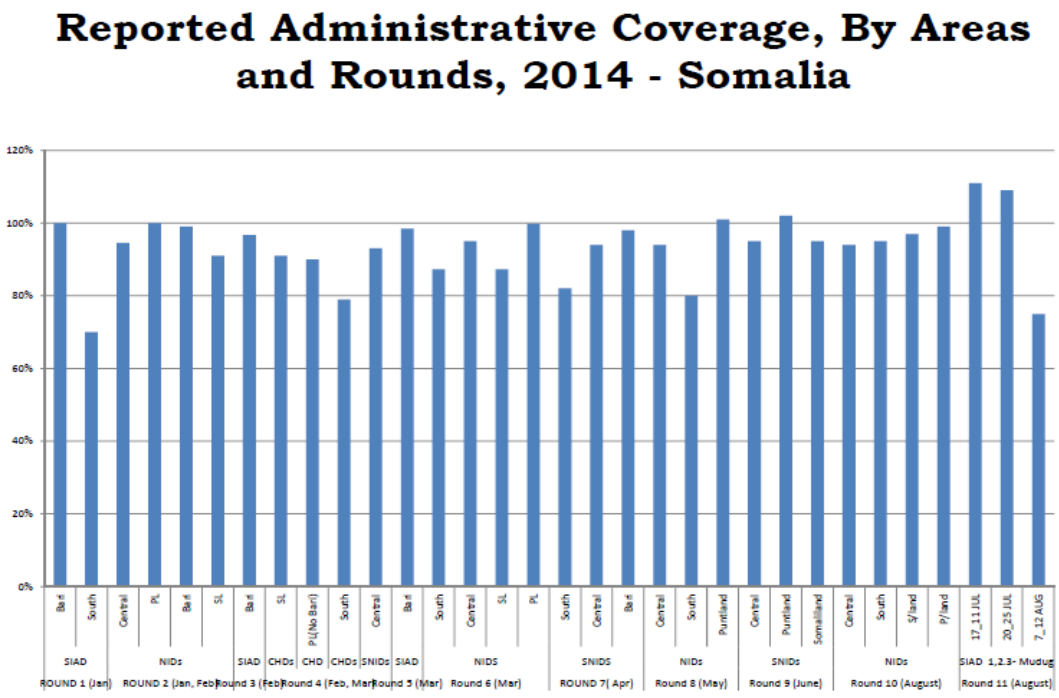


The figure shows the OPV3 immunization coverage based on the joint WHO-UNICEF estimates. As can be seen, Somalia is at a greater risk of cyclical outbreaks of polio if routine immunization coverage is not improved. Though much of Kenya has fairly strong routine immunization coverage, the target areas of the North East suffer from poor vaccination coverage rates.

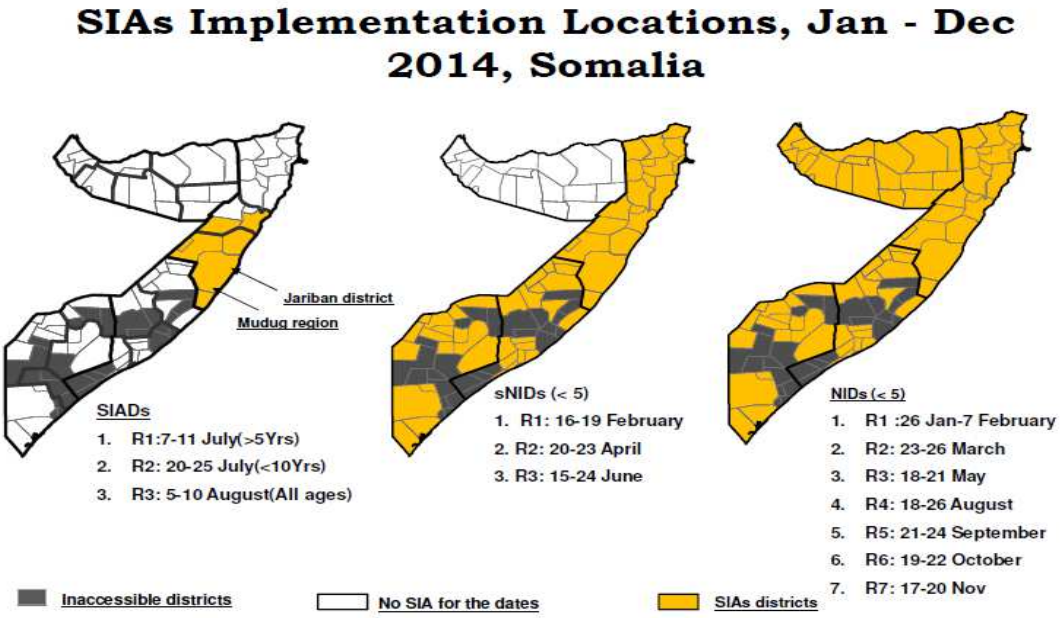
Objective 3: Support supplemental polio immunization activities

Despite extreme security challenges, Somalia mounted mass vaccination campaigns following the 2013 outbreak of wild poliovirus achieving high administrative levels of coverage in accessible areas although some of the areas with the greatest need could not be reached due to security concerns. Areas that become accessible over time are rapidly covered by vaccination campaigns.

SIA coverage in Somalia - 2014



Inaccessible areas in Somalia (data source: 39th week 2014 Somalia Weekly



Kenya conducted seven rounds of SIAs in 2013 and seven rounds in 2014 with administrative coverage rates over 80 percent in most areas. The figure shows the mass vaccinations mounted in Kenya using bivalent OPV following the outbreak in Somalia that crossed to Kenya. The polio outbreak appears to be controlled in Kenya with no new cases for more than a year.

SIAs in Kenya in 2013 and 2014 (Data source: Kenya Polio Sitrep 18th

Annex 1: SUMMARY OF POLIO SIAs CONDUCTED SINCE OUTBREAK IN 2013

YEAR 2013							
	Date	**Campaign type**	**Area**	**Target**	**Target pop**	**Vacc Type**	**Achievement**
Round 1	**27 - 31 May**	**sNID**	Dadaab Refugee Camps & host districts (Dadaab, Lagdera, Fafi)	< 15 yrs	421,874	bOPV	Administrative: 567,876 vaccinated. IM: 86 %
	27 - 31 May		Other 6 districts	< 5 yrs	90,736	tOPV	
Round 2	**17 - 21 June**	**sNID**	Dadaab Refugee Camps	All ages	441,872	bOPV	Administrative : 1,240,036 vaccinated. IM: 91%
	17 - 21 June		Host districts (Dadaab, Lagdera, Fafi)	< 15 yrs	133,468	bOPV	
	17 - 21 June		Other 22 districts	< 5 yrs	731,274	bOPV	
Round 3	**1 - 5 July**	**sNID**	Dadaab Refugee Camps	All ages	441,872	bOPV	Administrative : 4,661,881 vaccinated; IM: 93.3%
	3 - 7 July		Host districts (Dadaab, Lagdera, Fafi)	< 15 yrs	133,468	bOPV	
	3 - 7 July		North Eastern, Eastern and Coast provinces	< 5 yrs	1,159,258	bOPV	
	6 - 10 July		Nairobi, Nyanza, Western, and Rift Valley provinces	< 5 yrs	3,017,562	bOPV	
Mop-up	**27-31 July**	**Mop-up**	Divisions around the latest confirmed case of polio in North Eastern province includingDadaab, Liboi, Jarajilla and Sabuli.	< 5 yrs	25,787	bOPV	Administrative : 26,821 vaccinated
Round 4	**17 - 21 August**	**sNID** (122 districts + 6 refugee camps)	Dadaab Refugee Camps	All ages	441,872	bOPV	Administrative : 5,332,453 vaccinated. IM: 94%
	17 - 21 August		Host districts (Dadaab, Lagdera, Fafi)	< 15 yrs	133,468	bOPV	
	17 - 21 August		Other districts	< 5 yrs	4,176,820	bOPV	
Round 5	**21-25 September**	**sNIDS** (122 districts + 6 refugee camps)	Dadaab refugee camp, Garissa county and Habaswein district other districts	All age group <5 yrs	5,184,856	bOPV	Administrative result 5,545,528 (103%). IM:94%

Round 6	**16-20 November**	**NIDS**	All districts	< 5 yrs	8,244,507	tOPV	Administrative result 8,382,931. IM:94%
Round 7	**14-18 December**	**sNIDS**	Garissa, Mandera, Wajir Counties, Kakuma and Dadaab refugee camps	< 5 yrs	510,616	bOPV	Administrative result 539,304. IM: 91%
			Garissa County, Dadaab refugee camps and Sabuli Division of Wajir County	6wks-59 Months	126,110	IPV & bOPV	121514(IPV) 128967(bOPV
YEAR 2014							
Round 1	**18-22 Jan 2014**	**NIDS**	All country except North Eastern Region	< 5 yrs	8,305,381	bOPV	Administrative result 8,288,836. IM:94%
Round 2	**1-5 Feb 2014**	**sNIDS**	North Eastern Region	<5yrs	482,761	bOPV	Administrative result 493645. IM:92%
Round 2	**12-18 Feb 2014**	**sNIDS**	Kakuma refugee camp	<15yrs	55,890	bOPV	Administrative result 72,355. IM:98%
Round 3	**5-9 April**	**sNIDS**	122 districts + 6 refugee camps	<5yrs	5,405,042	bOPV	Administrative result 5,449,441. IM:93%
Round 4	**10-14 May**	**sNIDS**	122 districts + 6 refugee camps	<5yrs	5,405,042	bOPV	Administrative result 5,589,900. IM:95%
Round 5	**21-25 June**	**NIDS**	All country	<5yrs	8,806,946	bOPV	Administrative result 9,003,890. IM:95%

The CGPP Horn of Africa intervention supports routine and supplemental immunization systems by focusing strategically on cross border interventions to ensure that all target children are captured in both routine and campaign services.

Cross Border Initiative:

Based on recommendations by the the Horn of Africa TAG, CGPP plans to focus a great deal of attention on addressing cross border vulnerability to wild poliovirus transmission. The 11th HOA TAG held in Jordan in August, 2014 made two specific recommendations regarding the cross border interventions as follow:

- HOA coordination office should standardize the documentation of cross border activities including number, types and time of meetings and compare trends of cross border activity data over time.
- HOA Coordination office should compile and track vaccination at permanent transit vaccination points across the horn and present in HOA bulletin.

Cross border vaccination launched by Dr Ekitela, County Health Director, Turkana County

The recommendations recognized that cross border intervention for polio eradication as a process as opposed to a one time high profile meeting around SIAs and required a plan of action that would be implemented and monitored on a regular basis. It also recognized the need for permanent vaccination posts at border crossing points.

CORE's review of the current status of cross border collaboration indicates that it is not very active. In general cross border efforts have been seen as a one-time activity surrounding SIAs with little initiative to extend it beyond the narrow time frame of the SIAs. CORE is promoting cross border collaboration through the establishment of coordination mechanisms encompassing a cross border collaboration guide that outlines the

formation of cross border committees, focal persons and communication protocols; tools for mapping, profiling and analysing cross border communities, crossing points, transit hubs and health facility capacity; and a monitoring framework to monitor the implementation status of a joint cross border action plan.

CORE Group Polio Projects in South Sudan and Ethiopia have been very active in cross border meetings. CGPP South Sudan has facilitated meetings between South Sudan, Uganda, Kenya and the DRC. In August 2014 CGPP Kenya joined CGPP South Sudan to conduct a cross border meeting in Turkana between the Turkana County of Kenya and Kapoeta East county of South Sudan. There were 43 participants; 23 from South Sudan and 20 from Kenya. The two day meeting laid out joint action plans to address the polio eradication challenges in the border communities.

In October 22-23, a cross border meeting was held in Turkana among three countries-Kenya, South Sudan and Uganda to prepare for the NIDs in November and December 2014. A meeting was also held in Moyale between Marsabit county and Moyale Woreda of Ethiopia. Health department program managers and supervisors, WHO, UNICEF, CGPP and local NGOs participated in the workshop. The workshop used tools for mapping and profiling of cross border communities, crossing points and assessment of health facility readiness to identify/update the target cross border initiative and to reach a consensus on a joint plan of action between border counterparts. The Turkana meeting identified 39 undocumented crossing points.

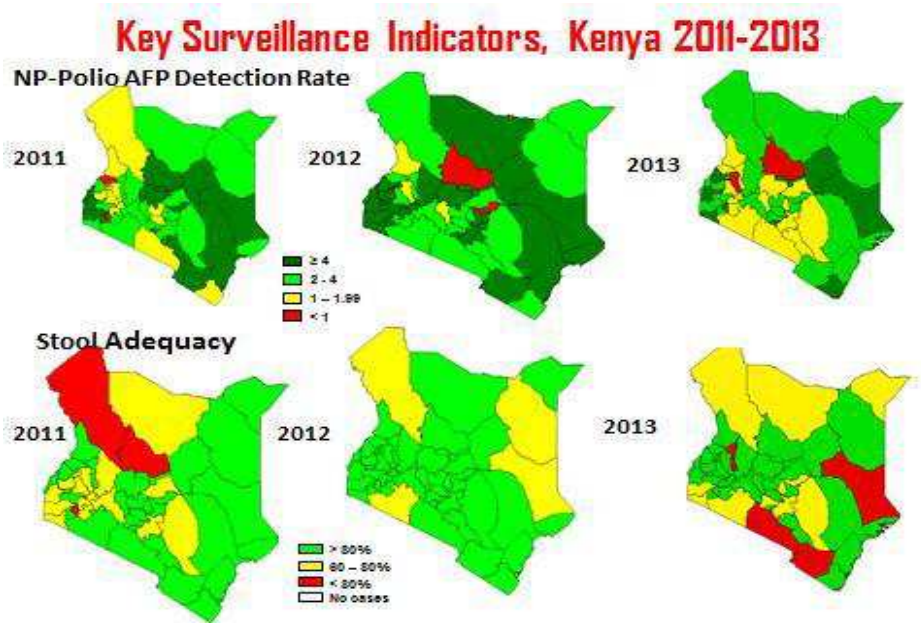
Mapping cross border communities and crossing points

The workshop was also used to inaugurate Cross Border Vaccination. A Cross Border Committee will meet to review the achievements in NIDs and will discuss and plan for strengthening AFP surveillance and routine immunization among cross border communities and populations.

CORE HOA and WHO wrote a paper on the cross border initiatives for polio eradication that has been submitted to Health Monitor Bulletin, WHO AFRO. The paper is included in Annex A.

Objective 4: Support efforts to strengthen AFP surveillance

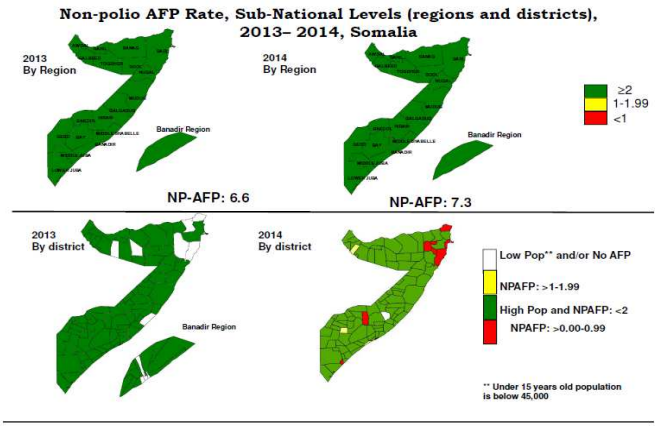
AFP surveillance in Kenya shows that while the non-polio AFP rate has improved over time, stool adequacy has deteriorated. Most of the border counties show sub optimal stool adequacy performance . It is partly due to the geographic spread of population and aggravated by insecurities arising from local tribal conflicts and Al-shabaab insecurity.

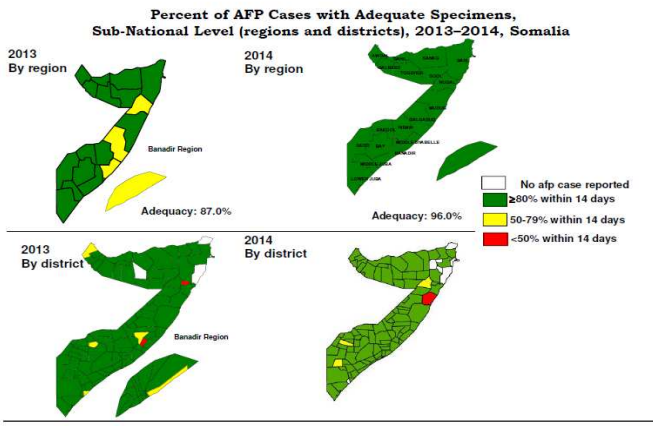


(Data source: Kenya MOH)

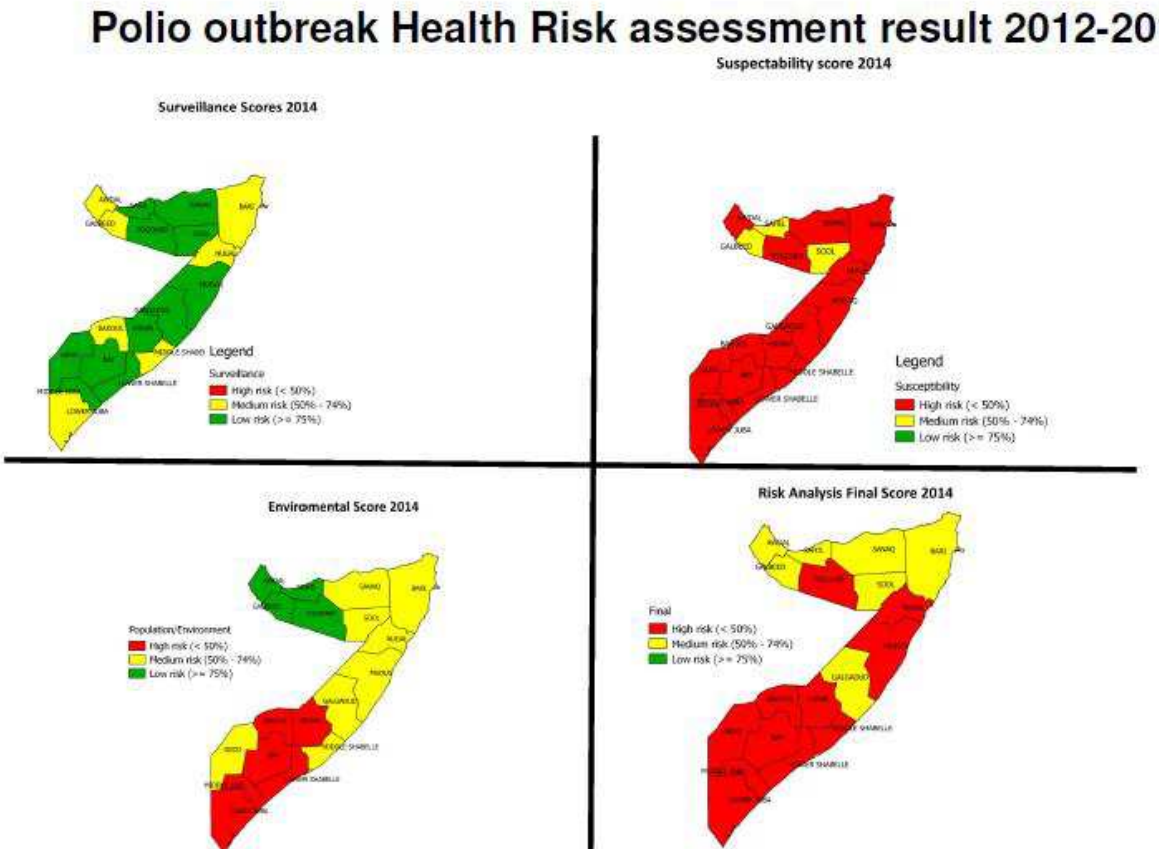
AFP surveillance in Somalia was strong in 2014 with some problems with stool adequacy in some of the regions and districts.

Key surveillance indicators, Somalia, 2014 (data source: 39th week 2014 Somalia Weekly





Somalia polio outbreak risk analysis (data source: 39th week 2014 Somalia Weekly Polio Update)



CGPP has begun laying the ground work to support and supplement the traditional facility based surveillance system with community based surveillance conducted by community volunteers and community informants. The HOA Technical Advisory Group (TAG) has recognized the value of community based surveillance (CBS) and asked for documentation of its benefits and challenges. HOA partners reviewed CBS activities that are operational under different names and variations in different countries. CGPP contributed to the CBS review with a report and analysis of data from its CBS model in Ethiopia and South Sudan which is featured in the review document as a good model.

Recognizing the inadequacy of CBS documentation, the CGPP has worked on a comprehensive list of indicators and related data collection tools. CORE plans to harmonize its CBS program in Ethiopia, South Sudan, Kenya and Somalia programs. CORE has held consultation meetings with CDC, Kemri, the CBS unit of DDSR, MOH and discussed the indicators and data collection instruments. Sub-grants to NGOs currently under review will allocate funds for community volunteers to conduct coummnity based surveillance.

The CGPP HOA and WHO have written a paper based on the *CORE Group's Report on CBS in Ethiopia and South Sudan* that has been submitted to Health Monitor Bulletin, WHO AFRO. The paper is included in Annex B.

Objective 5: Support timely documentation and use of information

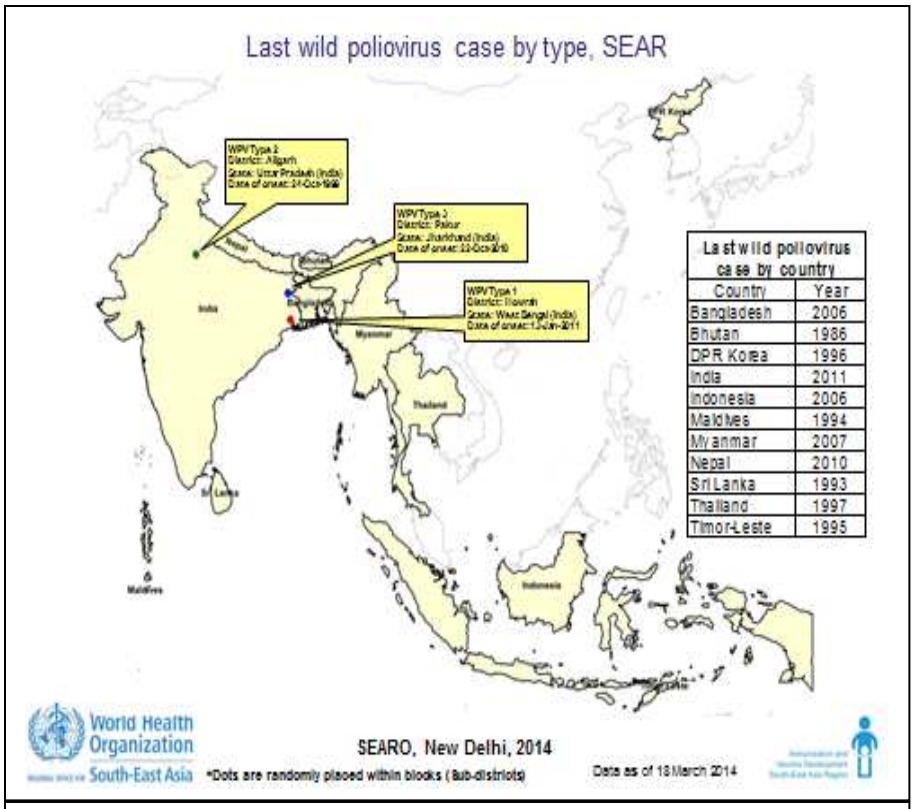
The CGPP HOA assisted CGPP HQ collect various tools and materials developed and used by CGPP in various countries which can be shared among the projects and utilized by new partners. The documents are categorized by surveillance, campaign, monitoring and evaluation, social mobilization and communication, routine immunization and security. The tool kit will build capacity and facilitate further preparedness and better practices in Polio eradication for NGOs and other grass roots health programs.

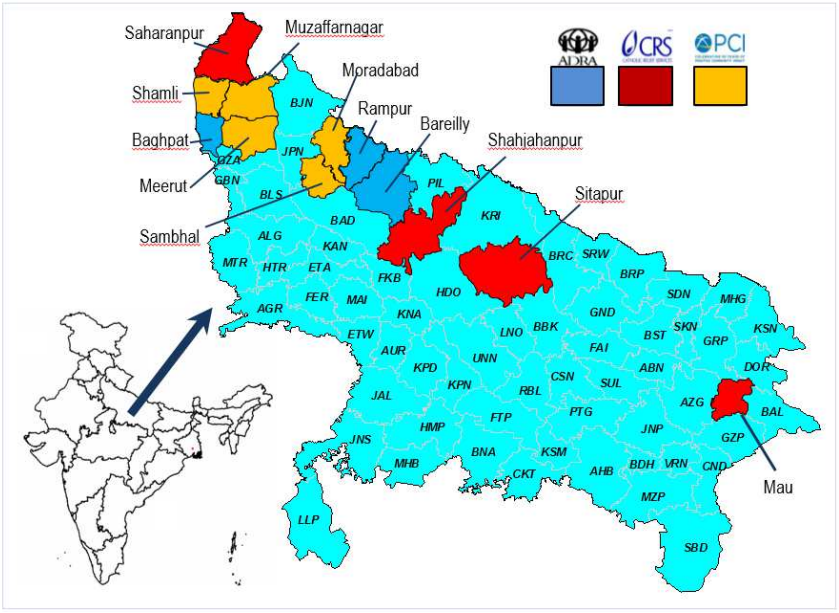
CGPP HOA prepared tools to facilitate cross border collaboration and identify border facilities to support effective SIAs, routine Immunization and AFP surveillance;

CGPP HOA also developed a comprehensive list of AFP surveillance indicators to track the contribution of community based surveillance on overall facility based surveillance. This includes indicators on inputs, process, outputs and outcome of community based AFP surveillance.

CGPP India

Introduction and Country Background





CGPP India work areas

On 27th March 2014, the Global Polio Eradication Initiative reached a major milestone when India was certified polio-free along with the entire region at the 7th meeting of the South–East Asia Regional Certification Commission for Polio Eradication (SEA-RCCPE) in New Delhi. Thus, four regions of WHO serving 80% of the world's population are now certified as polio free. This is very significant because many experts had feared that India would be the last country to eradicate polio. The determination and dedication of the government, state governments and partners, along with the active participation of the community proved sceptics wrong by overcoming formidable challenges. Almost every child was reached every time through effective micro plans and tools like bOPV.

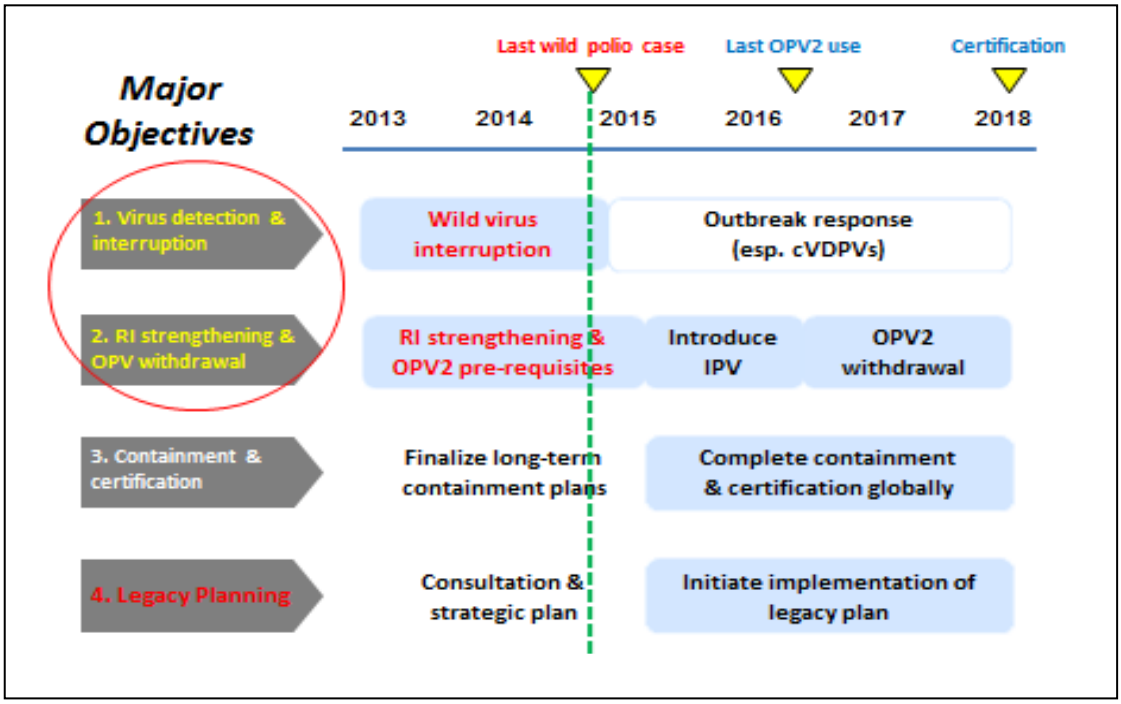
India has not reported any case of confirmed polio due to wild poliovirus (WPV) since January 2011. The states of Rajasthan and Uttar Pradesh (U.P) detected two cases of Vaccine Derived Poliovirus 2 (VDPV2) 30 September 2014.

Program priorities: CGPP India continued to work with the same consortium partners, ADRA, CRS & PCI and ten local NGO partners in 58 blocks of 12 districts of U.P because these are still high risk areas for the program due to high population density, poor sanitation and low routine immunization. A total of 1240 CMCs (Community Mobilization Coordinators) were deployed in the field to conduct social mobilization activities. Most CMCs are females and from the same area and community.

Polio Endgame

The country program priorities are guided by the 'Polio Eradication and Endgame Strategic Plan 2013-2018' of GPEI. Major objectives of this plan are:

- Poliovirus detection and interruption of transmission:
- Immunization system strengthening and OPV withdrawal
- Containment and Certification
- Legacy Planning



Poliovirus detection and interruption of transmission: India's polio surveillance system is highly sensitive, meets with gold standards and has the capacity to detect any importation. An Emergency Preparedness and Response Plan (EPRP) is in place to address any poliovirus importation. CGPP has trained a Rapid Response Team based on the West Bengal experience where the last polio case was detected. UNICEF has a standing agreement with CGPP to support communication initiatives in case of a polio emergency.

Immunization system strengthening and OPV withdrawal: CGPP supports the government's immunization system strengthening efforts by participating in special task force meetings at national, state and district levels. At the district level, the field staff provides support in improving micro plans, monitoring of routine immunization sessions and during Special Immunization Weeks (SIW). As per the endgame strategic plan, the Government of India is planning to introduce a single dose of IPV in March 2015 in the national immunization schedule. This will be administered to all children at the age of three and a half months along with DPT3 vaccination. Along with this, OPV2 will be withdrawn gradually in 2016. CGPP is contributing to developing the communication strategy for IPV introduction in India and withdrawal of OPV2.

Containment and Certification: Containment procedures involving a national survey of laboratories and poliovirus material was completed prior to certification in March 2014.

Legacy Planning: The government and partners are now preparing for polio legacy planning. This will help transform/utilize learnings and best practices and assets (human resources and social structures) created by the polio program for achieving other health goals. CGPP India also plans to have a dialogue with its HQ and USAID to get involved in this.

Objective 1: Build effective partnerships between agencies

CGPP India Partners:

PVO Partner	NGO Partner	Work Districts
ADRA	Innovative Approach for Social Development Society (IASDS)	Baghpat
	Malik Social Welfare Society Rampur (MSWS)	Rampur
	ADRA India	Bareilly
PCI	Society for All Round Development (SARD)	Meerut
	Adarsh Seva Samiti (ASS)	Moradabad
	Jan Kalyan Samiti (JKS)	Muzaffarnagar & Shamli
	Mahila Jagriti Sewa Samiti (MJSS)	Moradabad & Sambhal
CRS	Meerut Seva Samaj	Saharanpur
	Sarathi Development Foundation	Shahjahanpur & Sitapur
	Holy Cross Welfare Trust	Sitapur
	Gorakhpur Environmental Action Group	Mau

Indicators:

1. # of CORE PVO members participating in CGPP: 3
2. # of Local NGO partners participating in CGPP: 10
3. # of ICC meetings attended by CGPP: India has an **Immunization Action Group (IAG)** equivalent to ICC in other countries. CGPP is a member of this group and Dr. Roma represented CGPP in two meetings held on 21st Oct. 2013 and 20 June 2014.
4. # of Regional and International forums attended by CGPP:
   - Dr. Roma participated in the Global Health Practitioners Workshop, formerly 'CORE Group Spring Meeting' at Silver Spring, MD from 05th to 7th May 2014 to share the presentation on 'Engaging Civil Society'.

- Jitendra Awale & Manojkumar Choudhury made two presentations at the 141st APHA Meeting in Boston.

Note on data source and computation of coverage indicators – SIA and RI related coverage indicators presented in this report are based on administrative data and most of the RI related indicators are computed using proxy denominators, i.e. number of children born (during a specific period). The existing CGPP India MIS provides information on the number of children who received a particular vaccine during Routine Immunisation. Every month, absolute and cumulative numbers on the number of children receiving specific vaccines are reported by community level functionaries (CMCs). This number is used as a numerator for computing RI coverage related indicators. CGPP India tracks RI coverage by different age cohorts, e.g. 1) among children born during FY14 (Oct'13 to Sep'14) and 2) among children born during FY 13 (Oct'12 to Sep'13), etc.

Objective 2: Strengthen routine immunization systems

CGPP India is an active member of the Immunization Action Group (IAG) (Equivalent to ICC in other countries). Dr. Roma represented CGPP in two meetings held at the national level on 21st Oct. 2013 and 20 June 2014. At the state level, there are State Task Forces and District Task Forces on Routine Immunization where CGPP is an active participant.

CGPP teams assist government medical officers in refining micro plans and HRG (High Risk Group) data at the district and block levels. As needed, special immunization drives are organized to immunize unreached children. CMCs conduct IPC and other mobilization activities with families of eligible children prior to immunization sessions. Due lists of eligible children are developed and shared with Auxiliary Nurse Midwives (ANM) for vaccination. Because of all these good practices, the immunization coverage in CGPP areas has improved over the years.

Special Immunization Weeks (SIW): The Government of India organized four SIWs in FY14 on the following dates:

- 26-31 May 2014
- 30 June to 05 July 2014
- 04 -09 Aug. 2014
- 08- 13 Sept. 2014

CGPP field teams tapped this opportunity to reach areas with low RI coverage due to various reasons like vacant/absent ANM posts.

Example from the field: The ANM who resisted

Continuous mobilization of government functionaries is one of the key activities of social mobilization in reaching every child for immunization. The CGPP field staff work closely with the government frontline workers, especially with ANMs (Auxiliary Nurse Midwives) to ensure immunization for reached and unreached populations. So there is a constant interaction with government staff at all levels.

In Moradabad urban, the Zone 5 BMC, Khalid Hussain noticed that one of the Routine Immunization (RI) centers in Asalatpura was non-operational and the ANM, Sudha Rani had not conducted a RI session there for the last six months. As a result, a lot of children remained unimmunized. After discussing this with the district officials, he found that she did not feel that immunizing all children in her area, was her responsibility and she was reluctant to visit that area. Khalid classified her in the "XR" category (XR means families who are resistant to polio as per the polio program) and worked out a plan to change her behavior.

To start with, he initiated a dialogue with her about his professional life. Regular visits and interaction made her comfortable in sharing experiences and even her favorite recipes. Khalid shared a story of how a man was saving lives of star fish on the seashore. This went on for a few months till her attitude gradually changed. With the help of Khalid and CMCs (Community mobilisers) the center was reopened and timely immunization sessions began for all the children in Sudha's area.

Post-introduction evaluation (PIE) of Pentavalent Vaccine and Launch:

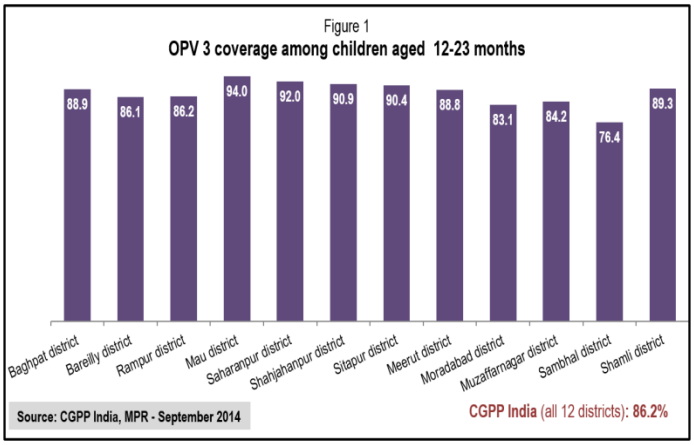
As per WHO recommendations, a post-introduction evaluation (PIE) was conducted to assess its acceptance and effect on the community, and impact on the existing immunization system. Rina Dey from CGPP participated in the evaluation.

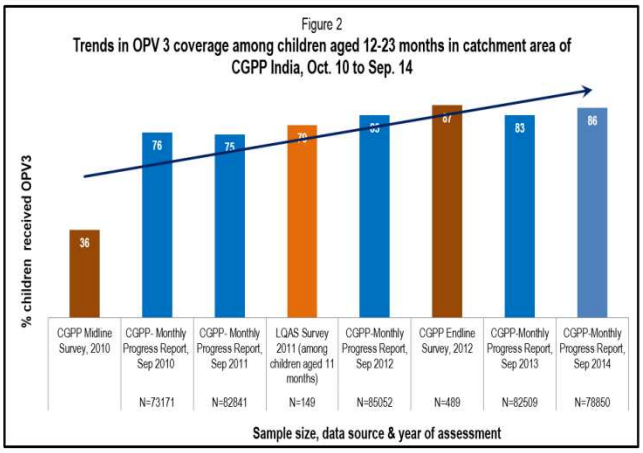
On 26 Sep. 2014 Dr. Roma attended the Government of India launch for Pentavalent vaccine in the states of MP, A.P, Punjab, Assam, Bihar, Uttarakhand, Jharkhand, W. Bengal, Rajasthan, Telangana, Chhattisgarh & Delhi. The MOHFW gave a series of presentations on both technical and communication issues related to the vaccine and all states were represented. The revised RI Mother & Child Protection card was also shared.

Indicators:

% of children 12-23 months with OPV3

Figure 1 presents OPV 3 coverage among children aged 12-23 months in CGPP India catchment areas. On average, the OPV3 coverage was about 86%, while district specific coverage ranged from 76% (Sambhal district) to 94% (Mau district). Progress in OPV3 coverage presented in *Figure 2* shows an increasing trend and an approximately 19 percentage points increase in the OPV3 coverage from the final evaluation survey of the previous phase - 2012 (67%).



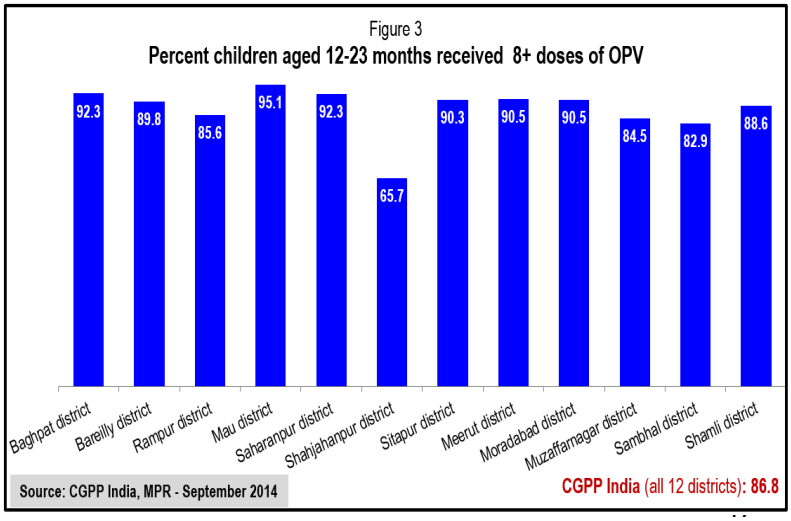


% of zero dose (No dose or never vaccinated) children

The existing CGPP India MIS does not compile (aggregate) this information. However, as per the final evaluation survey, 2012, none (0%) of the children aged 12-23 months from CGPP catchment areas were never vaccinated.

% of children one year and older with at least 8 doses of OPV

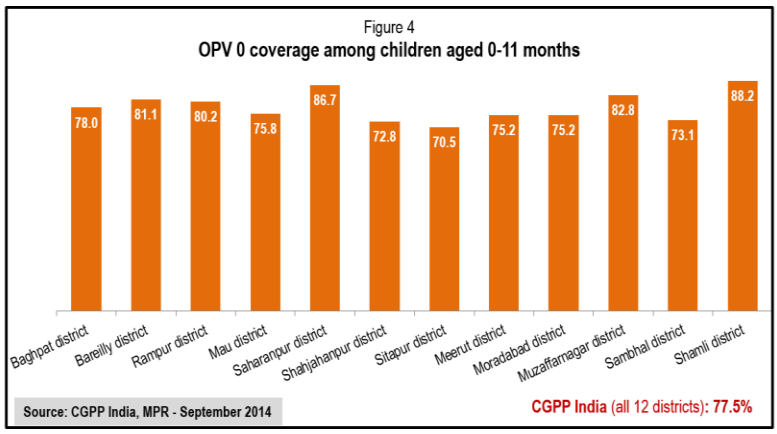
Figure3 presents the proportion of children aged 12-23 months who received at least eight doses of OPV at SIA or RI session. This ranged from 66% (Shahjahanpur district) to 95% (Mau district) in catchment areas of CGPP India with an average of 87%.

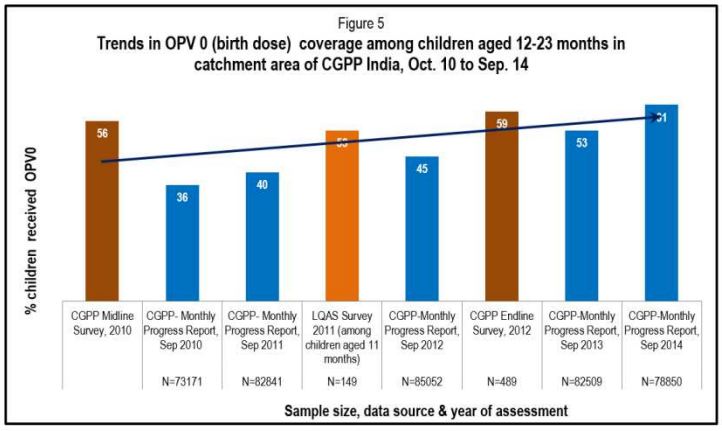


% of children under one with OPV birth dose (OPV0)

Figure 4 shows OPV Birth dose coverage among children below 12 months in CGPP areas. About 78% children received OPV0 dose. The coverage varies significantly by district (70% in Sitapur district to 88% in Shamli district). This variation is the compound effect of both demand and supply related issues.

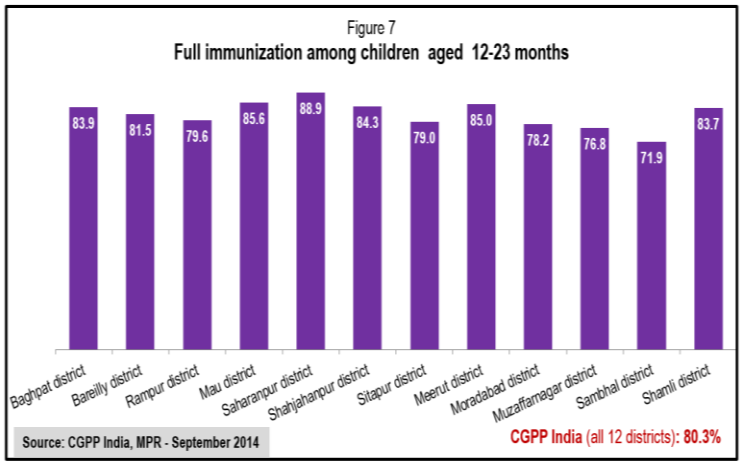
OPV0 coverage computed among children aged 12-23 months also report improving trends, presented in *Figure 5*. In the last one year the OPV0 coverage increased by eight percentage points, from 53 percent in September 2013 to 61 percent in September 2014.

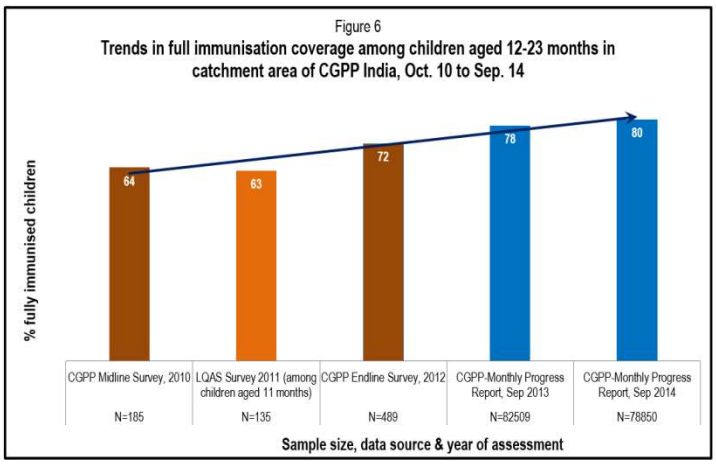




% of children 12 to 23 months fully immunized

Since the final evaluation survey, 2012, there has been an eight percent increase in fully immunized children in CGPP India areas (*Figure 6*). It is obvious from *Figure 7* that about 80 percent children aged 12-23 months in CGPP areas are fully immunized. The district-wise full immunization coverage ranged from 72% in Sambhal district to 89% in Saharanpur district.





- Total Number of Community Volunteers (NGO Partners & CMCs) – 1240 CMCs
- Total Number of families covered by community volunteers (NGO Partners) – 567,136 households
- Total Number of children under 5 in families covered by volunteers (NGO Partners) – 455,308 children
- Cumulative Number of volunteers trained – 1235 CMCs
- Annual number of trainings and persons trained

Details of trainings conducted by CGPP India, Oct. 2013 to Sep. 2014

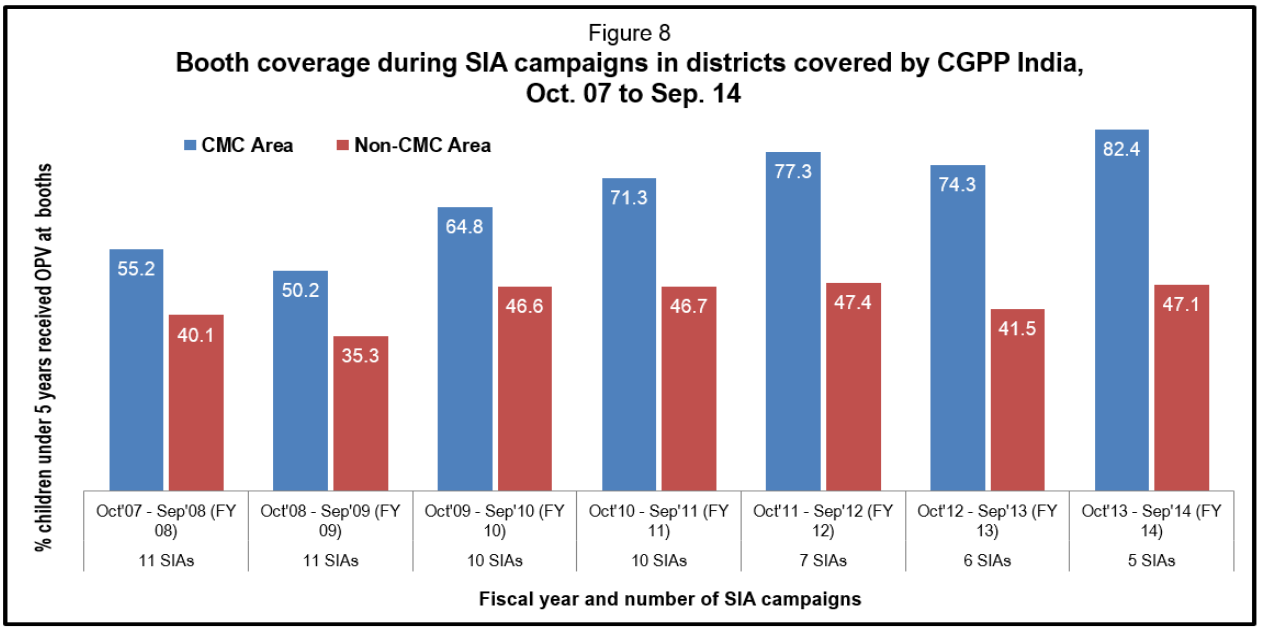
No.	Training	Participants	Dates	No. of batches	No. of participants		
					Male	Female	Total
1	Review Meeting	All DMCs, DUCs and SRCs	3.6.2014 to 5.6.2014	1	21	4	25
2	Training on data analysis and data validation	All DMCs, DUC, MIS Coordinators and SRCs	23.6.2014 to 25.6.2014	1	29	9	38
3	Training of master trainers	Selected DMCs, DUCs and BMCs	15.7.2014 to 18.7.2014	1	30	8	38
4	Training for interventions & activities of FY15	All SRCs, DMCs, DUCs, MIS Coordinators, BMCs	18.7.2014 to 24.7.2014	4	85	25	110
Total				7	165	46	211

Objective 3: Support supplemental polio immunization activities

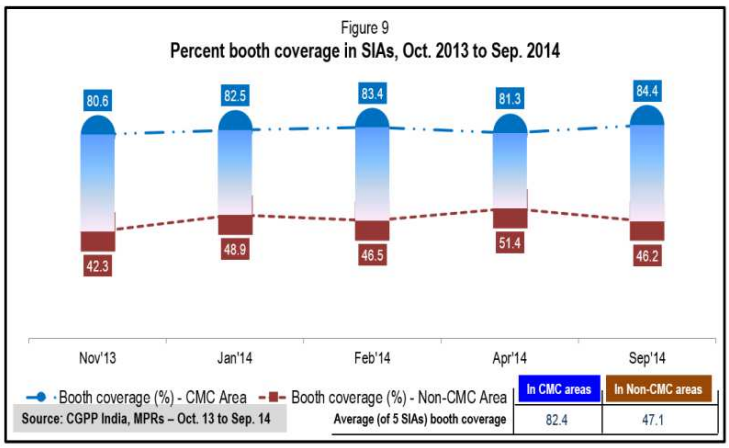
It is obvious from *Figure 8* that booth coverage in CMC areas is constantly improving in CGPP areas and is consistently higher than coverage in non-CMC areas.

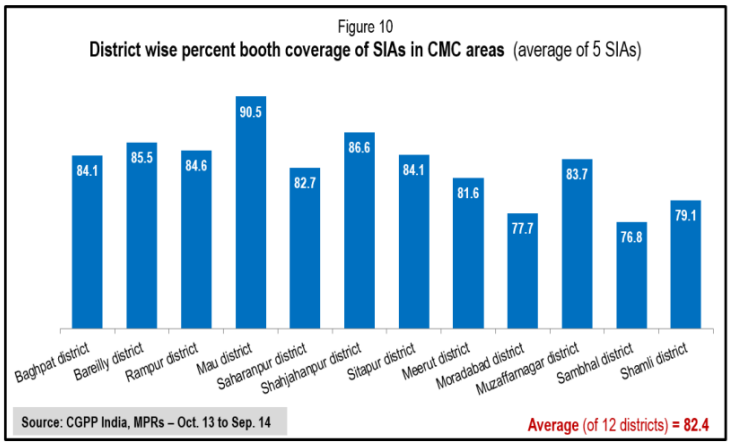
Figure 8

Booth coverage during SIA campaigns in districts covered by CGPP India, Oct. 07 to Sep. 14



During the reporting period (Oct.2013 -Sep.2014), five SNIDs were conducted in November 2013, January 2014, February 2014, April 2014 and September 2014 where on an average, 82% children below 5 years received OPV through about 1737 polio booths in each. It is obvious from *Figure 9* that booth coverage in CMC areas (82.4%) is much higher than in non-CMC areas (47.1%) of CGPP districts. The district wise booth coverage in CMC areas varied from 77% in Sambhal district to 91% in Mau district (*Fig.10*).



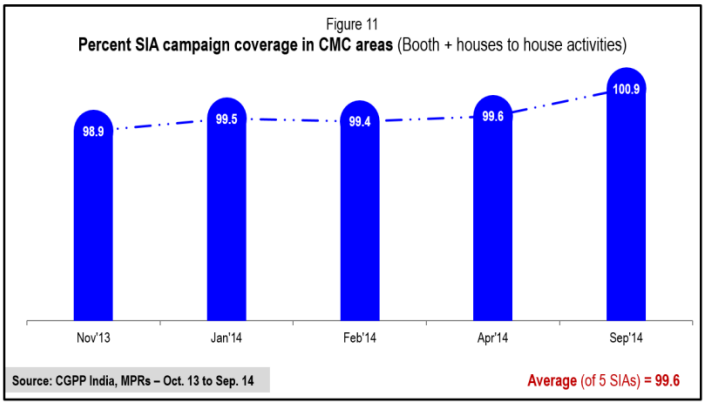


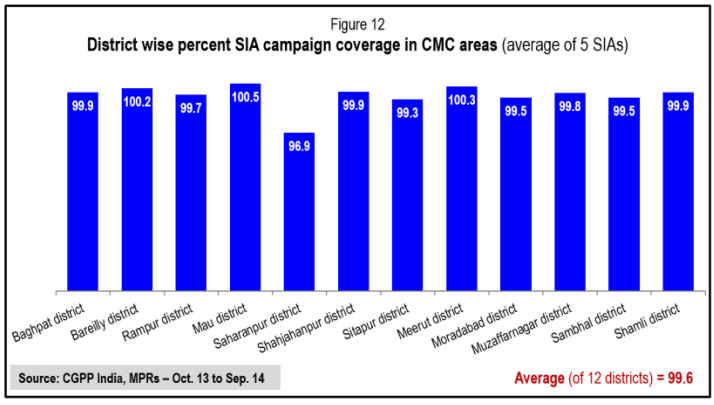
Examples from the field

Improvement in booth coverage and reducing missed children: *Booth coverage keeps improving consistently in CGPP work areas as the teams take innovative approaches to maintain the momentum of the programme. Apart from regular announcements from mosques, involvement of child mobilisers from Madrasas, booth inauguration by local influencers, etc., special IPC visits are made to families to urge them to bring their children to the booths and not wait for the team to visit their homes. The trend of missed houses and children is regularly analyzed to identify repetitive missed houses and this reduces missed children. This list is then shared with influencers in interface meetings and special family visits are made. High Risk Groups (HRG) such as nomads, brick kiln workers, etc are incorporated regularly in SIA micro plans and special teams are assigned to these HRGs during SIAs.*

SIA coverage (Under-five children vaccinated at booths and house-to-house)

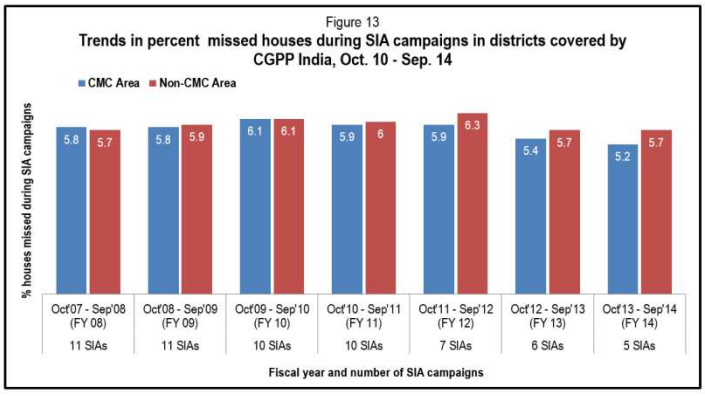
Figure.11 present percentage of under-five children who received OPV through booths and house-to-house activities in CMC areas. In addition to booth day activity, on an average, 543,229 households from CMC areas were visited by vaccinators, reaching 443,590 under-five children in each SIA. The total SIA coverage in CMC areas was 99.6 percent. District wise variation in SIA campaign coverage ranged from 97% in Saharanpur district to 100% in Mau district *(Figure 12).*

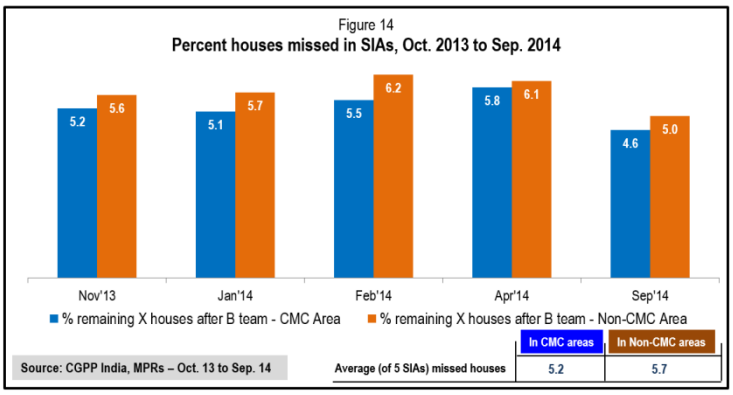




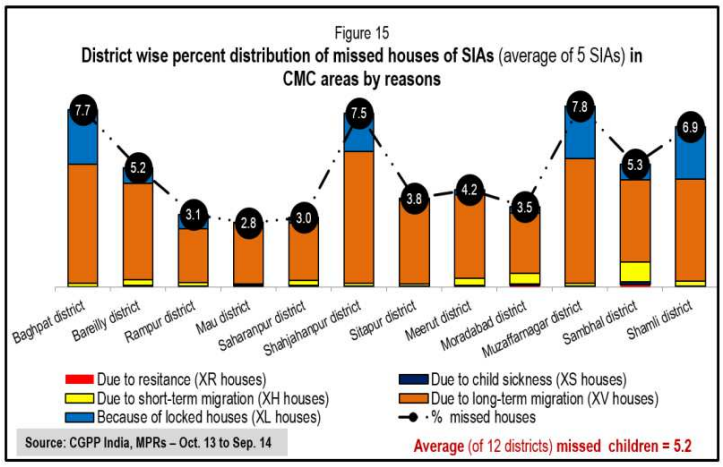
% of houses missed in each SIA

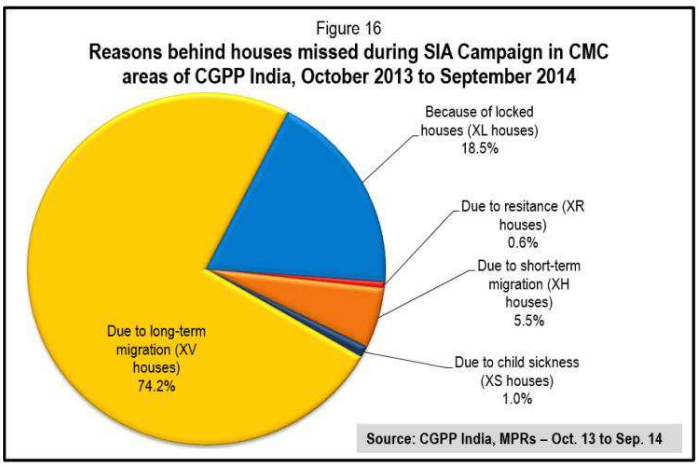
Trends in percentage of missed houses presented in *Figure 13* are more or less the same in both CMC and Non-CMC areas and it is constant. However, in the reporting year (Oct. 2013 to Sep. 2014) CMC areas reported comparatively less proportion of missed children than in non-CMC areas (*Figure 14*)





House-to-house vaccination teams in CMC areas visited about 543,229 households in each SIA out of which, about 5.2% households were missed in each SIA. Proportions of missed houses vary by district, ranging from 2.8% (Mau district) to 7.8% (Muzaffarnagar district) in CMC areas. *Figure 15 and* Figure16 show the reasons behind missed houses. A large proportion (80%) of houses from CGPP India areas are missed due to short-term (74%) or long-term (6%) migration. Only a very small proportion, i.e.0.6% houses were missed due to resistance to OPV.





% of children under 5 missed in each SIA

Out of 443,590 under-five children visited, about 8.3 percent were missed in every SIA in the reporting period. The proportion of missed children was lowest (7.3%) in September 2014 and highest (9.4%) in April 2014 *(Figure 17).* District-wise proportion of missed children ranged from 4.6 percent (Mau district) to 12% (Muzaffarnagar district) in CGPP areas *(Figure 18).*

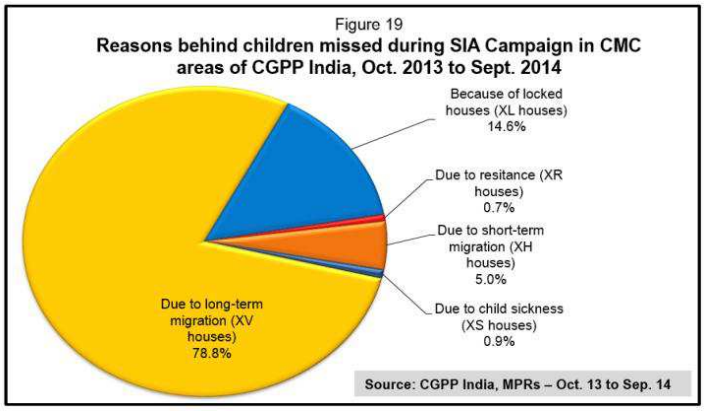
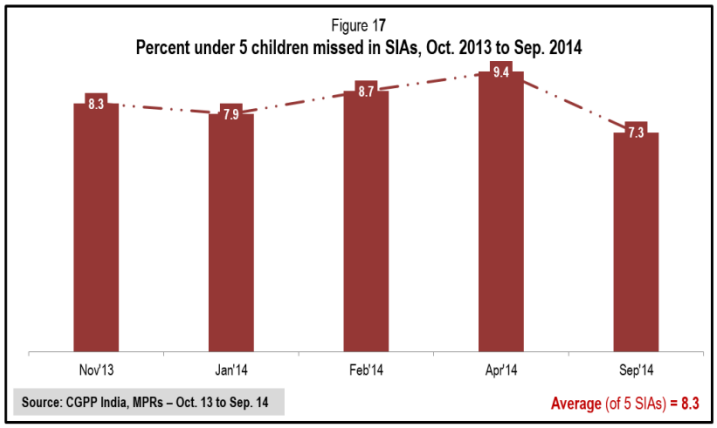
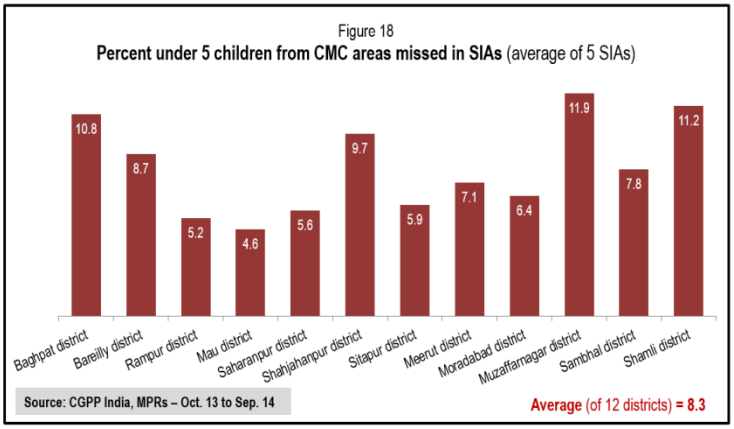


Figure 19 presents reasons of children missed in SIAs of reporting year. A large proportion (>80%) of missed children were out of reach of vaccination teams because of short or long-term migration. The proportion of children missed from resistant families is fairly low (1%).





Examples from the field

RI monitoring data is reviewed at state and district Task Force meetings and directives are issued to district officials for corrective steps. Vaccine supply has improved since the EVIN (Electronic Vaccine Intelligence Network) was activated at the state level.

Strengthening coordination among ANMs (Auxillary Nurse Midwives), ASHAs (Accredited Social Health Activists) and CMCs.

Coordination meetings of ANMs, ASHAs and CMCs are organized in each CGPP block. These meetings are chaired by block and district health officials where challenges are shared and solutions suggested. Many a time, ASHAs do not update the survey of children so CMCs provide due lists of eligible children taken from their tracking registers. The time and venue of the RI sessions are also re-planned. Plans for involving influencers for resistant families are discussed. This improved coordination reflects in the quality of immunization service delivery at the RI sessions and is much appreciated by the community.

Special RI drives

At the district level, regular advocacy is done by DMCs and SRCs to improve supply as well as to increase the number of sessions. Many ANM posts were vacant so a large number of children were missing immunizations. Regular advocacy yielded results and ANM posts have now been filled by the government. Sambhal is a high risk block with a population of 221,000 with just one ANM. CGPP teams organized special RI catch up drives in which more than 15-20 special RI sessions were held in a day by deploying ANMs from neighboring areas. This practice is now institutionalized and incorporated in the micro plans. This has helped tremendously in vaccinating missed children.

Table 2 - Consolidated number of Social Mobilization activities in the field: October 2013 to September 2014

Project area districts	# IPC visits		Number of group meetings								Number of health camps		Number of coordination meetings*		# of Govt. RI sessions monitored by CGPP team	
			Mothers/ Adolescent girls meetings		Fathers/ Adolescent boys meetings		Interface/ Influencers/ Religious leaders meetings		Total							
	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done
Baghpat	85950	77144	1788	1665	160	155	1240	1161	3188	2981	72	69	763	716	648	569
Bareilly	51802	48962	1298	1256	85	84	860	836	2243	2176	60	33	470	457	648	1029
Rampur	48855	45067	2053	1948	3	3	232	207	2288	2158	77	58	353	290	432	384
Mau	20452	20332	1704	1704	76	76	355	284	2135	2064	24	24	112	108	288	487
Saharanpur	20423	19418	1427	1392	451	409	431	360	2309	2161	25	24	109	109	432	543
Shahjahanpur	27188	26789	1426	1382	33	33	546	454	2005	1869	30	30	209	203	432	568
Sitapur	33435	30883	2387	2283	209	180	729	585	3325	3048	36	36	165	139	432	543
Meerut	32400	30529	2235	2188	13	13	64	59	2312	2260	44	43	280	253	576	587
Moradabad	112009	106582	2015	1925	7	7	597	586	2619	2518	32	30	265	189	936	975
Muzaffarnagar	55846	52441	2791	2228	64	61	697	672	3552	2961	41	36	287	235	864	1306
Sambhal	113004	96555	1923	1876	7	7	414	370	2344	2253	43	31	305	216	936	940
Shamli	13768	13194	835	831	0	0	251	251	1086	1082	15	12	107	77	216	306
CGPP India (12 districts)	**615132**	**567896**	**21882**	**20678**	**1108**	**1028**	**6416**	**5825**	**29406**	**27531**	**499**	**426**	**3425**	**2992**	**6840**	**8237**

Data Sources: *Baseline, Mid-term, & Final Evaluations; LQAS Surveys; National Coverage data; WHO and MOH AFP data and surveillance reports; Quarterly and annual partner report*

Objective 4: Support efforts to strengthen AFP surveillance

Non-Polio AFP rate: According to AFP surveillance indicators reported in the week ending 4th October 2014, the aggregated Non-Polio AFP rate in 12 CGPP districts was 20.4 per 100,000 children under 15 years but rates vary by districts. *Table 3* presents NP AFP rate by district. Mau district reported lowest at 8.1 and Sambhal reported the highest, at 27.8.

% of NPAFP cases with 2 stool samples within 14 days of onset of AFP: According to AFP surveillance indicators reported in the week ending on 4th October 2014, the aggregated adequate stool collection rate (2 specimen of stools collected within 14 days of onset of AFP) in 12 CGPP districts was 86.6 percent. Adequate stool collection rates vary by districts – Table 3. The highest rate was reported from Mau district (95.2%) and the lowest from Shamli district (78.7%).

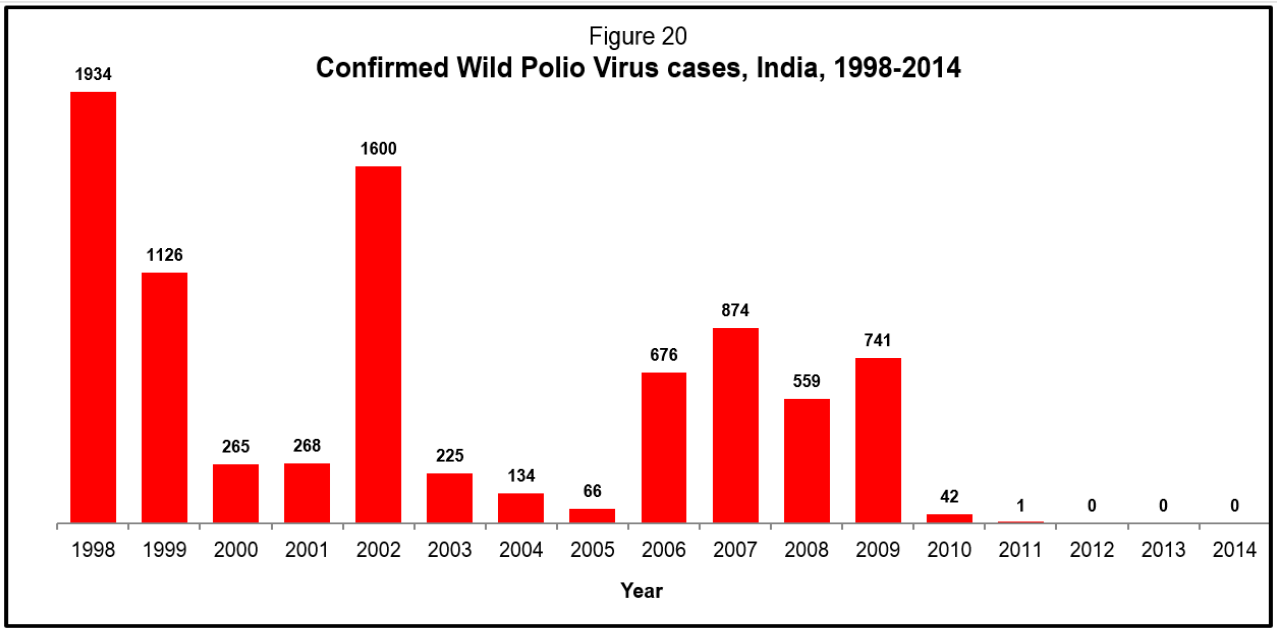
Table 3: Consolidated data table for period Oct.2013 to Sept.2014

Project area districts	Population of CGPP Catchment Area			# of CMCs deployed	# of training batches	# of persons trained	Polio cases	NP-AFP Rate	Adequate stool (% with 2 spec. stool within 14 days of onset) ♦	OPV 0 rate (children aged 0-11 months)	OPV 3 rate (children aged 12-23 months)	DPT 3 rate (children aged 12-23 months)	SIAs	Avg. SIA Coverage
	Total pop.	Under 5 pop.	Under 15 pop.											
Baghpat		44617		118	4	118	0	24.8	90.3	78.0	88.9	88.9		
Bareilly		27210		87	4	89	0	25.1	88.1	81.1	86.1	86.3		
Rampur		22709		85	4	84	0	21.9	87.7	80.2	86.2	87.9		
Mau		24152		71	3	71	0	8.1	95.2	75.8	94.0	94.0		
Saharanpur		25552		71	3	71	0	14.5	89.5	86.7	92.0	92.0		
Shahjahanpur		39083		91	4	90	0	23.1	85.0	72.8	90.9	91.0		
Sitapur		35623		112	4	110	0	19.6	81.5	70.5	90.4	90.7		
Meerut		31494		91	4	91	0	20.3	89.5	75.2	88.8	88.8		
Moradabad		45479		158	6	158	0	22.3	82.3	75.2	83.1	83.1		
Muzaffarnagar		60132		153	6	152	0	23.2	87.8	82.8	84.2	84.2		
Sambhal		57614		161	7	161	0	27.8	83.3	73.1	76.4	76.9		
Shamli		13466		40	3	40	0	14.6	78.7	88.2	89.3	89.3		
CGPP India (12 districts)	3648102 *	427131 **	1495722 ***	1238	52	1235	0	20.4	86.6	77.5	86.2	86.5	5	99.6

* Estimated based on Census of India 2001 and decadal growth rate
** Reported in Child tracking registers of CMCs as of Sep'2014
*** Estimated based on population for 2011 and age distribution in a census 2001 for UP
♦ Source: WHO - NPSP, AFP Surveillance Indicators-for week ending 4th October 2014

- **# of silent areas in project target areas –** There are no silent areas in CGPP districts.

Number of confirmed cases of Wild Poliovirus over 10 years



Objective 5: Support timely documentation and use of information

Indicators:

# of Journal Articles or case studies published by the Secretariat and PVOs

Two abstracts were selected for presentation at the 141st APHA Meeting at Boston, US in Nov. 2013.

- Partnership for Global Disease Eradication- Determinants of Success – Presented by Jitendra Awale
- Opening every door - reaching the last child with OPV in UP, India: Role of management information system in social and behavior change communication programs – Presented by Manojkumar Choudhary.

The following abstract by Jitendra Awale has been selected for Prince Mahidol Award Conference 2015 in Thailand: Reducing inequity by reaching marginalized groups to improve immunization coverage - Lessons from India Polio Eradication Program for health system strengthening and universal coverage.'

The following abstract by Manojkumar Choudhary has been selected for the 14th World Congress on Public Health, Kolkata, India in February 2015: Unsung Heroes of polio eradication programme in Uttar Pradesh, India - Role of influencers in acceptance of polio vaccine: A case of CORE Group Polio Project India'

Objective 6: Support PVO/NGO participation in certification activities

The secretariat gave inputs on polio legacy planning to Dr. Sigrun Roesel, WHO consultant for supporting SEARO for documentation of the certification process. Nellie Bristol from CSIS,USA visited India to document the legacy planning process. She visited various partners and government officials in New Delhi and Moradabad, UP to understand how polio legacy can be used for other public health issues and published a report *' Repurposing Global Polio Eradication's Tool Kit'.* Rina Dey accompanied her on the Moradabad trip.

Indicator: # of Independent Surveillance Reviews with CGPP participation – Not done

- **Conclusion including Challenges, Innovations and Future Plans**

After about 20 years of a long battle against polio, India and the entire Southeast Asia, home to about 25% of the world's population, is now certified as polio free. This is an extraordinary achievement in the history of public health. CGPP India's contribution has been very valuable as it was assigned some of the most high risk areas in the country. The project proved its worth through the tireless efforts of its mobilisers and community influencers in these very tough areas. Routine immunization coverage is consistently improving in CGPP areas and OPV3 coverage is in the range of 76% to 96%. OPV0 coverage is somewhat difficult to improve as there is a very short span of time to work in. However, the supply issues and a short time span were addressed by better micro planning, advocacy for more sessions and vaccination in labor rooms, etc. In FY14, 78% of newborns received OPV0. During SIAs, an average of 8.3% children were missed in CGPP work areas. Most of these children were not available during SIA days. CGPP however continued its capacity building efforts. Special training on data analysis and validation was conducted for district mobilization coordinators and MIS coordinators. All new CMCs had three days induction training and a total of 1235 CMCs underwent three days of training on improving skills and knowledge.

The CGPP India secretariat team also provided support to CGPP Nigeria and S. Sudan and also participated in the Afghanistan Polio Communication Review by UNICEF. CGPP is participating in GoI introduction of IPV in RI and withdrawal of OPV2.

Innovations

Newborn Congratulatory Card (*Badhai* card) Photo Session: To ensure that each child is reached and vaccinated, CGPP has distributed newborn Congratulatory cards in all its districts since 2008. This card is given to the mother after childbirth and has a specific place for affixing the child's photograph. The Rampur team initiated a mass photo session of infants in CMC areas with all eligible mothers and children. The cost of the photograph was paid for by families. This initiative enhanced the importance of the congratulatory card and was much appreciated by the community, especially mothers. In future such opportunities will be tapped to disseminate immunization & nutrition messages by introducing activities like healthy baby show/quiz competitions etc.

RI Message display at public places: The CGPP Baghpat team put up immunisation messages on water coolers installed by the district administration at various public places like markets, bus stands, etc. These messages were displayed on a banner-size sticker.

Improving OPV0 coverage among children born at institutions: Institutional deliveries are being promoted not only for safe delivery but also to protect the newborn from vaccine preventable diseases. However, due to various reasons like apathy among vaccinators/ANMs, OPV0, BCG and Hep.B vaccinations were usually not being given before the mother's discharge. Inconsistencies in immunization records were found in all districts. In keeping with CGPP's role of advocacy for every newborn's right to birth doses of OPV and Hep B, the Rampur team showed the way, identifying bottlenecks and trying to suggest institutionalising procedures to streamline the process. An Immunization Register, discharge slips, vaccine carriers in the labor room, etc were some of the practices that were suggested and accepted by the health authorities. This should improve OPV0 coverage, at least in all CGPP districts.

Challenges

Program Visibility: Sustaining community involvement for polio eradication and strengthening the routine immunization programme is becoming a major challenge because polio partners have shifted focus and minimized their efforts, like reducing IEC materials, etc during SIAs.

Threat of importation of WPV and incidence of VAPP: In the past, India has exported cases to Angola, Nigeria, and Tajikistan and migration of people from all socioeconomic strata is a growing phenomenon in India. The India program is very vulnerable for importation of WPV. Also, there are pockets of very poor routine immunization, which could be a breeding ground for VAPP. These challenges reminded the program planners to strengthen the RI program in all over country because poliovirus does not respect political or geographic boundaries of states and districts.

Future plans

- Based on program priorities, CGPP will work in coordination with national and state governments and partners on following major plans:
- Strategic communication efforts to reach out to every child every time in NIDs and SNIDs.
- Continue to support national, state and district level officials to improve the quality of the Routine Immunization program especially reaching the High Risk Groups.
- CGPP will be a part of working groups for the introduction of new vaccines such as IPV, Pentavalent, Rotavirus, etc.
- CGPP plans to develop a communication plan in tandem with the national plan for CORE SMNet.
- Legacy Planning: CGPP would be part of the national legacy planning process.
- CGPP India will continue to support other country programs as per the need and the guidance of CGPP HQ.
- Documentation of contribution provided by influential people in polio eradication program.

Key Activities:

UNICEF India –C4D Polio Network Meeting, New Delhi,28 Nov. 2013

UNICEF India organized a meeting of the C4 D Polio Network at Hotel Metropolitan, New Delhi, where officials from the polio network from different state offices of UNICEF India and other sections like immunization, nutrition, sanitation were present. Jitendra represented CGPP and gave a presentation on CGPP's work. GoI was represented by Dr. Khera, Dy. Commissioner, Child Health, and NPSP and Rotary were represented by Dr. Sunil Behel and Lokesh Gupta respectively.

A Gateway to Grants workshop was held in Gurgaon from the 9-13 December 2013 for CGPP India staff as well as partners. The resource persons were from World Vision US as well as Patricia Kaleebu, Sr. Finance Officer responsible for CGPP at the HQ level.

Country Director's Meeting with Ellyn Ogden at Secretariat,17 Feb. 2014: Among those present, were Edward Scholl, CD PCI, Ataur Rab, SRC PCI, John Shumlansky, CD CRS, Parul Ratna, SRC CRS, Rajendran Ganapathy, Finance Director ADRA, Vivek Biswas, SRC ADRA, Roma Solomon, Rina Dey & Manojkumar Choudhury, CGPP.

Issues discussed:

- Regional certification: Ellyn talked about SEAR polio-free certification in March 2014 and said that she would participate in the ceremony in Delhi.
- IPV introduction will be from late 2015, along with the DPT3 dose.
- Surveillance will be continued as actively as it is being done now.
- The partners felt that the CGPP had very unique and rich experience that they could use for other programs and this needs to be documented. For example, how to work with the government, do activity audits, work

with community members like influencers, use collected data, work on women's empowerment, mHealth, CSO role in the outbreak of an epidemic, etc.

USAID meeting, 20 Feb 2014.: Each section head described his/her projects and an open discussion followed. John Beed, Mission Director presided and Dr. Roma represented CGPP in this meeting.

Program Review meetings

The secretariat and partners organized program review meetings and the secretariat staff participated in review meetings organized by PVO partners.

CGPP India review meeting, 3 -5 June 2014, Bangalore: All SRCs, DMCs, DUCs and secretariat team participated along with Derek Glass, Program Director ADRA India and Deepti Pant, CRS UP State head.

The findings of the RI data validation exercise that was conducted in all CGPP districts were shared:

- The quality of data needs to be checked at every stage before submitting any report to the supervisors.
- Supervision of field activities needs to improve as there was a feeling that fatigue/complacency may be setting in among field staff, esp. for targeted activities like IPC.
- Accountability of any lapses needs to be fixed.
- Apart from RI data validation, each PVO presented the findings of supervisory checklists and an update on sanitation activities.

ADRA Program Review Meeting, 30 March - 04 April 2014, Gir, Gujarat: Manojkumar Choudhury participated in this meeting with all ADRA CGPP Staff and the ADRA India senior management team.

The objectives of the review meeting were:

- Critical analysis of performances across the districts/blocks.
- Identification of gaps, considering the analysis of the first half of FY14 performances and last review minutes; preparing a road map to fill the gaps during 2nd half of FY14.
- Develop understanding about data validation and related issues.

All the three (Rampur, Bareilly, Baghpat) district teams presented district specific highlights and challenges related to SIA and RI and developed a road map based on the strategies and activities shared by the highest performing blocks. Manojkumar briefed the participants about the concept of 'data validation' and upcoming RI data validation exercise in April-May 2014 in all the CGPP India districts.

PCI Program Review meeting, 7-9th May 2014, New Delhi: Rina Dey participated. The focus was on avoiding complacency and maintaining high levels of motivation both in the field staff as well as in the community and other partners. Targets for booth coverage needed to be revisited since it is stagnant for a long period. It was decided reiterated that field teams should conduct activities as per seasonality of diseases. Team's capacity should be built on understanding or establishing links with coverage & activity.

ADRA Program Review Meeting, 23-25 Sep.2014, Nainital: Rina Dey participated in the meeting. Data revalidation was conducted in all ADRA districts. Greater involvement of MIS coordinators was ensured. The following recommendations were made:

- District and block mobilizers should identify and strengthen missed opportunities for information, education and communication with specific audiences.
- CMC area mapping sheets & data should be utilized for planning of mother meeting.
- Strategic communication activities like group meetings or big community meetings should be planned for selected area and audiences. Prior to these meetings, proper planning and preparation must be made like why, what, where and how.
- It must be stressed that family contact is not interpersonal communication and other methods should be used to measure IPC efficacy.
- Team members from other districts should be involved in the data revalidation exercise.

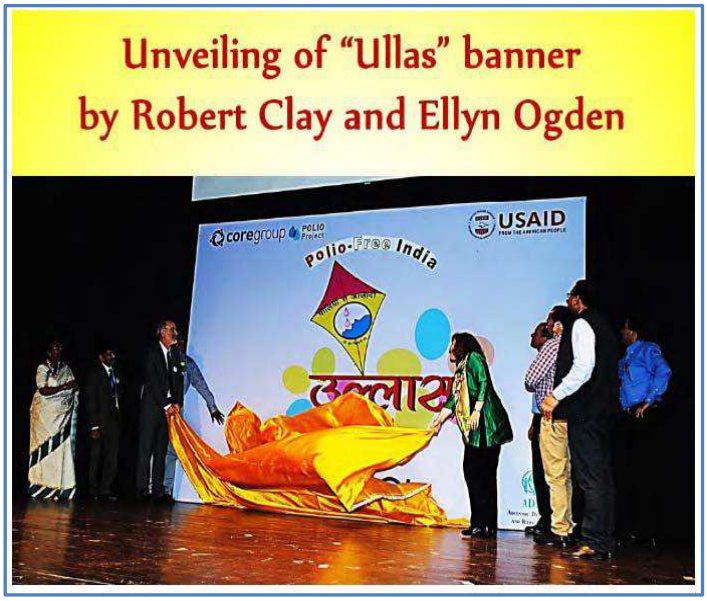
Visit to Afghanistan, 22 -29 Oct. 2013: Jitendra Awale visited Kabul and Jalalabad with local teams to participate in UNICEF's Polio Communication Review. The focus areas were Immunization Communication Network, convergence, high risk groups, monitoring and evaluation and media and IEC. The objective was to identify areas and collaborations with other programmes to ensure investments in polio lead to strengthening platforms for broader child survival and development, especially routine immunization.

Support to CGPP Nigeria and S. Sudan, Feb. & Aug. 2014: Jitendra Awale and Rina Dey visited the Nigeria Programme to provide technical support. Both visits were valuable in terms of assistance in developing a training curriculum, training of master trainers, development of a BCC strategy, supervisory check lists and BCC material, etc. In coordination with South Sudan team, Rina Dey designed flip book on polio/immunization for the field staff.

Celebrating victory over polio: A series of celebratory events was organized to celebrate India's victory over polio. The first and largest one was organised on 11 February 2014 in Delhi by the Ministry of Health and Family Welfare, Government of India and presided over by the president, Mr. Pranab Mukherjee. It was attended by the then Prime Minister, Dr. Manmohan Singh, Health minister and WHO Director General, Margaret Chan, among others. The President said that India's success against polio was a milestone towards universal health care in the country and proved the efficacy of innovative tools and strategies. He expressed his appreciation towards the 2.3 million vaccinators who could reach 170 million children, multiple times a year with a high level of enthusiasm and total commitment. The event was attended by field staff of the government, WHO, CORE, UNICEF & Rotary international.

CMC Utsavs and Ulhas: To celebrate the success of polio eradication and boost the motivation of field staff, five events (*CMC Utsav)* were held for all the 12 districts of CGPP in five districts from Feb. and March 2014. CMCs, ANMs and officials from the health department and other government departments were felicitated for their contribution in the programme.

On 28th March 2014 a motivational event - *'Ulhas'* was organized at Gurgaon for all the CGPP Staff and NGO partners. It was chaired by Robert Clay, USAID's Dy. assistant administrator in the Bureau for Global Health



and Ellyn Ogden, USAID's Worldwide Polio Eradication Coordinator. All BMCs, DMCs, DUCs, PVO directors and NGO representatives were felicitated for their contribution in polio eradication. It was a joyful event with games, songs, etc performed by field staff.

Polio Gallery, Moradabad

After installation of the polio *chowk*, a polio gallery was established by CGPP at the district hospital, Moradabad on 15th of February 2014. This first such polio gallery in the world projects the journey of polio eradication in India, along with a display of handcrafted samples of local craftsmanship. These latter were voluntarily made and given by the community. The gallery was inaugurated by Dr. S. Yadav, CMO Moradabad and Ellyn Ogden, Janine Schooley PCI, Sr. VP Programs, Dr. Roma, Director, CORE India, polio partners WHO, UNICEF, Rotary International & field staff of CORE districts attended.

Polio Eradication Gate: Muzaffarnagar is a district located in Western U. P, popularly known as 'The Sugar Bowl' of the country. It now has the distinction of having the first 'Polio eradication gate' in the world'! PCI's perseverance and multifaceted approach to social mobilization, under the technical umbrella of the CGPP and in collaboration with other stakeholders resulted in tremendous achievements, some more visible than others.

A Village Council headman, Akhlaque Qureshi, on learning about the 'Polio Chowk' and Polio gallery in the city of Moradabad (U.P), was motivated to do something similar in his block too, using village development funds. CORE secretariat, designed a 'Polio Eradication Gate' and the Block Development Officer and other officials provided full support during its construction that took six months. A grand inauguration was held in August 2014 and was attended by senior local government officials, polio partners, members of the community and CGPP staff. The words, 'Polio *Unmoolan* (Eradication) *Dwar* (Gate)' are inscribed on the front in Hindi and on the other side, in Urdu and blue vaccine carriers are placed strategically on top of the two pillars. The gate stands as a living testament to the sustained efforts of communities and civil society contribution to polio eradication.

Influencers' felicitation: Sustaining motivation of the influencers at this time of the program is very critical because there are fewer SIA rounds so the program is losing its priority for government. In all the CGPP districts, a special program to felicitate and give thanks to influencers was organized and was chaired by senior government officials like district magistrates, chief medical officers, etc. This activity will give produce rich dividends in terms of sustaining motivation of influencers.

Sanitation Activities: In order to improve immunity against WPV, it is necessary to improve sanitation practices especially through promotion of construction and use of sanitary toilets. In all the CMC areas, CMCs through IPC/meetings promoted the use of sanitary toilets and with the help of BMCs and local influencers, motivated families without sanitary toilets to construct them. About 9000 toilets have been constructed or converted to sanitary toilets through these efforts in Moradabad and Sambhal.

Example from the field

There are very interesting anecdotes about how CMCs motivated families to use toilets and stop open defecation. If CMCs observed that the family was using sanitary toilets, then 'green stickers' designed by CGPP were pasted on their door. People now take pride in having these stickers. A CMC shared that a person whose house carried a green sticker was found to be going for open defecation in the morning. The CMC then went to his house and tried to take out the green sticker from the door. The family felt ashamed and assured that they will use the toilet constructed in the house.

Diarrhea management:

In order to improve immunity against polio, CGPP continued with it's diarrhea management activities. All field staff was trained on the use of ORS and Zinc in diarrhea management and collaborated with Clinton Health Access Initiative (CHAI) who has a very big program in U.P for the same. During this year, an agreement was made with CHAI who conducted training of BMCs and DMCs and provided IEC material on diarrhea management.

mHealth: A pilot was successfully carried out in seven blocks, however due to paucity of funds this project was discontinued after 30 September 2014.

Negative propaganda on polio – a communication challenge

Case 1

The Village Pradhans Association and Akhil Bharteeya Ambedkar Yuvak Sangh (ABAYS) of 30 villages from the Manota block of the Sambhal district boycotted the polio round during the November 2013 SIA. The community demanded villages be included in Moradabad district. As a result of the boycott, more than 6,000 children remained unimmunized during the November 2013 SIA. The CORE PCI team met the community leader and local influencers and informed the government health and administration officials about the problem. In consultation with Divisional Commissioner-Moradabad Sub Divisional Magistrate (SDM) and the Block Development Officer (BDO), medical officers, the CORE-PCI and the Rotary team met community leaders from different groups and motivated them to immunize their children. As a result of these intensive efforts most of the children were immunized during the January 2014 NID. The Divisional Commissioner of Moradabad specially thanked CGPP PCI team for these efforts.

Case 2

In the September 2014 SIA round in Moradabad, one infant died after polio vaccination. This child was sick and was not fed for two days, but the family alleged that the child died due to OPV. About a thousand people gathered and confined the vaccination team and CMC. Representatives of print and electronic media gathered at the place. Sensing the potential fallout of this event if the media gave negative publicity, the PCI team called the district administration and medical officials and conducted a meeting with the people gathered there and the family members of the child. The medical officer himself took the vaccine from the same vial to demonstrate that the vaccine vial was safe. After a lot of persuasion the family members and community leaders were convinced that the vaccine was safe and not the cause of death of the infant.

Legacy Planning

- *Improvement in micro plans, social mobilization and service delivery, etc., resulted in improving immunization coverage, immunity and thus reducing the number of polio cases.*

- *Synchronization of SIA micro plans with RI micro plans - bringing in all the marginalized population into the ambit of health care and addressing the issue of equity.*

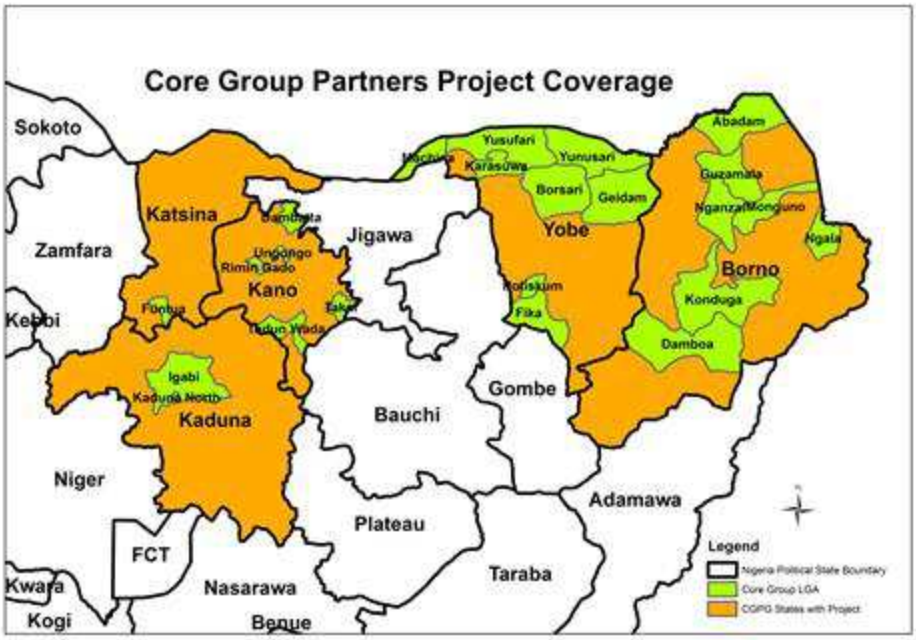
- *CGPP's social mobilisers are now well trained health workers and can take up any other health issue like RI, TB, malaria or sanitation. State governments, in coordination with the Ministry of Health are contemplating various ways to integrate these health workers in the public health system. The UNICEF SM Net now spends fifty percent of its time for RI.*

- *Strategic activities (like health camps, working with children, influential people), Innovations, monitoring, accountability partnership and timely availability and use of data are the key elements of the success of the India Polio Program. Remaining endemic countries can take up lessons from this and adapt to their country situations and implement with the same rigor and enthusiasm as India did.*

CGPP Nigeria

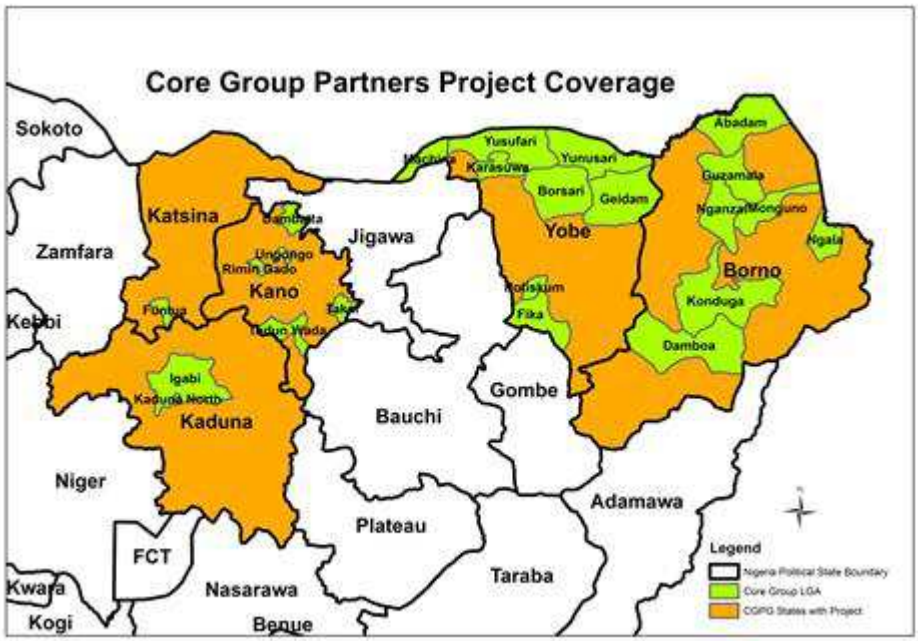
Polio eradication in Nigeria has made rather dramatic progress in the last two years moving from the country with the highest number of cases globally in 2012 (101) to 50 cases in 2013, and only six cases so far in 2014. With the last case detected in July of this year, Nigeria has a very real chance of interrupting wild polio virus this year which could lead to a polio free Africa in the very near future. Although clearly only one small partner out of many, CGPP has played an important role in introducing the voice and skills of civil society to Nigeria's polio eradication efforts and contributing to community level promotion of immunization and case detection. Nevertheless, Nigeria has a history of high performance followed by complacency resulting in cyclical outbreaks of polio. Insecurity in Borno and Yobe in the past year has resulted in the deterioration of routine health services as well as poor performing IPDs. The targeted killing of polio workers early in 2013 and recent attacks by Boko Haram are a reminder of the operational challenges facing the country and the need for nimbleness to adjust to local conditions. In areas not affected by insecurity, low routine immunization, poor program management, missed settlements, distrust of the vaccine, poor use of funds, migrant and mobile populations, and a lack of accountability continue to hamper the program. Under the guidance of the Government of Nigeria (GON), the Ministry of Health, the EOC, WHO, UNICEF, CDC, and various NGO and PVO partners established a National Emergency Action Plan to improve operational quality and provide systemic oversight. The pressure to eradicate polio has reached a new peak as political, fiscal, and human capital is expended and numerous partners join the fight. While there has been significant improvement in most of the country, sustaining the improvements and increasing coverage in the new settlements identified in recent mapping efforts remains a challenge. Ongoing transmission in Kano threatens to return virus to other parts of Nigeria unless high levels of coverage are sustained during IPDs and routine immunization services are improved.

The CGPP launched polio eradication activities in Nigeria in 2013 with sub-grants to three NGOs and the establishment of a Secretariat to contribute to the goals of the national emergency action plan in high risk areas, in a manner that is integrated with ongoing child health services. N-CGPP joined the other implementing partners under the general operational auspices of the National Emergency Operations Center (EOC) and State EOCs. The project has emphasized capacity-building to measurably improve the health and well-being of children and women through collaborative action and learning. The project has promoted collaboration between N-CGPP members, their local NGO partners, the national EOC, local Ministries of Health, WHO, UNICEF and local levels of government.



Objective 1: Build effective partnerships between agencies

CGPP Nigeria has made impressive progress in integrating the project into the national polio eradication initiative, as a full member or the national Emergency Operating Committee (EOC) representing CORE Group partners in meetings with the MOH and the spear heading partners. From an initial reluctance to the idea of CGPP working in Nigeria, senior members of the Nigerian EOC have now embraced CGPP's



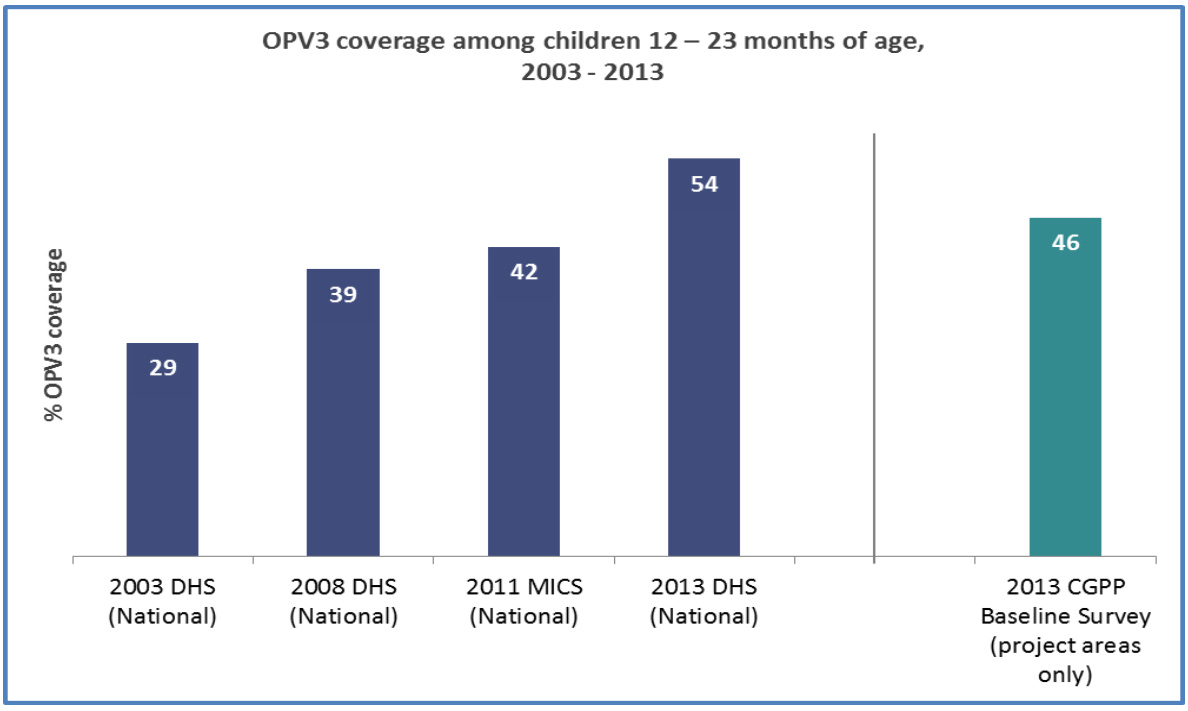
contribution and the Secretariat Director plays a central role in operational aspects of the Nigerian eradication program. Through sub-grants to three major NGOs; Catholic Relief Services (CRS), Save the Children, and Public Health Services Systems (PHSS), CGPP launched polio eradication activities in five high risk priority states of Northern Nigeria; Kano, Kaduna, Katsina, Yobe, and Borno. Save the Children is working in two very high risk LGAs in Katsina through two local CBOs, Health Care and Education Support Initiatives (HESI) and Family Health and Youth Support Initiatives (FAHYE). CRS is working in Kaduna and Yobe through sub-grants to DACA, the Federation for Muslim Women, Associations of Nigeria (FOMWAN); Community Development Foundation (NIRA); Waka Rural Development Initiative (WAKA); and Yetim Care Foundation (YETIM). PHSS directly implemented project activities in seven high priority LGAs in Kano and 8 high priority LGAs in Borno.

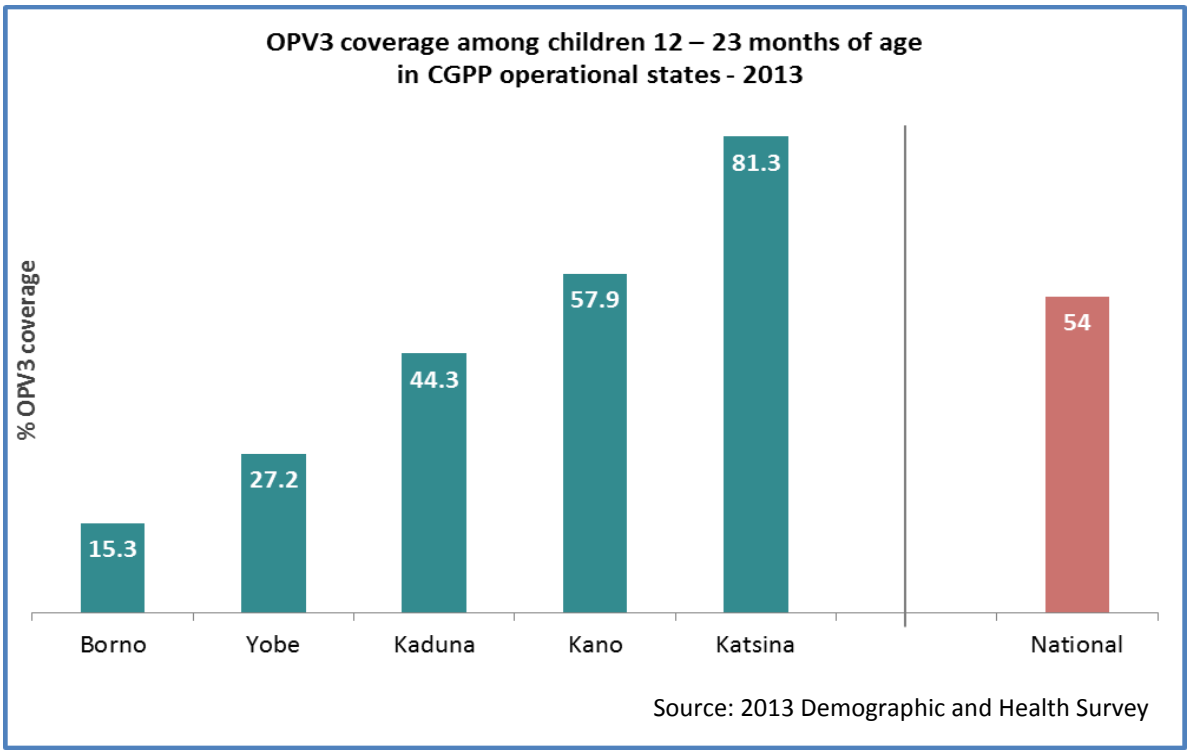
The CGPP Secretariat, housed in CRS Abuja, convenes regular meetings of the principal NGO partners to coordinate their efforts and communicate the national EOC plans, policies and strategies. The Secretariat has worked very closely with CDC, UNICEF, WHO, and the MOH to recruit, train and establish a large number of community mobilization volunteers (CMVs). Staff from all of these partner agencies graciously volunteered their time and resources to facilitate training sessions for CGPP partners.

Despite being the youngest partner to join the Nigerian PEI program, CORE has in a short time registered its presence very strongly. This is evidenced in its participation in the 27th ERC as well as making a presentation at the 28th ERC this year.

Objective 2: Strengthen routine immunization systems

While Nigeria has made impressive progress in the quality and coverage of supplementary immunization activities (SIAs) in recent years, routine immunization services have lagged far behind depriving the Nigerian polio eradication initiative of the added boost that routine immunization can give. The 2013 Nigeria Demographic and Health Survey found national OPV 3 coverage of 54% for children 12–23 months of age and among the 11 high-risk states, the range was from a low of 2.6% in Sokoto to a high of 43.7% in Kaduna. In CGPP operational states the OPV3 rates in 2013 were Borno 15.3%, Yobe 27.2%, Kaduna 44.3%, Kano 57.9%, and Katsina 81.3%. The trend has been upwards from 29% OPV3 nationally in 2003 and 39% in 2008. A MICS survey conducted by UNICEF in 2011 found OPV3 coverage of 42%.





In order to establish baseline numbers to evaluate future project outcomes, the project contracted a consultant to implement a baseline 30 cluster coverage survey in the targeted LGAs in the five project

states in August 2013. The survey was conducted using the standard WHO 30 cluster methodology with a sample size of 228 for each state for a total of 1,150 households surveyed using a population proportionate to size sampling methodology. The survey found 46% OPV3 coverage based on immunization card and mother's recall.

Stock outs of critical vaccines and supplies are common and the cold chain is unreliable in many parts of Northern Nigeria at the greatest risk for continued circulation of wild polio virus. These problems are compounded by a lack of strong demand on the part of care givers.

N-CGPP is promoting community engagement and social mobilization targeting hard to reach and underserved areas to increase demand for immunizations, reduce refusals and catch absent children. The project is working to increase both demand for and availability of routine immunization services by supervising fixed post vaccination sights to ensure vaccine supply and cold chain standards while using community volunteers to motivate mothers to take their children for vaccination.

Drawing from CGPP's experience in other countries, the project has established a cadre of Voluntary Community Mobilizers (VCMs), supervised by Volunteer Ward Supervisors (VWS), who conduct social mobilization, new born tracking, house-to-house support for immunization teams during the Supplemental Immunization Activity (SIAs), resolution of noncompliance, and community based surveillance. The project has also recruited local government facilitators, cluster consultants and state coordinators to oversee immunization activities at the LGA level.

Voluntary Community Mobilizer in Nassarawa LGA, Kano

CGPP has introduced vaccine registers, house mapping, outreach vaccination, and health camps to increase routine immunization coverage which should complement the gains in SIAs. The project has recruited 647 VCMs and 106 VCM supervisors working in 23 very high risk LGAs in five critical states with plans to greatly increase that number in 2015.

CORE worked with other partners to support the introduction of Injectable Polio Vaccine Polio (IPV) to rapidly boost the population immunity in hard-to-reach areas of Borno and Yobe where insecurity has

interrupted routine and campaign immunization services. CGPP supported the entire process and the administrative coverage rates for both Borno and Yobe states (CGPP focal states) was over 100%.

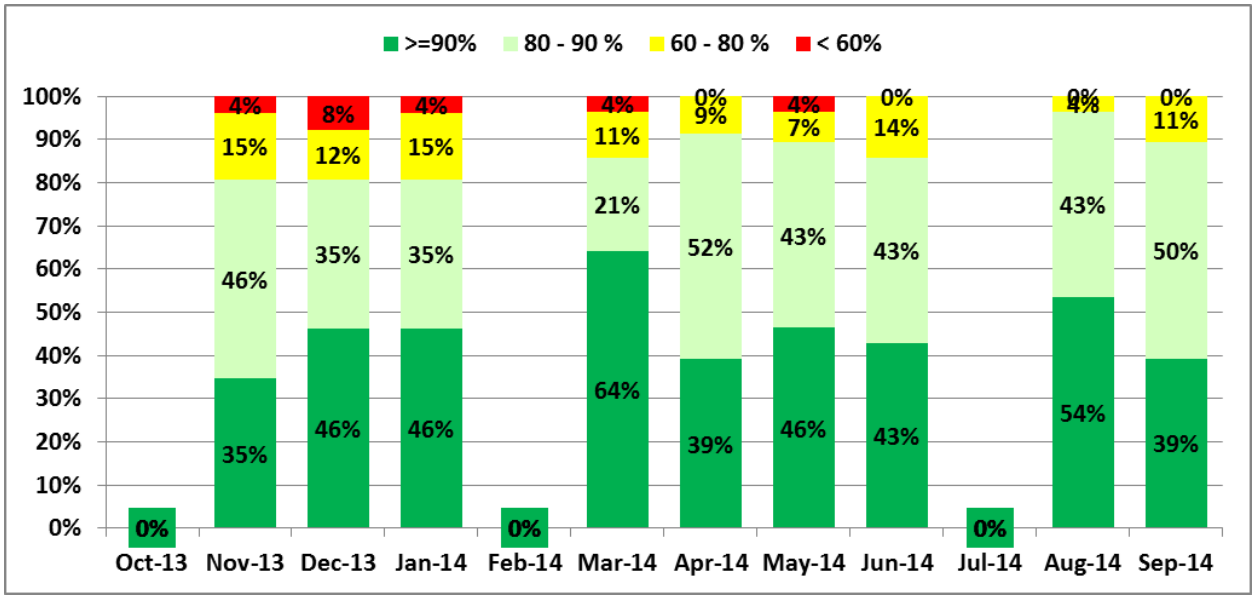
Objective 3: Support supplemental polio immunization activities

Nigeria conducted 19 rounds of SNIDs and two rounds of NIDs using bOPV and three rounds of NIDs using tOPV in the 19 month period from January 2013 to September 2014. Starting in December of 2013, CGPP has played an increasingly active role in the planning, implementation and supervision of SIAs in the five CGPP focal states. Despite lingering pockets of poor performance and a lack of access to security compromised areas, campaign quality and quantity have clearly improved over the last two years and the results are noticeable. LQAS campaign monitoring results found that 98% of the 85 high risk LGAs achieved at or above 80% coverage in the November SIA rounds. In the absence of a solid routine immunization system, polio eradication in Nigeria remains highly dependent on maintaining herd immunity levels through numerous massive campaigns. The introduction of IPV, a greater involvement of civil society, greater numbers of community mobilizers, health camps, greater accountability, and the eyes of the world are all moving toward the creation of a tipping point in favour of virus interruption. It may be impossible to attribute success to one single factor but each of these additions, including the entry of the CORE Group, tips the balance in favour of eradication and puts a greater spotlight on the government to finish the job.

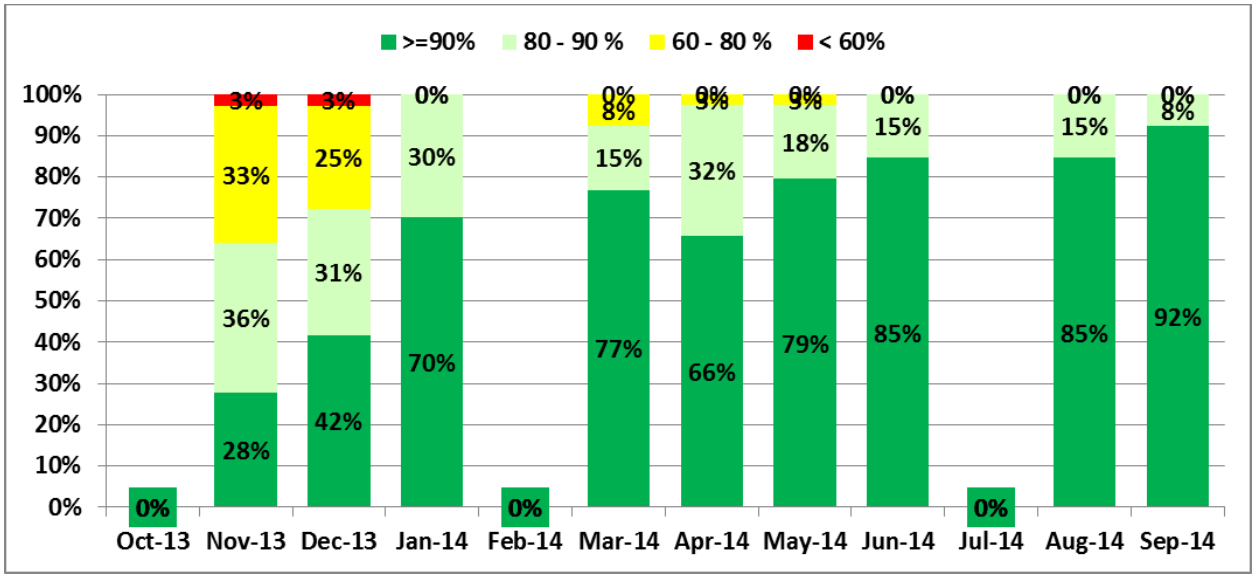
VCMs in rural Tudun Wada LGA, Kano during IPDs

A major focus for SIA implementation is in two "transmission zones; that is, the "Kano zone", which includes local government areas (LGAs, equivalent to districts) in the south of Kano as well as LGAs in north-eastern Kaduna and north-western Bauchi, and the "Borno/Yobe zone" where CORE is the major partner implementing PEI interventions. In Kano, another CORE focal state, any new WPV case detected is treated as an outbreak. In response to the most recent case detected in Kano in July 2014, three outbreak

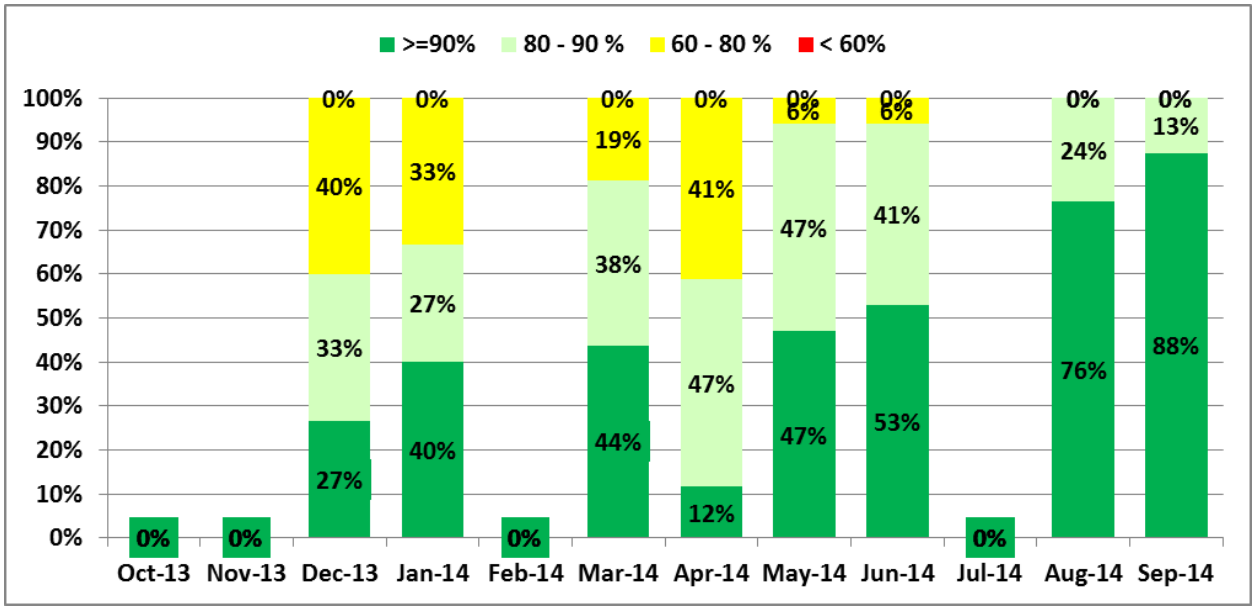
response SIAs were organized with support from CORE to supplement already scheduled sub-national SIAs. In Borno and Yobe (CORE focal states), innovations are being implemented to address challenges caused by insecurity, including permanent health teams, transit-point vaccination, vaccination in camps for internally displaced persons and short-interval SIAs that take advantage of transient access to inaccessible areas. These are all implemented with support from CORE. In June and August 2014, inactivated polio vaccine (IPV) was included along with tOPV in SIAs conducted in 27 LGAs of Borno and Yobe in which an estimated 1.7 million children aged 14 weeks to 5 years were vaccinated. These interventions have increased coverage and reduced missed children and missed houses.



SIA LQAS trend for Katsina in 2014 showing greater that 80% coverage in most campaigns

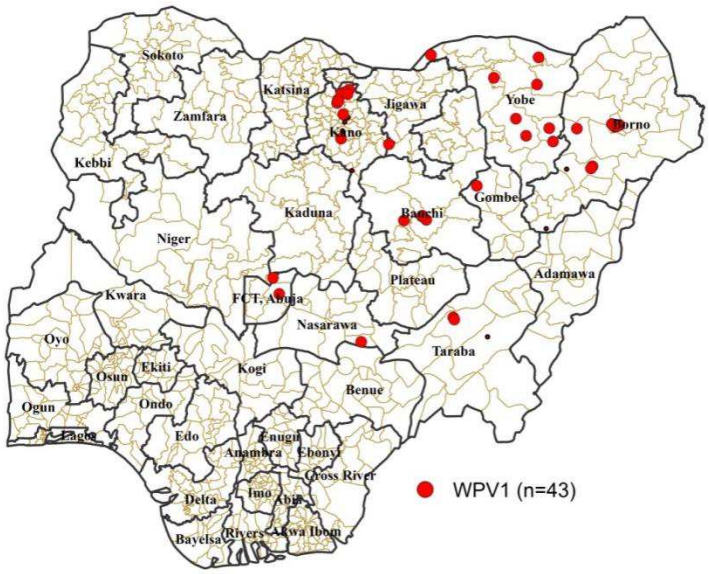


SIA LQAS trend for Kano in 2014 showing 92% coverage in the September 2014 SIA.

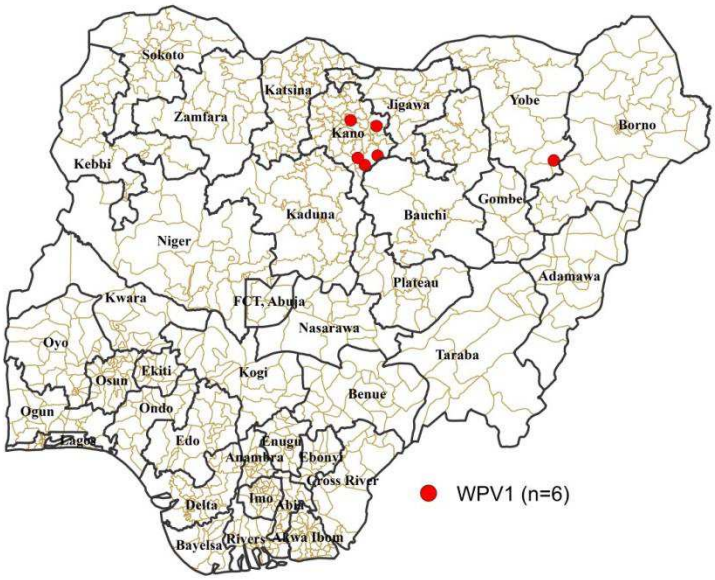


SIA LQAS trend for Kaduna in 2014 showing 88% coverage in the September 2014 SIA.

As discussed under objective two, one of CGPP's primary contributions to the SIAs, is the deployment of community volunteers (VCMs) to promote the campaigns, guide vaccinators to ensure houses are not missed, resolve issues of non-compliance, track absent children, and provide an additional independent set of observers for each campaign to ensure campaign quality. Independent campaign monitoring registered less than 5% of houses missed and only 1.1% of children missed in the most recent campaigns.



Nigeria Wild Polio Virus Cases in 2013

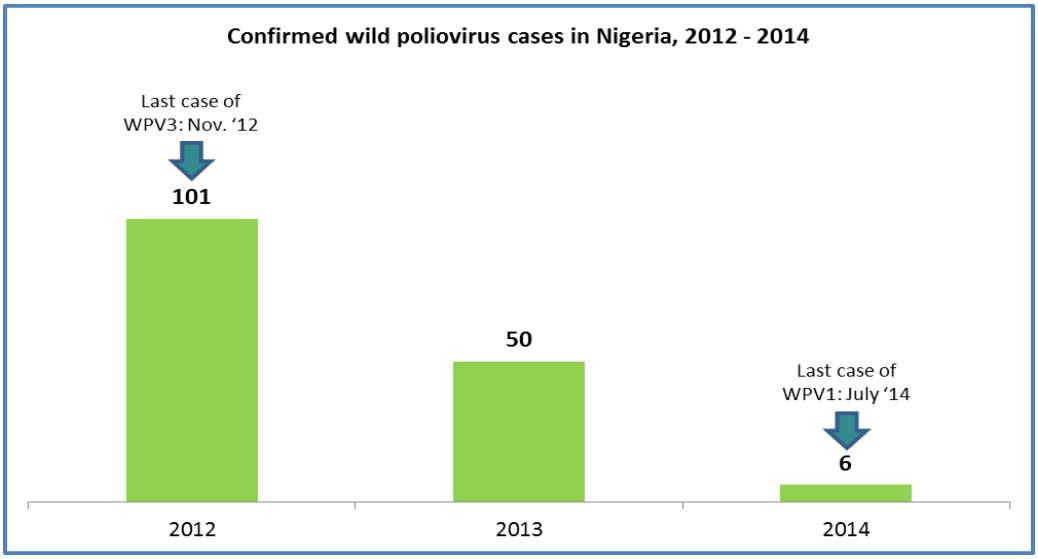


Nigeria Wild Polio Virus Cases in 2014

Objective 4: Support AFP case detection and reporting

The annualized NPAFP rate for 2014 is 14.4 per 100,000, and 98.8% of AFP cases had adequate stool specimen collection. This is higher than the 2013 NPAFP rate of 12.1 cases per 100,000, and 96.9% of AFP cases with adequate stool collection. All of the high-risk states (including CORE focal states) met both indicators in 2013, and have continued to do so in 2014. The proportion of LGAs (including CORE focal LGAs) within these states that met both indicators also increased from 91.8% in 2013 to 99.3% in 2014. The AFP rates greatly exceed the expected rate of two cases per 100,000 in children under 15 indicating that they are picking up a great deal of "trash" or suspect cases along with the real AFP cases. This is not necessarily bad since it hopefully ensures that they are in fact catching most of the actual cases and they are actively searching for and reporting anything that might possibly be polio.

Confirmed cases of wild polio virus have dropped remarkably form 101 in 2012, to 50 in 2013 and only 6 in 2014. The last case of WPV type one was reported in July 2014 and the last case of WPV type three was reported 24 months ago in November 2012. The geographic area of wild polio virus circulation has seen an 81% restriction from 27 LGAs in 2013 to only 5 LGAs in 2014 and the genetic cluster of WPV1 has been reduced from 8 to 1.



As in other countries, CGPP has introduced community based surveillance as a component of the community volunteer arsenal to support the more traditional facility based surveillance system. As members of the communities they serve, CMVs may identify or hear about cases before they enter the formal health sector and they may also identify cases taken to healers outside the formal health sector. CGPP is working in close collaboration with the MOH, CDC, and WHO surveillance officers to ensure that the contributions of the community volunteers are integrated into the existing surveillance system in order to strengthen and complement the system rather than create a parallel system. Over time, more diseases can be added such as measles and tetanus. N-CGPP uses the WHO process for reporting and specimen collection procedures. In the future N-CGPP intends to utilize hand-held electronic devices capable of reporting and sharing data to all levels of the health chain in Nigeria. In the long-term N-CGPP will seek to develop a facility-based mechanism for improved reporting of community incidence of childhood disease morbidity and mortality.

Objective 5: Support timely documentation and use of information

CGPP supported Independent campaign monitoring in Kano state in 2014. CGPP also partnered with the national polio program to develop and disseminate two journal articles for the global health council and the CDC Morbidity and Mortality Weekly Report (MMWR). In addition, CORE supported EOC presentations during the 27th and 28th ERC conducted this year. The project baseline survey was also conducted and the results used in the development of this report.

CGPP Nigeria is still in the process of developing and implementing a health information system including the collection of household level information from vaccination registers by the community

volunteers that can be collated and analysed by the project. The project has distributed the register to the VCMs and given them initial training on how to utilize them.

Annex A

CROSS-BORDER INITIATIVE ON POLIO ERADICATION IN the HORN OF AFRICA

Samuel Oumo Okiror[1], Anthony Kisanga[2],Bal Ram Bhui[3]

INTRODUCTION

The Horn of Africa (HoA) was hit by a wild polio virus outbreak in April 2013 with record number of cases: 19 in Somalia, 14 in Kenya and 10 in Ethiopia. While the outbreak occurred primarily in Somalia, it spread into bordering areas of Kenya and Ethiopia. The Global Polio Eradication Initiative (GPEI) has entered a new phase with significant reduction in case counts in endemic countries and heightened recognition of risk for international spread of the virus. To combat the international spread, in May 2014, the WHO declared polio a public health emergency of international concern and issued recommendations requiring proof of polio vaccination for travel to and from countries experiencing polio cases.

At the 7th HOA Technical Advisory Group (TAG) meeting held in February 2012, it was noted that the risk of significant WPV outbreaks was primarily due to, evidence of undetected circulation of WPV in countries, large pools of susceptible children, and geographically inaccessible areas due to security issues. In addition, because of the large number of pastoralists affected by or at risk for polio in the HOA, the TAG stressed the need for better cross border initiatives as a compelling strategy for polio eradication in the region.

In response to these recommendations, the WHO and CORE Group Polio Project (CGPP) have been organizing cross border initiatives in HOA countries. In August 2012, cross border meetings were held in 4 sites in Ethiopia bordering with Somalia, Djibouti, Kenya, South Sudan and Sudan. Since then, over 28 cross border counties/districts/regions have collaborated and initiated cross border discussions and activities.

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[3] Bal Ram Bhui, CGPP, HOA Regional Secretariat, balram.cgpp@gmail.com

List of Countries and border areas engaged in cross border initiatives in HOA	
South Sudan - Morobo	DRC-Adi, Uganda- Koboko
South Sudan -Maiwut/Akobo/Kapoeta East	Ethiopia - Gambela, Kenya -Turkana
South Sudan - Kajo-Keji	Uganda - Yumba&Moyo
South Sudan - Magwi	Uganda - Adjumani, Amuru, Lamwo
Ethiopia - Amhara,Benishangul, Tigray	Sudan
Ethiopia - Somali, DiredawaCity	Somalia - Punt Land, Eritrea - Djibouti
Ethiopia -Somali, Oromia, SNNPR	Kenya - Moyale , and Somalia

The objective of the cross border meetings is to coordinate efforts to strengthen surveillance, routine immunization and supplemental immunization activities for polio eradication among bordering areas. Specifically, it aims to improve information sharing between countries on polio eradication, identifying and addressing immunity gaps in migrant and hard to reach populations along the border, and planning for synchronized supplementary immunization activities along the borders.

Process

The cross border meetings involved communication between governments at national and local level and were held at the border area. WHO, UNICEF, CORE Group and NGOs supported the process, which involved sharing the situation analysis from both sides including mapping of border areas with a focus on communities, population movements, socioeconomic and cultural status, health behaviors and health resources.

Outcomes

The meetings verified that there is significant movement of population between countries for trade, employment, pastures, health care, and cultural reasons. In addition, refugees and those affected by clan conflicts are also frequently moving across borders. These border areas vary in terms of socioeconomic status, heath infrastructure, and health seeking behaviour of the population and there has been a lack of information sharing between health management across border. Polio eradication activities, coordination and synchronization of SIAs and Acute Flaccid Paralysis (AFP) surveillance has also been lacking. In general, the border communities are hard to reach, underserved and at high risk for polio.

This cross border initiative has brought together border stakeholders to discuss and plan ways to jointly combat circulation of polio. Joint action plans, which focused on activities to be carried out in individual countries, activities needing synchronization, sharing of information, and joint review and planning, have been developed. Cross border coordination committees have been formed and focal persons on both sides of the border have been designated. At some crossing points, static polio vaccinations team have been established and have vaccinated thousands of children. The action plans also call for resource mobilization to ensure implementation.

CONCLUSIONS

The implementation of these cross border initiatives is going well despite some critical challenges. A major challenge is lack of resources from collaborating governments for cross border activities. As a result, the government ownership and leadership is minimal. The cross border initiative is designed based on a coordination model where parties enjoy autonomy and independence, use their own resources to carry out committed activities, and come together regularly to review and improve further partnership. The governance structure for the cross border initiative is informal and weak in part due to a lack of a comprehensive framework and guidelines to inform its planning, implementation and monitoring and evaluation. WHO/AFRO has developed a draft which provides a clear framework for the success of the cross border initiative. WHO and CORE Group will review its current cross border initiatives using these guidelines and will advocate for and provide support to countries for improved effectiveness.

REFERENCES

WHO, Enhancing Implementation of Cross-Border Initiative on Epidemic Diseases and Other Public Health Issues in the WHO African Region.

Federal Ministry of Health of Ethiopia, Meeting Report on Cross Border Collaboration for Polio Eradication in the Horn of Africa, 2012

CORE Group Polio Project, Reports on Cross Border Meetings in Sudan and border countries, 2012-2014

Annex B

Community Based Surveillance on Polio Eradication in Horn of Africa

Samuel Oumo Okiror[4], Filimona Bisrat[5], Mercy Lutukai[6], Bal Ram Bhui[7]*

Introduction

The Horn of Africa (HoA) experienced an outbreak of wild poliovirus type 1 (WPV1) in 2013 with epicentre in Somalia spreading to Kenya and Ethiopia. Somalia recorded 194 cases and Kenya and Ethiopia had 14 and 9 cases respectively. The 7th Technical Advisory Group (TAG), Horn of Africa convened in 2012 had warned that HOA is at a greater risk of polio outbreak by potential importation of virus due to three reasons: - 1) Clear evidence of undetected circulation of WPV in countries (the confirmed WPV case identified in

Rongo district, Kenya, in 2011, genetically linked to the 2010 Uganda outbreak; WPV was not detected in Somalia in between 2010 to 2012 despite that AFP surveillance is meeting the standards but detected in 2013 when outbreak erupted), 2) Clear evidence of large pools of susceptible children, and 3) Inaccessible areas due to security issues. A year after it was warned, the outbreak occurred in HoA. Massive and frequent vaccination campaigns were conducted to control the outbreak.

Recognizing the need to expanded AFP surveillance to ensure no polio virus circulation go undetected, HOA TAG recommended to use community based surveillance (CBS) to improve the sensitivity of acute flaccid paralysis (AFP) surveillance. Community Based Surveillance is operational in several HOA countries under different names and forms.

WHO HOA and CORE Group Polio Project have collaborated in establishing, implementing and evaluating CBS in HOA region. This paper describes the CBS in Ethiopia and South Sudan with focus on process, results and challenges.

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Methods:

Community Based Surveillance (CBS) complements the existing facility based surveillance system. It is an on-going activity conducted at community level by community volunteers (CV) that includes active case search during house to house visits, religious and traditional healing sites (Holly water, Kalicha, prayer, Church, Mosque) visits and reporting to the nearby health facilities.

The CBS was initiated in Ethiopia in 2003 and 2010 in South Sudan CGPP project areas. There are over 6,465 community volunteers in 81 Woredas of CGPP areas which cover over 5.1 million population. In South Sudan, there are 742 community surveillance volunteers covering about 1.2 million population. South Sudan was part of Sudan until their independence in 2012. The CBS was implemented in mostly remote, hard to reach and migratory population.

Community Volunteers are trained for three days initially and refreshed on the case definition, reporting and roles of volunteers and facility workers in notification, investigation and response. The community based surveillance is an integrated one that covers AFP, Measles and neonatal tetanus (NNT) and other health conditions and events. The CV work under the guidance and support from health facility workers in their respective areas, to whom they submit monthly reports.

CV are not paid but they receive non-monetary incentives such as gowns and umbrellas embossed with the project logo, as well as bags in which to carry supplies and educational materials. Since they hail from the communities they serve, they are well accepted and trusted.

Results and Discussion

CBS in Ethiopia and South Sudan documented a number of quantitative and qualitative results of CBS including challenges, lessons learnt and ways forward.

CBS contributes significantly to AFP surveillance. In Ethiopia 30% to 59% of AFP cases reported yearly in FY 2008-FY 2014 were attributed to CBS as indicated below (Figure 1).

In South Sudan too, percentage of AFP cases reported by CBS ranged from 31% to 44% in the year FY 2012 to FY 2014 (Figure 2).

Further, the programs reported improved AFP surveillance to remote, hard to reach and migratory population, higher detection of suspects and paralysis cases that were unlikely to visit health facility due

Figure 1: Community based surveillance in Ethiopia

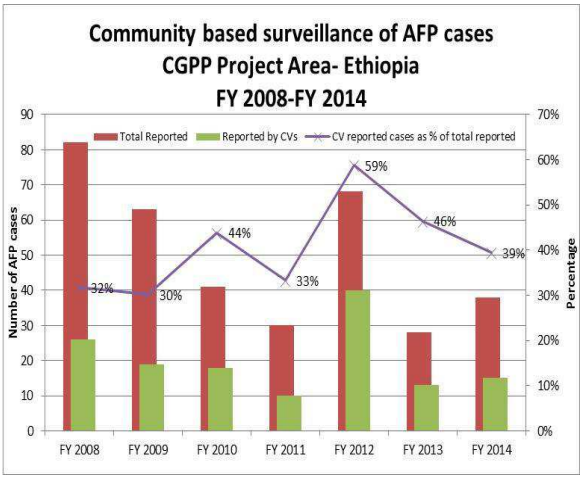
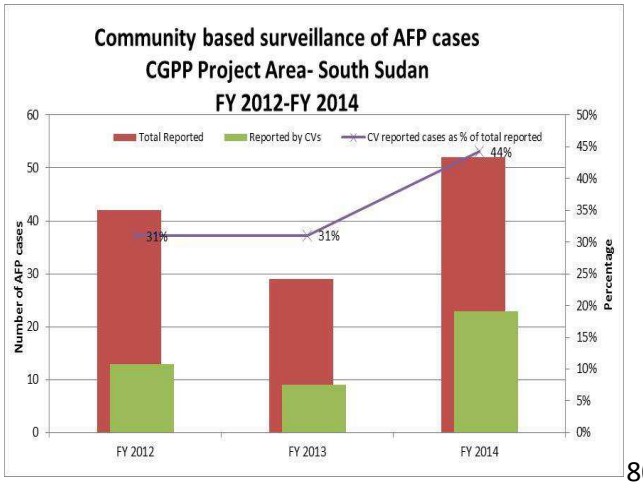


Figure 2: Community based surveillance in South Sudan



to taboo. There was also less cost as CBS integrated with other diseases and medical conditions and events and promoted community participation and positive health behavior.

The challenges implementing the CBS include nominal leadership of MOH, inadequate motivation to community health volunteers and limited capacity of community health volunteers. Lack of resources for CBS program management; incentives, supervision, information system, planning and review are a hurdle too. The challenges documenting specific attribution to overall AFP surveillance performance includes lack of adequate information system in place and lack of full integration of CBS to formal AFP surveillance system.

To strengthen CBS and document its benefits, there should be an increased government ownership by enacting CBS policies, integration of CBS with national AFP surveillance to enhance rapid response and provision of motivational package to volunteers. A set of performance indicators for CBS should be developed and information system should be developed to capture CBS data adequately so that its benefits can be well documented.

References

CBS CGPP program reports, Ethiopia and South Sudan, 2014

Reaching beyond the health post: Community-based surveillance for polio eradication, Development in Practice, 2013-Dora Curry, Filimona Bisrat, Ellen Coates, and Penny Altman