CORE Group Polio Project
Annual Report FY17

October 1, 2016 to September 30, 2017

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Executive Summary

Global Polio eradication has been a long battle with a very long tail and an almost certain outcome. Only 20 Wild Polio Virus cases have been confirmed in 2017. There were only 37 confirmed cases in 2016 and 72 cases in 2015, all record low years. As has often been stated, there were an approximate 350,000 cases in 1988 when the World Health Assembly set the goal of polio eradication. When this project started in 1999 there were still several thousand cases annually, including over a thousand cases a year in Angola and India where the project established a strong NGO community focused presence. There is a very real opportunity to see an interruption of transmission in the low season of 2018 and a strong probability that if not then very soon thereafter. The global effort to eradicate polio cannot waiver in the final phase.

Over the past 18 years, the CORE Group Polio Project has made significant contributions to polio eradication and developed an effective consortium model and community strategies that can and have been replicated by others. The Angola program ended in 2016 while two of the other original target countries, India and Ethiopia, have continued to maintain polio free status through high quality community based social mobilization and interpersonal communication. Over the last six years, the project has expanded to South Sudan, Nigeria, Kenya, Somalia and Afghanistan and will probably add limited work with South Sudanese refugees in Uganda in 2018. The primary focus of the project continues to be the achievement of high population immunity through the promotion of high quality campaigns, routine immunization and community based surveillance. The backbone of this effort is achieved by community mobilizers trained and supervised by Non-Governmental Organizations who form the CGPP civil society coalition of approximately 30 local NGOs and ten international NGOs including CRS, ARC, IRC, Save the Children, ADRA, PCI, IMC, AMREF, CORE Inc., and World Vision who remain the prime.

The project has increased the national, regional, and global visibility of the coalition through publications and participation in a number of planning and oversight meetings such as the IMB, Polio Partners Group, Expert Review Committees, Technical Advisory Group meetings, APHA, the CORE Fall and Spring meetings and others where project staff are very active participants and presenters. As we near the end of polio eradication the project has begun to develop transition plans and engaged various constituencies both internally and externally in discussions on how to document and utilize the human resources, strategies, and lessons learned for the benefit of other global health concerns. In summation, the project has matured, achieved, and contributed to polio eradication, continues to contribute and will likely be felt in the global health arena long after we see the last case of polio in the world.

Lee Losey, Deputy Director and Technical Lead, December 2017

Acknowledgements

This report was developed with the contributions of many people, starting with the submission of annual reports from approximately 30 implementing partners in six countries. The Secretariats consolidated the partner reports into country reports. The final global CGPP report was written by Lydia Bologna, the project Communications Technical Advisor, with assistance from Kathy Stamidis, the project M&E Technical Advisor, and overall guidance from Lee Losey, the Deputy Project Director and Technical Lead.

Hard to reach population in Turkana, Kenya.

Objectives

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

Religious leaders in Ethiopia learn more about EPI activities.

Acronyms

ADI	Addis Declaration of Immunization
ADRA	Adventist Development and Relief Agency
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AFP	Acute Flaccid Paralysis
AMREF	African Medical Research Foundation
APHA	American Public Health Association
AVW	African Vaccination Week
BCC	Behavior Change Communication
BMC	Block Mobilization Coordinators
bOPV	Bivalent oral polio vaccine
CBHC	Cross Border Health Committees
CBI	Cross Border Initiative
CBS	Community Based Surveillance
CCRDA	Consortium of Christian Relief and Development Associations
CGPP	CORE Group Polio Project
CHV	Community Health Volunteer
CI	Community Informant
CMC	Community Mobilization Coordinator
CRS	Catholic Relief Services
CSIS	Center for Strategic and International Studies
CV	Community Volunteer
CSO	Civil Society Organization
cVDPV	Circulating vaccine-derived poliovirus
cVDPV2	Circulating vaccine-derived poliovirus type 2
DMC	District Mobilization Coordinator
EOC	Emergency Operating Committee

EPI	Expanded Program for Immunization
ERC	Expert Review Committee
GAVI	Global Alliance for Vaccines and Immunization
GPEI	Global Polio Eradication Initiative
HDAL	Health Development Army Leader
HEW	Health Extension Worker
HOA	Horn of Africa
HTR	Hard to Reach
IAG	Immunization Action Group
IBR	In Between Rounds
ICC	Interagency Coordinating Committee
ICM	Independent Campaign Monitoring
IDP	Internally Displaced Person
IMB	Independent Monitoring Board
IMC	International Medical Corps
IDSRU	Integrated Disease Surveillance and Response Unit
IPC	Interpersonal Communication
IPD	Immunization Plus Days
IRC	International Rescue Committee
LGA	Local Government Area
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NBT	Newborn Tracking
NC	Noncompliance
NGO	Non-Governmental Organizations
NID	National Immunization Day
NPAFPR	Non Polio Acute Flaccid Paralysis Rate
NPHCDA	National Primary Health Care Development Agency
NTLC	Northern Traditional Leaders Committee on Primary Health Care
OBR	Out Break Response

OPV	Oral Polio Vaccine
PC	Pastoralist Concern
PCI	Project Concern International
PPG	Polio Partners Group
RI	Routine Immunization
SAGE	Strategic Advisory Group of Experts on Immunization
SIA	Supplementary Immunization Activity
SNID	Subnational Immunization Day
SOP	Standard Operating Procedures
SPHCDA	State Primary Health Care Development Agency
STC	Save the Children
SVP	Special Vaccination Post
TAG	Technical Advisory Group
tOPV	Trivalent oral polio vaccine
UNICEF	United Nations Children's Emergency Fund
VCM	Volunteer Community Mobilizer
VWS	Volunteer Ward Supervisor
VDPV	Vaccine Derived Polio Virus
WHO	World Health Organization
WPV	Wild Polio Virus
WPV1	Wild poliovirus type 1
WV	World Vision

CORE Inc.

Since 1997, CORE Inc., an international development organization, has worked to advance the field of community and maternal health by advocating for in-country collaboration between global partners, local NGOS and government ministries of health. A group of nine PVO members of CORE Inc. serve as long-term implementing organizations for the CORE Group Polio Project: ADRA, ARC, AMREF, CRS, IMC, IRC, PCI, Save the Children, and World Vision.

As a sub-grantee of CGPP, CORE Inc. provided extensive support in FY17 in the areas of communication and education, including upgrades to the project website section, promotion of CGPP achievements at various meetings and development of the evaluation report for the Newborn Pilot Project in Ethiopia. In FY18, CORE Inc. will continue to facilitate and support CGPP efforts in partnership building, communications, education, publication as well as capacity-building and knowledge-sharing strategies.

In celebration of CORE Inc.'s 20th anniversary year of impact and collaborative action, CORE Group Executive Director Lisa Hilmi invited the Secretariat Directors to present on the accomplishments of the CORE Group Polio Project during a plenary session of the Fall conference. CGPP staff built from this opportunity to host a management retreat and one-day workshop to discuss transition issues.

CGPP headquarter staff organized the CGPP Senior Management Retreat from September 19-21 in Middleburg, Virginia. All Secretariat Directors attended the retreat to discuss country-specific issues such as BCC strategies in security-compromised areas, management of partner sub-grantees, and implications of the GPEI transition processes.

On September 22, more than 70 participants attended the Reaching Every Child: Sharing approaches to improve child health workshop in Washington, DC. Project leaders and workshop participants explored the Secretariat Model and other CGPP strategies to reach vulnerable children in insecure, fragile communities. The workshop provided an opportunity to share approaches to transition the best practices of CGPP to broader health interventions and public health challenges. USAID's flagship Maternal and Child Survival Program, CORE Inc, World Vision, PATH, The Communication Initiative, United Nations Foundation, JSI, CRS and PCI all collaborated with CGPP to plan the workshop. This report may be found at https://coregroup.org/our-work/programs/core-group-polio-project/

CGPP organized a plenary session at CORE Group's Fall 2017 Global Health Practitioner Conference on Wednesday, September 27 entitled Realities: Coordinated Impact at the Country and Global Level. The session provided an overview of the lessons learned from the polio eradication project with an emphasis on how they could be of value across a variety of maternal and child health projects. Secretariat Directors shared experiences from the past 18 years and how they could be best applied to other health initiatives through discussions of CGPP country initiatives such as the non-traditional consortium and collaborative model, evolution of communication strategy, innovations, and relevance to other infectious diseases. The report may be found on the CGPP website at https://coregroup.org/our-work/programs/core-group-polio-project/

CORE Group Polio Project Secretariat Directors at the CGPP Senior Management Retreat in September 2017. From left: South Sudan Director Anthony Kisanga, Kenya-Somalia Director Ahmed Arale, India Director Dr. Roma Solomon, Nigeria Director Dr. Samuel Usman and Ethiopia Director Dr. Filimona Bisrat.

Our Partners

ETHIOPIA

1. Amref Health Africa
2. Catholic Relief Services (CRS)
3. International Rescue Committee (IRC)
4. Save the Children International (STC)
5. World Vision (WV)

Local NGOs

6. Ethiopian Evangelical Church Mekane Yesus
7. Ethiopian Orthodox Church
8. Pastoralist Concern
9. Wabishebele Development Association
10. Organization for Welfare Development In Action

KENYA

1. Adventist Development and Relief Agency (ADRA)
2. International Rescue Committee
3. Catholic Relief Services
4. World Vision

SOMALIA

1. The American Refugee Committee (ARC)

Local NGO

2. Somali Aid

INDIA

1. Adventist Development and Relief Agency
2. Project Concern International (PCI)
3. Catholic Relief Services

Local NGOs

1. Innovative Approach for Social Development Society
2. Malik Social Welfare Society Rampur
3. ADRA India

4. Society for All Round Development
5. Adarsh Seva Samiti
6. Jan Kalyan Samiti
7. Mahila Jagriti Sewa Samiti
8. Meerut Seva Samaj
9. Sarathi Development Foundation
10. Holy Cross Welfare Trust
11. Gorakhpur Environmental Action Group

NIGERIA

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

Local NGOs

1. Healthcare Education and Support Initiative (HESI)
2. Family Health and Youth Empowerment (FAHYE)
3. Community Support and Development Initiative (CSADI)
4. Archdiocesan Catholic Healthcare Initiative (DACA)
5. WAKA Rural Development Initiative
6. Federation of Muslim Women Association of Nigeria (FOMWAN)
7. African Healthcare Implementation and Facilitation Foundation (AHIFF)

SOUTH SUDAN

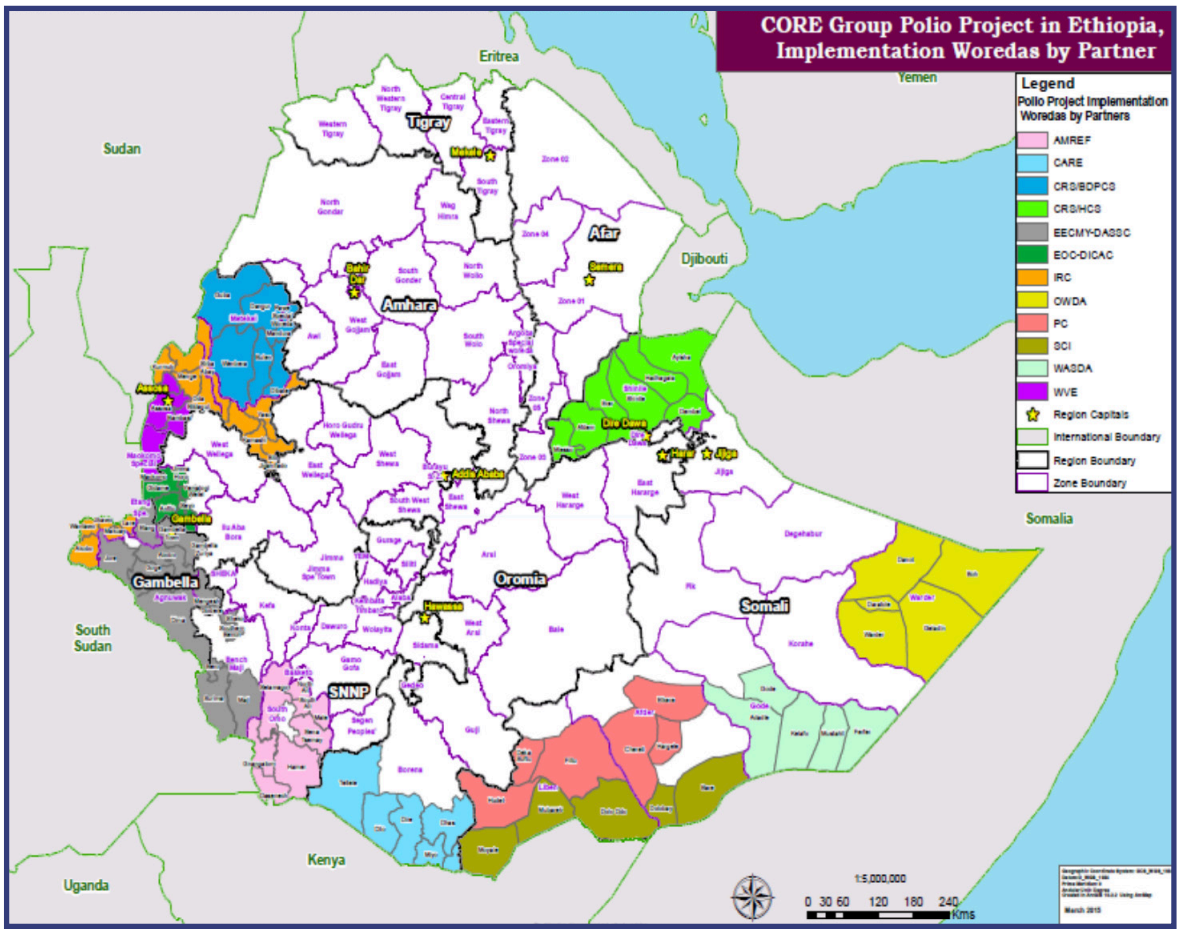
Local NGOS

1. Bio Aid
2. Universal Network for Empowerment Agency
3. Support for Peace and Education Development Program

Country Report: **Ethiopia**

Ethiopia helped move the region closer to certification upon achieving the critical three-year mark without a case of wild polio virus. The country remained vigilant to the threat of polio importation from South Sudanese and Somalian refugees crossing borders to escape conflict. In FY17, CGPP Ethiopia and its eleven implementing partners trained 13,781 community volunteers and health workers to reach 1.8 million people along its porous borders with routine and supplementary immunization, AFP surveillance and health information. CGPP Ethiopia also contributed to the development of a polio transition plan for the entire country.

During the reporting year, the Ethiopian government declared a state of emergency for more than six months due to violence in the Oromiya and Amhara regions. Many parts of the country also were affected by severe drought or flash flooding that resulted in severe malnutrition and acute diarrhea. These events impacted the ability of Community Volunteers (CVs) and Health Development Army Leaders (HDALs) to track pregnant women, newborns and defaulters for missed vaccinations. Despite these barriers, CGPP Ethiopia reported strong results for AFP surveillance, a strong indicator of the country's ability to detect the disease.



1

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

Established in November 2001, CORE Group Ethiopia continued its work in 85 border districts, or woredas, in the border regions of Gambella (13 woredas), SNNPRS (13 woredas), Oromia (11 woredas), Somali (28 woredas) and Benshangul Gumuz (20 woredas). The project targeted a total population of 5,745,130 including 182,400 children under one; 767,092 children under five years and 2,655,572 under fifteen years.

CGPP Ethiopia partnered with six international agencies: Amref Health Africa, CARE, Catholic Relief Services, International Rescue Committee, Save the Children International and World Vision. The international NGOs worked with five local on-the-ground NGOS: Ethiopian Evangelical Church Mekane Yesus, Ethiopian Orthodox Church, Pastoralist Concern, WabiShebele Development Association (WASDA) and the Organization for Welfare Development in Action (OWDA). Due to unsatisfactory performance, WASDA was replaced with local NGO OWDA. In FY2017, CARE discontinued its work after 15 years in the Oromiya region of the Borena zone and was replaced by the Ethiopian Orthodox Church.

CGPP Ethiopia is a key immunization partner and member of the National EPI task force and the Communication Technical Working Group. CGPP Ethiopia Secretariat Director Dr. Filimona Bisrat convened or participated in the following national and international meetings and trips:

- Attended three Interagency Coordinating Committee (ICC) meetings organized by the FMoH.
- Traveled to Nairobi, Kenya to the CGPP Horn of Africa (HoA) office twice, from November 28 to December 06, 2016 and again from January 22 to February 11, 2017, to provide additional support and direction.
- Attended the Institutionalizing Community Health Conference (ICHC) in Johannesburg, South Africa from March 27 – 30, 2017. Dr. Bisrat delivered a presentation on “Linking Partners across Funding and Technical Streams: The Ethiopia Experience with CORE Group Polio Project.”
- Attended the 16th Horn of Africa Technical Advisory Group (HOA TAG) meeting in Nairobi, Kenya on May 11 and 12, 2017.
- Attended the WHO African Health Forum in Rwanda, Kigali from June 25-29, 2017.

Ethiopia celebrated its 7th Annual African Vaccination Week in April 2017.

2

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

An endline evaluation of the CGPP Ethiopia implementation area indicated a significant increase in polio immunization coverage in children 12 to 23 months old, as well as gains in routine immunization coverage. Baseline birth dose (OPV 0) coverage increased from 27.2% at baseline to 54.2% at endline. More than 90 percent of deliveries occur at home, making birth dose administration difficult. OPV3 coverage increased significantly to 73.5% from 35.2% at baseline.

The 2017 endline survey based on card coverage rates found Pentavalent 3 immunization coverage of 69.8%, an improvement from the baseline of 37.2%. Measles coverage is 84.7%, according to the final survey, and is more than 50 percentage points higher than baseline results of 30.3%. Significant coverage gains have been made over the project period, and CGPP Ethiopia will continue to implement innovative strategies to improve these further.

Number of confirmed Wild Polio Virus cases in Ethiopia as of September 30, 2017

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Total
WPV cases	0	3	0	0	0	0	9	1	0	0	0	13
VDPV	n/a	3	2	6	0	1	0	1	1	0	0	14

FY17 WHO polio update week 37 and CGPP Ethiopia five-year summary report

CVs and HDALs participated in training about community-based surveillance and newborn tracking in the Somali region of the Shebelle zone.

TRAININGS

During FY17, the Secretariat and implementing partners conducted 89 training sessions to improve the knowledge and skills of 3,729 immunization service providers; 532 health workers and 950 HEWs received training on immunization, interpersonal communication, cold chain, community-based surveillance and newborn tracking. The CGPP Secretariat provided training to 13 participants on data quality assurance from June 21-23, 2017 at the CCRDA training center.

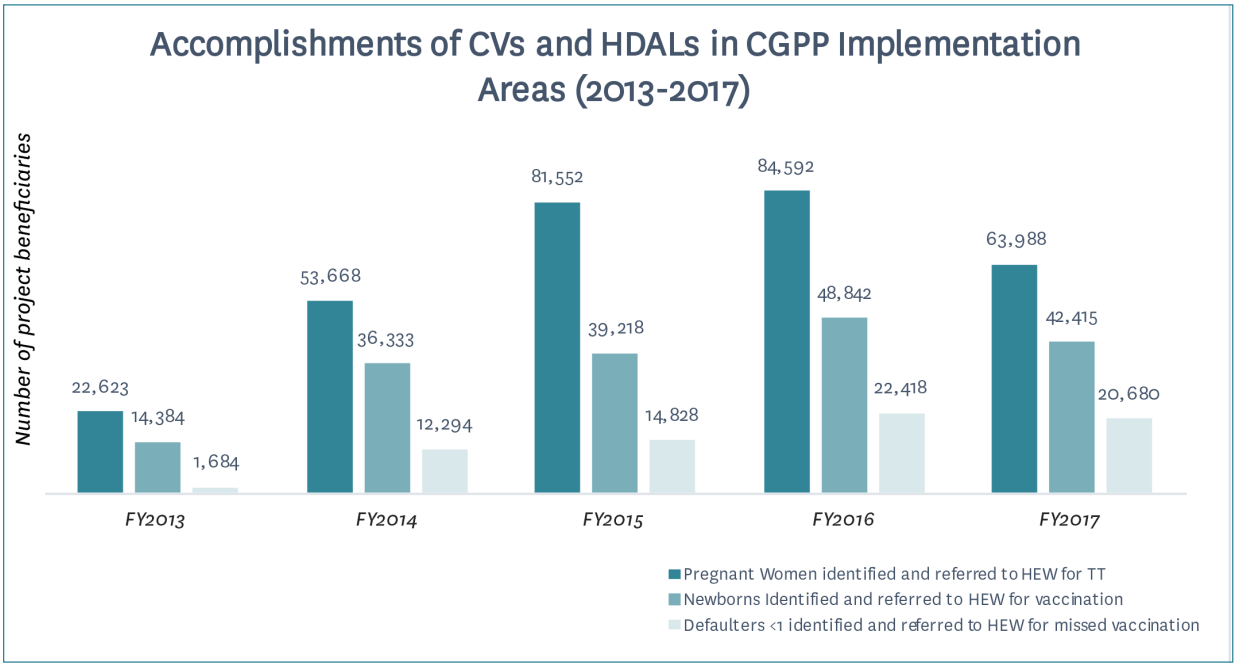
CVs/HDALs received training on community-based surveillance and newborn tracking in the Somali region of Shebelle zone.

CGPP conducted EPI Mainstreaming through Religious training in Siti Zone Erer woreda from July 3-6, 2017 to increase the participation of the religious community in immunization and surveillance activities. A total of 46 participants attended from Siti Zone Islamic Affair, including health officials, representatives of mosques from 14 kebeles and social mobilizers. Additionally, CGPP Ethiopia conducted a Sensitization Workshop for 257 religious and political leaders.

Partners	HDALs	CVs	Total
AMREF	0	466	466
SCI	0	265	265
PC	0	534	534
CARE	1740	0	1740
WVE	1439	0	1439
IRC	2107	0	2107
EOC	0	353	353
EECMY	382	351	733
WASDA	0	130	130
CRS	5518	201	5719
OWDA	0	295	295
Total	**11,186**	**2,595**	**13,781**

SOCIAL MOBILIZATION ACTIVITIES

Community Volunteers (CVs), Health Development Army Leaders (HDALs) and Health Extension Workers (HEWs) actively searched and reported on cases of Acute Flaccid Paralysis, measles and neonatal tetanus and tracked newborns from early pregnancy. They regularly conducted house-to-house health education sessions and social mobilization activities during routine and supplementary immunization campaigns. In the reporting period, CGPP Ethiopia trained, supervised and supported 13,781 CVs and HDALs to visit 729,662 households and reach 1,836,750 people with health information. CVs and HDALs tracked 63,988 pregnant women, 42,415 newborns, and 20,680 defaulters for missed vaccinations. Reported activities in the project year were lower than in the 2016 fiscal year due to drought and conflict that pushed CVs and HDALs out of the implementation area. To support activities, CGPP partners supplied 82,523 liters of fuel for 157 kerosene-operated vaccine refrigerators and 39 motorcycles for hard-to-reach health facilities.



The CGPP Secretariat organized and facilitated the CORE Group and GAVI-CSO partners' midyear review and planning meeting on April 27 and April 28, 2017. A total of 76 staff attended: 18 participants in Hawassa, 14 in Bahir Dar, 21 in Dire Dawa and 23 in Jimma. Each partner provided a review of the first six months of project implementation and identified any gaps in monitoring or coordination.

In celebration of African Vaccination Week, CGPP Ethiopia mobilized political and community members to trace and vaccinate missed children. Four hundred people attended the opening panel discussion organized by CGPP held in Oromiya region in Feche town

Additionally, CGPP Ethiopia staff participated in the following trainings and conferences:

- The CGPP finance officer attended training on financial management and auditing of donor-funded projects from July 30 to August 6, 2017 in Pretoria, South Africa.

- CGPP Director and secretariat technical staffs attended the National Immunization Conference organized by CCRDA's health forum on November 21 and 22, 2016 at the Elily Hotel. The CGPP Secretariat Deputy Director presented on CGPP midterm evaluation findings.
- A Program officer attended and presented at the African Annual Vaccinology Course in Cape Town, South Africa from November 7 – 11, 2016.
- The M&E officer attended a project monitoring tool development training at the Maastricht School of Management in the Netherlands from January 23-27, 2017.
- The Secretariat Deputy Director attended the RITAG meeting from June 6 - 7, 2017 in Brazzaville, Congo.
- The M&E officer attended a training from June 13-15, 2017 in Nairboi, Kenya on the ONA platform used for data collection, analysis and data visualization using mobile devices and ODK Collect.
- The CGPP Director, Deputy Director and a program officer attended the biannual immunization and surveillance review meeting organized by WHO and the FMoH on August 14 and 15, 2017. CGPP
- The CGPP Secretariat Director and communication officer attended the Acting on the Call (AOTC) Summit 2017 held on August 24 and 25, 2017 at the African Union Conference hall. CGPP Ethiopia is a member of the Summit's Organizing Committee.

3

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

The CGPP Secretariat and partners conducted two rounds of SIAs and one Measles campaign with 82% coverage of the first SIA and 103% coverage of the second SIA. About 6,700 community volunteers served as social mobilizers or vaccinators, and 169 central and field staff members provided technical support during all phases of the campaigns. Partner NGOs provided 81 vehicles for transporting vaccination teams and vaccines; 37,684 liters of fuel; 592 social mobilization materials (megaphones, dry cells and banners); and 550 CBS training manuals printed in Amharic, English and Somali.

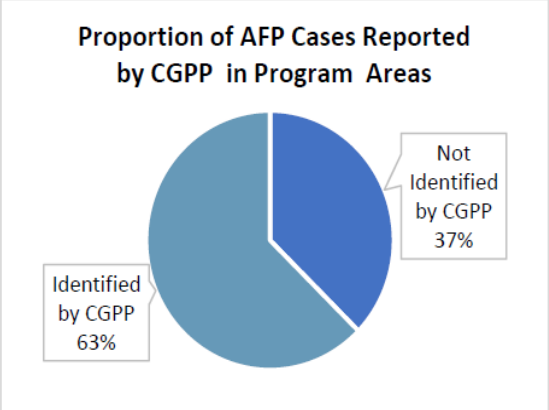
Community volunteers conducted SIA activities in B/Gumuz region in Pawi woreda.

FY17 achievements of the two Polio SIAs and Measles campaign

Partner	December 2016 polio SIAs			March 2017 Measles Campaign			August/September 2017 polio SIAs		
	Target	Achieved	%	Target	Achieved	%	Target	Achieved	%
Amref	DNA	DNA	DNA	92,840	95,324	103	111,911	125,018	107
CARE	64,195	65,419	102	46,049	48,791	106	NA	NA	NA
CRS	71,758	69,296	97	DNA	DNA	DNA	DNA	DNA	DNA
EECMY	45,359	44,752	99	58,297	57,125	98	47,437	47,927	101
IRC	16,879	17,990	107	DNA	DNA	DNA	18,683	18,862	101
EOC	179,447	171,497	96	DNA	DNA	DNA	NA	NA	NA
PC	85,671	83,416	97	163,454	135,294	83	85,461	83,588	98
SCI	96,820	96, 877	100	38,453	41,427	108	DNA	DNA	DNA
WASDA	57,285	56,795	99	DNA	DNA	DNA	45,704	50,342	110
OWDA	DNA	DNA	DNA	36,260	29,302	81	61,234	56,751	93
WVE	44,081	35,359	80	21,780	21,421	98	DNA	DNA	DNA
Total	**661,495**	**544,524**	**82**	**457,133**	**428,684**	**94**	**370,430**	**382,488**	**103**

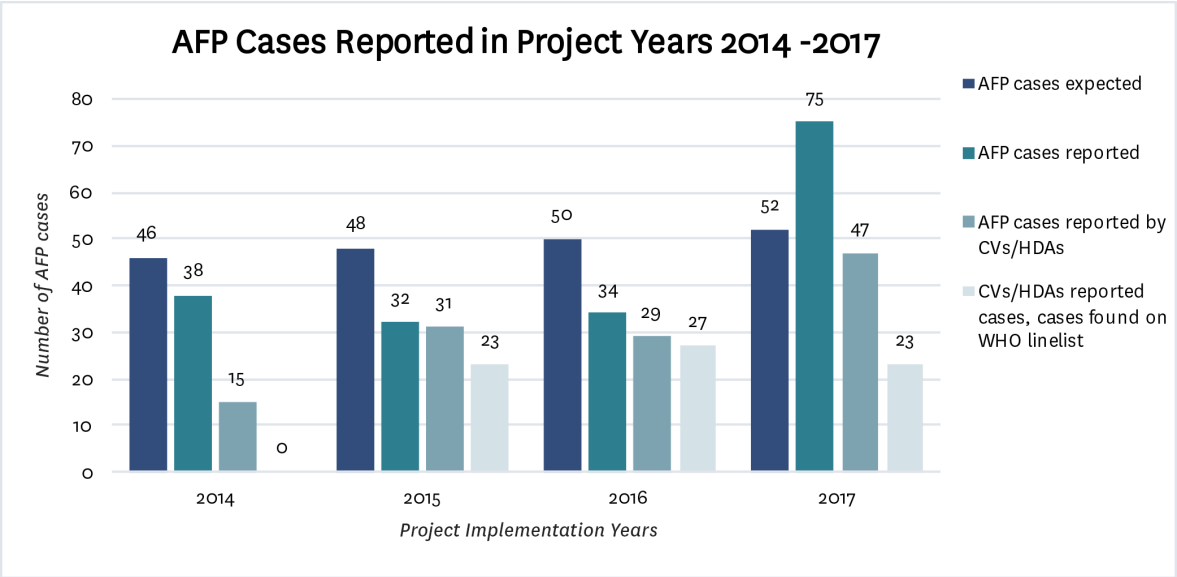
4 Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection (and reporting and detection of other infectious diseases)

In Ethiopia, active surveillance for AFP is conducted at both the community and health facility levels. CGPP trained 1,990 CVs and HDALs on CBS and NBT. In the project year, CGPP deployed 2,595 CVs and 11,186 HDALs to conduct house-to-house surveillance for AFP, NNT and Measles and to track the status of pregnant women and newborns. CVs and HDALs conducted 729,662 house-to-house visits to provide health education to 1,836,750 people.



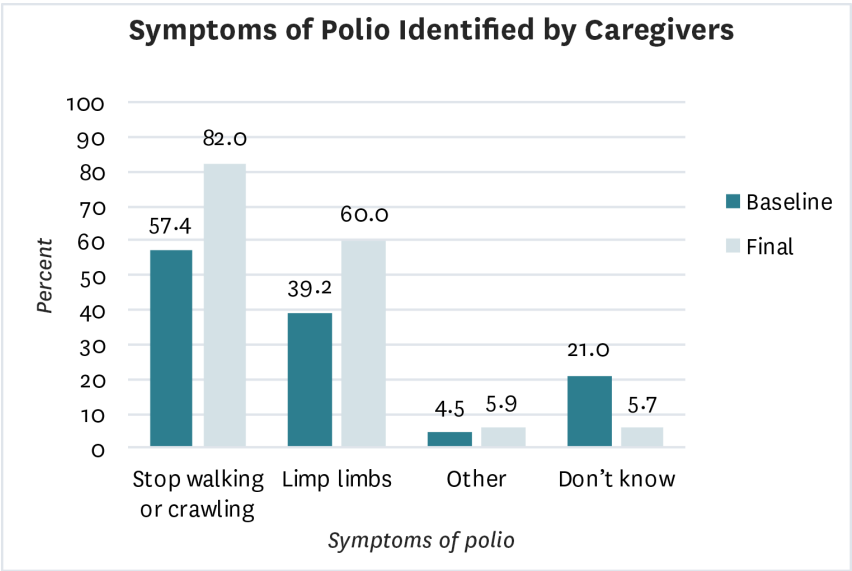
Per week 37, Ethiopia reported 742 AFP cases throughout the country. The non-polio AFP rate in the CGPP target districts was 2.5 per 100,000 children under 15 years old with a stool adequacy rate of 92%, a marked improvement from FY16 figures that showed 709 AFP cases, 2.4 NPAFP rate and 90% stool adequacy rate. Agnuwak and Majang zones and Itang special woreda from Gambella region were silent areas, according to WHO polio update week 37. In CGPP focal areas, 75 AFP cases were reported. Forty-seven (63%) of the AFP cases in CGPP project areas were reported by CGPP volunteers. Volunteers also identified and reported 220 measles cases. CGPP partners transported 22 stool samples for testing.

The Secretariat implemented a mobile device and web-based surveillance data collection and online submission system called m-Health. In FY18, CORE Group will work to strengthen the use of this resource to improve project effectiveness and efficiency. AFP cases expected, total cases reported, cases reported by CVs/HDALs and cases confirmed through ODK from October 2014 through September 2017 in CGPP implementing areas are show in the graph below.



Source: CGPP Ethiopia implementing partners' FY2017 project report.

Endline survey results showed a considerable improvement in knowledge among mothers and caretakers on the symptoms of AFP: 82 percent understood that a child who stopped walking or crawling could be have polio symptoms, compared with 57 percent surveyed at baseline. Similarly, 60 percent understood that limp limbs could be an indicator for AFP compared to 39.2 at baseline.



Source: CGPP Ethiopia final project evaluation survey report Sep. 2017

Summary of AFP Surveillance indicators by Region, Ethiopia Jan 01 – Sep 30, 2017

Region	Expected Cases (2017)	Reported (this period 2017)	Reported (same period 2016)	Reported this Week	NP-AFP Rate (annualized, 2017)	NP-AFP Rate (annualized, 2016)	Stool Adequacy (%)	Stool Cond. (%)	VDPV Cases	WPV Cases
Addis Ababa	17	17	13	0	2.8	2.1	94	92	0	0
Afar	17	8	19	0	1.3	3.3	88	100	0	0
Amhara	171	166	165	5	2.7	2.7	93	92	0	0
B/GUMUZ	14	19	10	1	3.8	2.8	89	94	0	0
Dire Dawa	3	3	3	0	2.8	2.8	100	100	0	0
GAMBELLA	4	2	8	0	2.8	1.4	100	100	0	0
Haeari	2	0	1	0	0	1.4	0	0	0	0
OROMIA	351	292	263	8	2.3	2.2	90	93	0	0
SNNPR	178	138	131	2	2.2	2.1	95	95	0	0
SOMALI	50	62	73	0	3.5	4.3	95	98	0	0
Tigray	42	33	29	1	2.2	1.9	91	87	0	0
NATIONAL	**849**	**742**	**709**	**17**	**2.5**	**2.4**	**92**	**93**	**0**	**0**

Source: FY2017 WHO Polio update, week 37

Summary of AFP Surveillance indicators, Ethiopia, 2008-2017

Indicator	Target	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
NP-AFP rate	2	2.9	2.2	2.8	2.7	2.9	2.9	3.1	3.1	2.4	2.5
Stool Adequacy Rate	80%	82%	82%	85%	88%	89%	87%	87%	92%	90%	92%

Source: FY2017 WHO Polio update, week 37

COLLABORATIVE ACTIVITIES AMONG CROSS BORDER DISTRICTS

Ethiopia remains at high risk of importation due to the 2016 outbreak in Nigeria. CGPP Ethiopia continues to advise health workers to intensify surveillance efforts at the bordering areas of Somali, Benishangul Gumuz, Oromiya, Gambella, and SNNP regions. To strengthen CBS, improve routine and supplemental activities and prevent importation, CORE Group Ethiopia Secretariat and implementing partners in collaboration with other stakeholders organized and conducted four in-country local-level cross-border meetings.

CGPP and partners identified and mapped migrant, mobile and hard-to-reach populations along the Ethiopia, Kenya, Djibouti and Somalia borders. The four meetings drew a diverse group of 137 stakeholders, including district administrators, health office and health facility leaders, CGPP partner national and field staff and other staff from NGOs working on immunization and surveillance activities in the area.

- From August 9 - 10, 2017, CGPP Ethiopia and Save the Children met in Moyale town with seven border districts along Kenya.
- From September 13 – 15, 2017, CGPP Ethiopia and Hararge Catholic Secretariat meet in Dire Dawa town with four border districts along Djibouti and Somalia.
- From September 19-21, 2017, CORE Ethiopia and OWDA met in Warder town with five bordering woredas along Somalia and in a separate meeting, with Save the Children in Dolo Ado town with three border districts along Kenya and Somalia.

In FY18, the Secretariat will continue to lead efforts to organize national and local-level cross border meetings, as per the recommendation of TAG. Cross notification of polio HOT cases and synchronization of SIAs with neighboring countries should be continued and further strengthened.

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

Four CGPP Secretariat staff presented five abstracts (three oral presentations and two posters) at the American Public Health Association (APHA) annual meeting in Denver, Colorado from October 29 – November 2, 2016. At APHA, CORE Group Ethiopia attended two trainings on "Scientific Writing for Peer Reviewed Publications for Public Health Professionals" and "Using Systems Thinking to Address Public Health Challenges." Two journal articles were also published in peer reviewed journals. Several others are currently in process for FY18.

The Secretariat and implementing partners are working to establish recording, reporting and filing systems at all target health facilities, woreda health offices and project field offices. CGPP distributed 2,350 reporting formats on documentation and proper use of the immunization monitoring. The Secretariat Communications Officer prepared quarterly newsletters on current immunization and surveillance-related information and were distributed to government offices and other partners.

Joint supportive supervision The Secretariat's technical and financial staff conducted supportive supervision visits jointly with partner staff at 65 Woredas and 15 zones in five regions, an increase from the 58 woredas visited in FY16. Staff found poor documentation at woreda health offices and outdated immunization monitoring charts at most health facilities. The Secretariat office provided immediate onsite verbal feedback and followed up with written reminders. CGPP staff also checked on progress through email and telephone with all woredas and partners offices.

STAFF RETREAT

CGPP Ethiopia held a staff retreat from August 28-September 3, 2017 in Arbaminch town's Mora Height Hotel to review the Secretariat's 2017 performance and develop a plan for 2018.

CGPP Secretariat staff gathered to review 2017 performance (right) and posed for group photo on Lake Chamo (left) during a break.

6

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

National and international teams conducted an external outbreak response assessment. The Ethiopian Secretariat is a member of the African Region Certification Committee (ARCC).

POLIO LEGACY TRANSITION PLANNING

CGPP Ethiopia is developing a comprehensive polio legacy plan to strengthen community-based surveillance and immunization activities and transition resources to the government. Since transition efforts began in 2016, the Secretariat has completed mapping of polio personnel and physical assets; developed a detailed plan of action and key transition strategies for essential and non-polio functions and drafted a budget for the transition plan.

In addition, supportive documents have been developed to highlight best practices and lessons learned; assessments of pastoralist and border populations and low-performing woredas; the resource mobilization strategy; the communication and advocacy strategy; the polio transition human resource plan and the capacity assessment and capacity building plans.

In response to the high demand by pastoralists for veterinary services, CGPP Ethiopia tested a pilot program in the Dollo zone of the Somali region to integrate animal vaccination services with child immunization services. This innovative approach reached 165 children with OPV and 230 mothers with neonatal tetanus.

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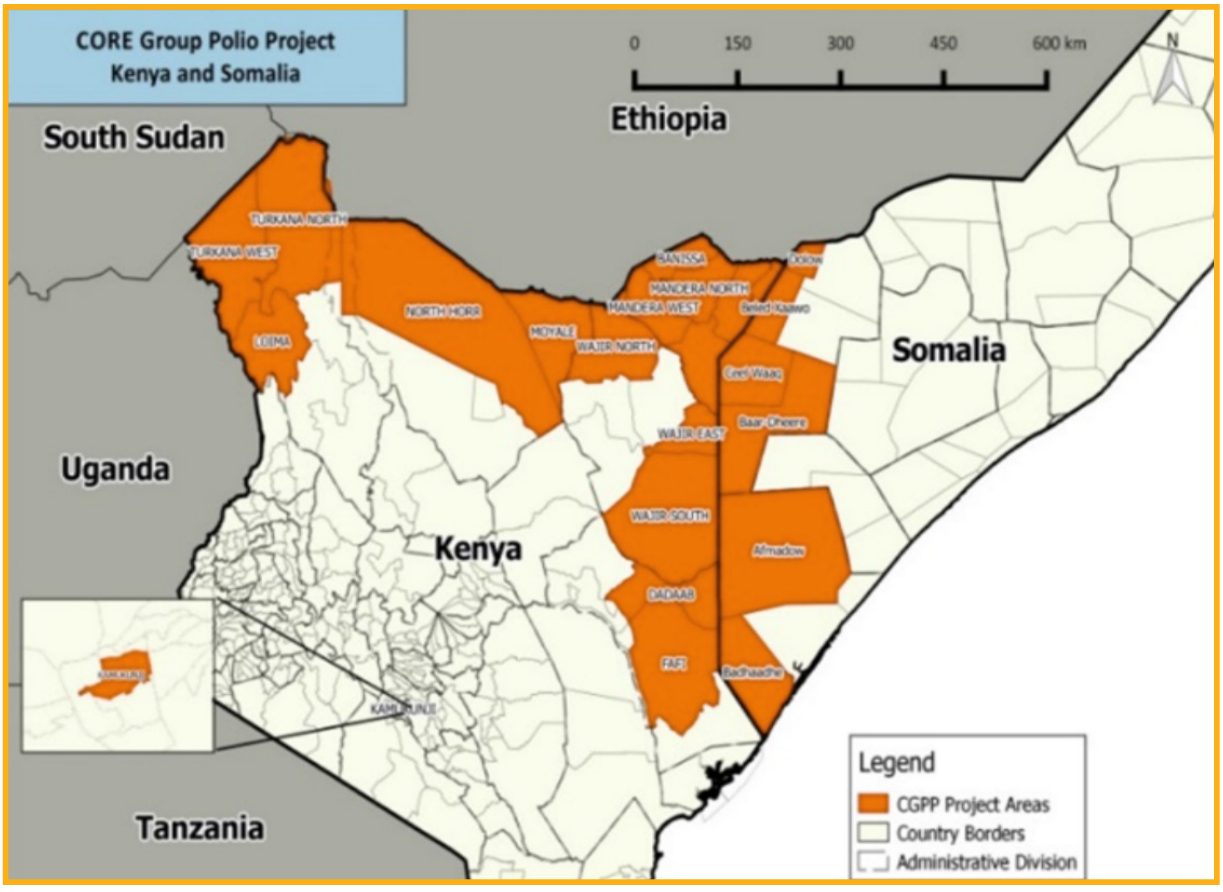
Country Report:
Horn of Africa

The CORE Group Kenya-Somalia program promotes immunization and surveillance activities in high-risk, hard-to-reach border communities. The area hosts IDPs, refugees and nomadic and pastoralist herders. Long-standing threats from insurgents and regular tribal clashes, political instability, weak health systems, and fluid movements of vulnerable and marginalized populations have created the ever-present risk of wild polio virus importation.

In FY17, CORE Group Kenya and Somalia trained community health workers to provide services through 97 health facilities, up from 88 in FY16. The workers mapped seasonal migration routes, shared data, synchronized NIDS, tracked population movements at cross border points to establish and support special vaccination sites and integrated immunization programs with animal health programs.

In Somalia, 148 Community Health Volunteers (CHVs) and 21 Community Mobilizers (CMs) targeted more than 165,000 children through supplementary and routine immunization campaigns and active AFP case detection. In Kenya, CORE Group reached 178,599 under-fives along 138 crossing border points with 400 CHVs and 80 CMs.



1

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

Based in Nairobi, the CORE Group Kenya-Somalia Secretariat continued its partnership with five international NGOs: Catholic Relief Services (CRS), Adventist Development Relief Agency (ADRA), International Rescue Committee (IRC), American Refugee Committee (ARC) in Somalia and World Vision- Kenya (WVK). CGPP Kenya worked through 75 health facilities in the hard-to-reach nomadic counties of Garissa, Mandera, Marsabit, Turkana and Wajir and five health facilities in Nairobi's high-risk Kamukunji Sub County.

In Somalia, ARC and Somali Aid, a local NGO, worked along the hard-to-reach six border districts of Lower Juba and Gedo regions in Jubaland state located in the South-Central zones. ARC implemented work in Lower Juba and Somali-Aid focused on the Gedo region. CGPP Somalia supported services to 17 health facilities at the border districts of Badhadhe, Afmadow, Bardere (Gerille sub-districts), Elwak, Belet-Hawa and Dollow reaching 148 villages.

CGPP Kenya-Somalia conducted activities in coordination with WHO, MoHs, and UNICEF. CGPP Kenya-Somalia convened and participated in regional, national, county and health facility level meetings during the reporting period:

KEY REGIONAL, NATIONAL AND SUB-NATIONAL LEVEL MEETINGS

- Attended the 16th HOA TAG meeting on March 3, 2017 and presented on the Cross Border Health Initiative
- Participated in the development of Standard Operating Procedures (SOPs) for hard-to-reach (HTR) areas in coordination with GPEI, WHO AFRO, WHO EMRO, WHO HOA from July 25-27, 2017
- In coordination with the Kenya MOH Integrated Disease Surveillance and Response Unit (IDSRU and WHO, participated in the International Health Regulation Kenya Joint External Evaluation meeting from January 27 to March 3, 2017 in Nairobi
- In coordination with IDSR, conducted National MOH 2 National surveillance review
- Supported national planning of SIAs from March 18-22, 2017 with IDSRU and WHO-Kenya
- Attended National Polio Executive Committee (NPEC) and National Polio Coordination Committee meetings in June
- Attended coordination meetings with MoH during all planning phases of SIAs at the county and sub-county levels
- Planned and participated in county surveillance and data review meetings
- Attended county planning meeting for EPI and surveillance activities.

- Renewed quarterly meetings of the county technical working group on disease surveillance

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

2

KENYA

Indicator	Percentage
% of children with OPV3	56%
% of zero dose (never vaccinated)	4%
% of children under one with OPV birth dose	51%
% of children one year and older with 7 or more doses of OPV	72%

In Kenya, CGPP supported the MoH to conduct monthly integrated outreach sessions in hard-to-reach nomadic communities and urban areas through its 80 health facilities. The project targeted children under one year living in routinely neglected remote areas located along international borders. Eighty community mobilizers and 400 community health volunteers covered a total of 848,163 people, including 169,633 children under 5 years.

CORE Group conducted RI training for both health facility staff and community health volunteers on social mobilization, data management, reporting and micro-planning. Thirteen trainings were held during FY17 for 357 volunteers and 89 health staff. The Secretariat procured three solar batteries to power the central cold chain system that stores all vaccines for Kibish sub-county in Turkana County, thus eliminating vaccine stock-outs and delays in delivering vaccines to cross-border facilities.

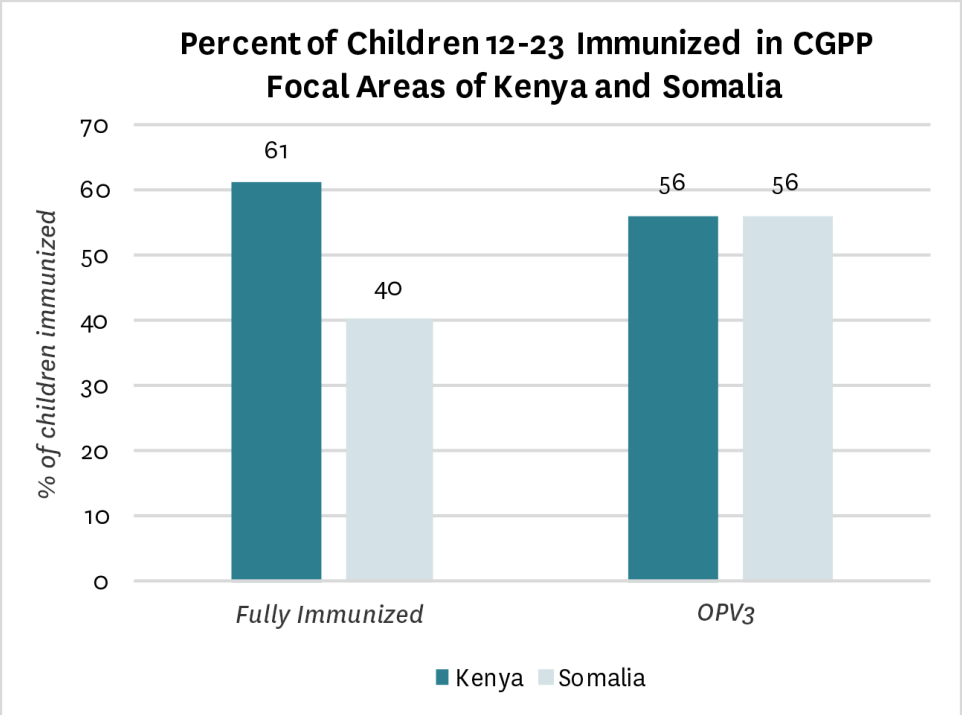
Two major labor stoppages of health workers in Kenya negatively impacted routine and polio immunization coverage rates. Sixty one percent of children 12 to 23 were fully immunized, while 56% of children were immunized with OPV3.

Doctors went on strike between December 2016 and March 2017; similarly, nurses held a labor stoppage beginning in June 2017. The labor disputes disrupted RI service delivery in many CGPP Kenya project areas. As many of the affected health facilities were left attended by poorly trained staff, CGPP worked with surveillance officers to train available staff on detecting AFP and other diseases.

In addition to labor disruptions, cattle raids, disease outbreak and severe drought and famine contributed to lower routine immunization coverage. Four health facilities were closed due to insecurity - two facilities located along the Kenya and Somalia border and two located in Turkana County along the Kenya and Uganda border. A cholera outbreak in Wajir lasted from October through December 2016 and Mandera endured a Measles outbreak from March through June 2017. Severe drought and famine in Turkana, Wajir, Garissa and Mandera counties forced the migration of populations to neighboring countries in search of water and pasture for livestock. In Kenya, the Secretariat developed all project tools, training methods and manuals in coordination with the IDSR and the National Vaccine Immunization Services unit. CORE Group

Kenya utilized these resources for polio and other vaccine-preventable diseases.

SOMALIA



In Somalia, about 75% of the population does not have access to basic health care. Somalia has no functional health care system and no national immunization program. Al Shabab bans polio vaccination and eradication activities in areas under their control. Somalia also has a very nomadic population moving across international borders between Ethiopia, Kenya and South Sudan with the ever-present threat of virus spread.

ARC implemented routine immunization services at border health facilities in Lower Juba in April 2016. Through sub-grants provided by ARC, Somali Aid provided RI outreach in Gedo region. The start-up of RI services was soon disrupted by funding gaps to key partners in the area.

CGPP Somalia worked closely with border district medical officers (DMOH), WHO representatives and key health partners in the region for planning, coordination and management of routine immunization services at the targeted border districts of Jubaland state. CGPP Somalia worked closely with the MoH and other partners to provide technical support on vaccine handling and

Child of IDP family in Dobley, Somalia receives OPV drops.

cold chain management, micro-planning for border health facilities, and integrating routine immunization with nutrition services.

CGPP Somalia's target area includes a total of 96,436 people and 48,976 children under 5. Through a combination of monthly, weekly and bi-weekly outreach sessions, CGPP Somalia reached 5,461 children in the six border districts. Since the inception of CGPP in Gedo and Lower Juba, OPV3 coverage has improved in the project areas from 37% to 56%. In FY17, 22% of children under one received the OPV birth dose and 4% were had never been vaccinated. Approximately 40% of children were fully immunized.

In Somalia, CMs and CHVs conducted active social mobilization activities to track and identify nomadic families for integrated health and nutrition and EPI services. CHVs are selected from hard-to-reach areas and travel with nomadic populations.

During the reporting period, CHVs conducted 24,271 house-to-house visits, reaching 97,436 people, and conducted 1,343 visits to border health facilities. CMs conducted community dialogue sessions with 22,742 pregnant and nursing mothers and 14,538 men on the importance of routine immunization.

During FY17, CGPP Somalia conducted numerous trainings for CHVs, health facility staff and traditional birth attendants on integrated trainings for microplanning, community-based AFP surveillance, supplementary immunization, routine immunization, and reporting.

Type Training	Type trained	Number Trained
Refresher Routine Immunization Training	CHVs/CHWs	120
	CMs	21
	TBAs	12
Integrated RI, CBS and SIA training (Partners)	CMs	120
	CHVs	148
	EPI Staff	69
	Health Staff	17
	CHWs	112
	TBSs	85
TOTAL		**704**

3

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

KENYA

Kenya conducted two SIAs in January and April 2017 reaching 360,842 children under five years, along 138 border crossing points. An average of 8% of children under 5 were missed during SIAs. Prior to conducting the campaigns, CGPP Kenya mapped 75 health facilities located along borders with Ethiopia, Somalia and South Sudan. CORE Group provided 121 extra SIA teams to support the campaigns. During both campaigns, 764 children received zero dose OPV. Noteworthy coverage was achieved in Wajir County during the April 2017 SIA, with all sub-counties meeting the 90% benchmark.

LQAS in Wajir county by WHO-Kenya, April 2017.

Sub-county	LQAS coverage of the SIAs	Independent Monitoring Coverage	Overall SIAs coverage
Wajir south	> = 90%	99%	98.6%
Wajir East	> = 90%	98.25%	98%
Wajir north	> = 90%	99.25%	75.8%

Data Source: MOH/WHO-Kenya SIAs report (April 2017)

SOMALIA

Due to a collapsed formal health infrastructure, Somalia continued to depend on supplementary immunization activities in FY17. According to WHO, 115 districts remained inaccessible and 235,000 children have not been reached with immunization campaigns since the HOA outbreak in 2013.

In Somalia, CGPP partners worked with WHO and the MoH to conduct four national SIAs and two short interval vaccination days in the Gedo and Lower Juba regions. CGPP placed 88 extra teams at major crossing points, transit areas, markets, IDP centers and other locations with high concentrations of nomads and pastoralists. During the NIDs, vaccinators reached 9,175 children; vaccinators reached 2,483 children during the two interval vaccinations. Campaign coverage was 94% of target during the FY17 campaigns. Four percent of children had zero doses.

CGPP Somalia conducted integrated trainings for community based volunteers and health facility staff to improve SIA campaign implementation. Volunteers used theses skill to reach 157,302 people through social mobilization activities.

The Somalia team also attended SIA review and microplanning meetings with WHO regional polio officers, district medical officers and the MoH. During the supplemental polio activities, the CGPP Somalia project hired one vehicle per border district to transport project teams and extra vaccinating teams to border villages and hard to reach nomadic settlements. The vehicles also supported daily project team movement for supervision activities, including verifying finger and house marking, ensuring correct record keeping and following up on refusals. CGPP also provided transportation and per diem support to district medical officers who conducted monitoring and evaluation activities.

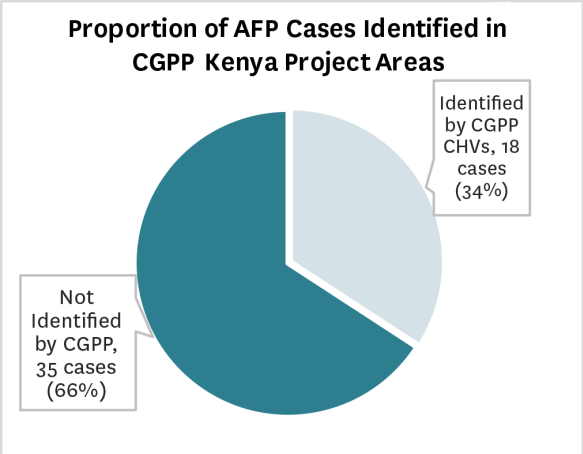
Cross Border Health Initiative (CBHI)
CGPP developed a work plan of the CBHI committee to synchronize implementation of activities and share information. Committee members included representatives from national and county governments, MOH, IRC, WHO and UNICEF.

The project provided technical support to WHO-HOA and WHO-AFRO on planning, implementation and monitoring of CBHI. The HOA countries were organized by four clusters for meeting purposes: Cluster 1 included Kenya, Ethiopia and Uganda; Cluster 2, Ethiopia, Somalia and Djibouti; Cluster 3, South Sudan and Sudan and Cluster 4, Kenya and Somalia. One meeting was held in the reporting year between Kenya's Mandera County and Somalia's Gedo region from July 18-19, 2017.

4

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

CGPP Kenya strengthened AFP surveillance in the target sub-counties and provided logistical and technical support to the project areas for case investigation, stool collection and transportation of stool samples to the KEMRI national laboratory. After expanding to Mandera County, each of the 80 health facilities was staffed by a trained CHV.



During the project year, CHVs reported 18 cases (34%) of 53 AFP in CGPP Kenya focal areas. CGPP Kenya reported a non-polio AFP rate of 2.5 per 100,000 children under age 15 in program focal areas and a stool adequacy rate of 29%. There was a total of four silent sub-counties, two in Nairobi and two in Turkana.

AFP SURVEILLANCE OF CGPP COUNTIES COMPARED TO CGPP CHVS CASES REPORTED IN THE COUNTIES.

County	Cases expected in 2017	Cases detected in 2017	CGPP CHVs detected/ reported cases	NP AFP rate	Stool adequacy Rate	No of silent sub-counties
Mandera	15	11	11	2.84	91%	0
Nairobi	6	6	1	4.04	67%	2
Marsabit	57	35	2	2.47	80%	0
Wajir	10	12	2	4.97	92%	0
Turkana	22	7	7	1.29	86%	2
Garissa	8	8	4	3.78	75%	0

Data source: WHO week 40 AFP surveillance report (FY 2017)

Furthermore, the project provided CBS training to health staff and 833 CHVs including those assigned to health facility community units. The training focused on AFP surveillance and reporting of other IDSR diseases. CGPP trained sub-county disease surveillance coordinators to conduct field visits to health facilities and support community dialogues. Reporting increased from 69.9% in 2014 to 100% in 2017. Community-based surveillance activities in Kenya began in 2016.

SOMALIA

CGPP Somalia collaborated with WHO regional officers, district polio officers, the MOH and other key health partners to monitor both community and facility-based AFP surveillance. Tools were developed for the program to track the movement of nomadic pastoral communities so

children are not missed and surveillance is kept high. In CGPP Somalia project area, 16 AFP cases were detected: ten cases from Lower Juba's Badhadhe district and six cases from Gedo region in Belet-Hawa. Of these, 9 (56%) were identified by CGPP. Somalia reported a non-polio AFP rate of 4 per 100,000 children under age 15. The national stool adequacy rate was 86 percent. Somalia reported one silent area.

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

CGPP participated in the development of the Kenya Polio Outbreak Simulation Exercises (POSE) from March 28-29, 2017. The Secretariat provided technical support to WHO and the MoH to ensure a robust outbreak plan and response. CGPP Kenya became a member in July 2017 of the National Polio Experts Committee and participated in AFP case validation as per HOA-TAG recommendations and participated in the National Coordinating Committee meeting.

During FY17, CGPP Kenya presented on "Strategies to immunize children in conflict-affected, inaccessible areas" at the American Public Health Association's annual meeting and published two articles in peer-reviewed, open-access journals on the use of community mobilizers for AFP case detection and the use of cross-border health collaboration during polio campaigns in Kenya. CGPP Somalia made six conference presentations.

In August/September, CGPP HOA embarked on data collection for the endline program evaluation. A consultant and data collectors were hired to administer a KAP survey a 30-cluster survey methodology and qualitative data was collected from community members, community mobilizers, and staff.

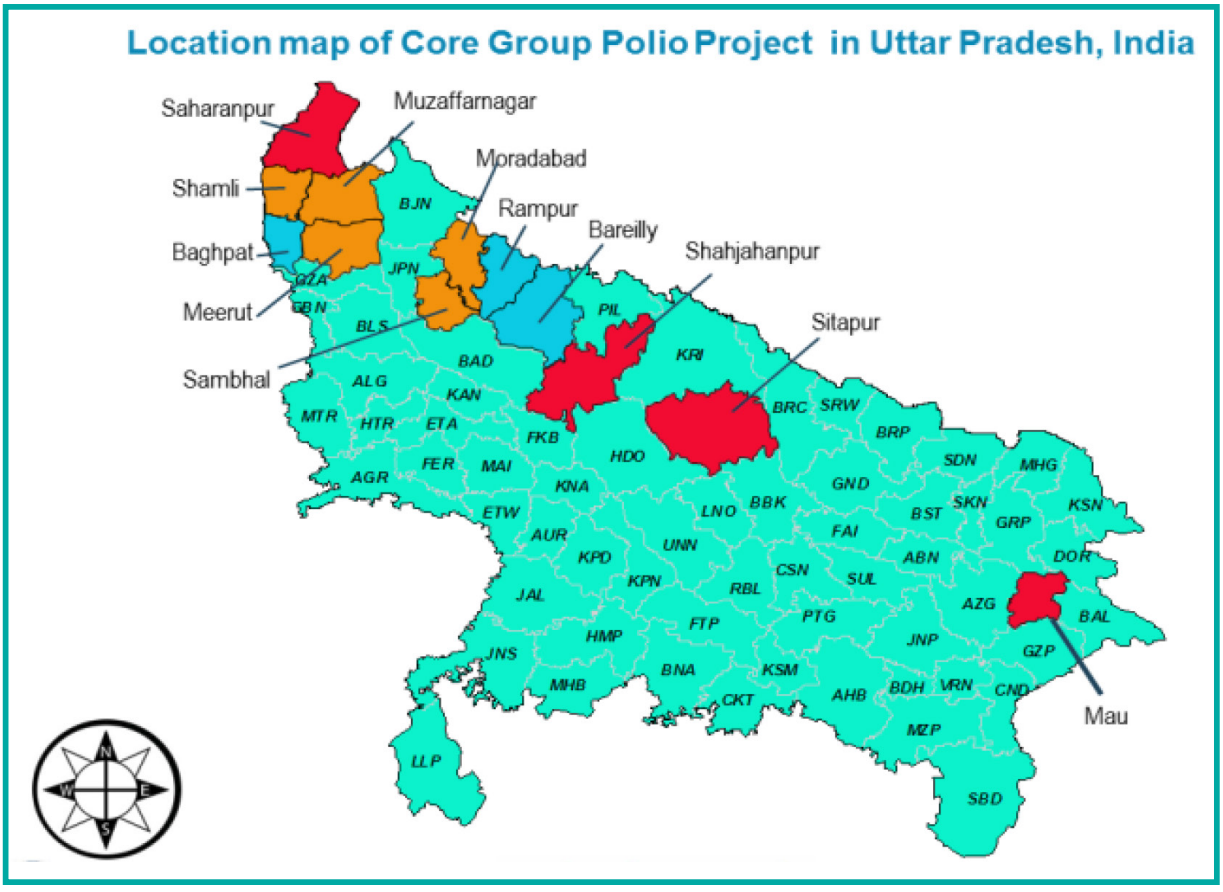
6 Support PVO/NGO participation in national and/or regional polio eradication certification activities

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

Country Report: **India**

India stopped wild polio virus transmission in 2011 and the Southeast Asia Region was declared polio free in 2014. Since then, this country of 1.3 billion residents has successfully maintained high population immunity to stave off any potential importation of the wild polio virus and any outbreak of circulating vaccine-derived polio virus. Two high-quality national and four sub-national campaigns, a robust disease surveillance system and a solid routine immunization program all contributed to India's ability to keep polio outside of its borders in FY17.

Neighboring Pakistan and Afghanistan, both endemic countries, reported the only remaining cases of wild polio virus in FY17. As a result, CORE Group Polio Project India kept up its vigilance to address pockets of low routine immunization coverage, gaps in surveillance, and a significant population of migrants and underserved communities – all risk factors for WPV importation and VDPV outbreaks.



1

Build effective partnerships with PVOs, NGO(s), and international, national and regional agencies involved in polio eradication

In FY17, CGPP India continued to work with Adventist Development and Relief Agency (ADRA), Catholic Relief Services (CRS) and Project Concern International (PCI) and their local NGO partners in 58 blocks of 12 districts in Uttar Pradesh (UP), the most populous state in the country. About 1,100 Community Mobilization Coordinators (CMCs) conducted social mobilization activities to reach 522,000 households and 376,000 children under five years old. India's Immunization Program is one the largest in the world in terms of quantity of vaccine used, number of beneficiaries and number of immunization sessions organized.

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)	Muzaffarnaga r& 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

CORE Group India collaborated with the MoH, WHO, UNICEF and Rotary to strategize plan implementation. During the reporting period, CGPP India organized, directed and attended numerous meetings with government health officials, donors, and leading partners. Throughout the year, CGPP India conducted multiple meetings to discuss project activities and implementation plans in the field and hosted senior level managers from USAID and CORE, Inc. CGPP India and WHO India hosted a delegation of NGOs from Afghanistan to observe a polio campaign in Moradabad, UP in April 2017.

CGPP India Secretariat Director Dr. Roma Solomon represented civil society at the following regional and international meetings:

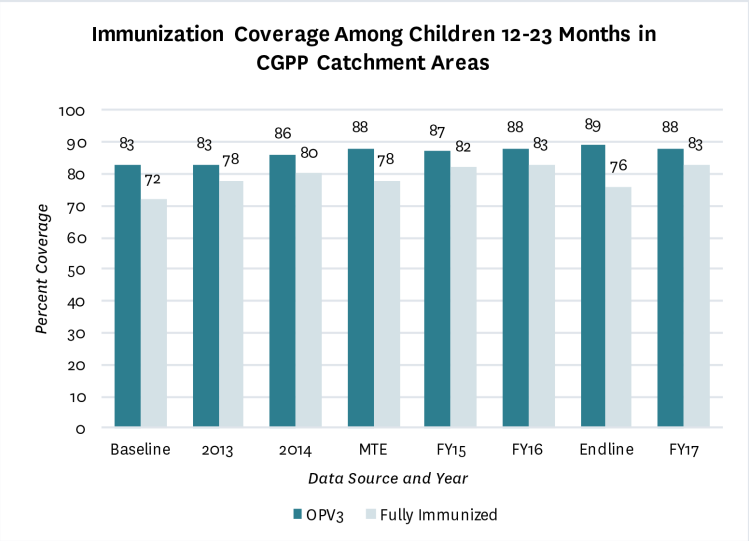
- The Strategic Advisory Group of Experts (SAGE) meetings in Geneva in October 2016 and April 2017 to acknowledge the GVAP 2016 report for CSOs to compare their work maps against national immunization plans. The report stressed the importance of promoting CSO's geographic and programmatic scope and measure and share the impact of their work and discuss issues related to polio eradication, cholera, Ebola vaccines and Diphtheria.
- The India Immunization Advisory Group (IAG) meeting on December 5, 2016 to discuss Gavi

funding and to receive updates about phase-ins of new vaccines. The IAG is the equivalent to the ICC in other countries.

- All meetings of the South-East Asia Regional Technical Advisory Group (ITAG) to review the progress of national EPI performance against the strategic goals outlined in the South-East Asia Regional Vaccine Action Plan. Key areas of focus included measles elimination and rubella control, strengthening routine immunization systems and services, polio eradication and endgame strategy, introduction of new vaccines and the availability of safe and effective vaccines.

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

CORE Group India built upon the strong routine immunization rates in its underserved communities. During FY17, Block Mobilization Coordinators (BMCs) and District Mobilization Coordinators (DMCs) assisted government medical officers by updating micro plans for high-risk groups including nomads and slum dwellers and through monitoring of 10,890 RI sessions. CGPP India has consistently met the 80% threshold of OPV3 coverage with 83% of children from CGPP catchment areas receiving at least eight doses of oral polio vaccine. Survey-based coverage for 2012, 2015 and 2017 was based on data recorded in vaccination cards; other project year data was extracted from monthly progress reports (MPRs).



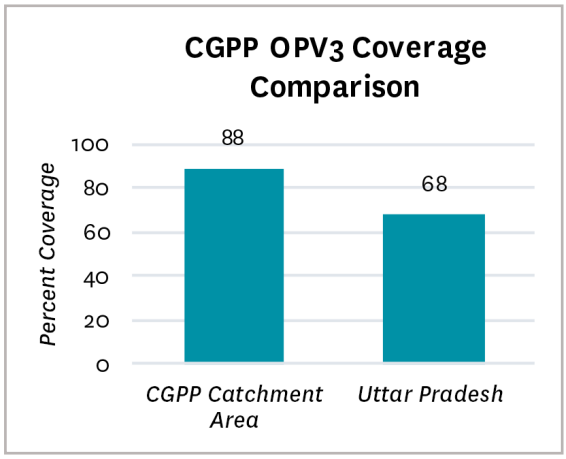
Source: CGPP Evaluations; CGPP MPRs

PROMOTING BIRTH DOSE OF ORAL POLIO VACCINE AT HEALTH FACILITIES

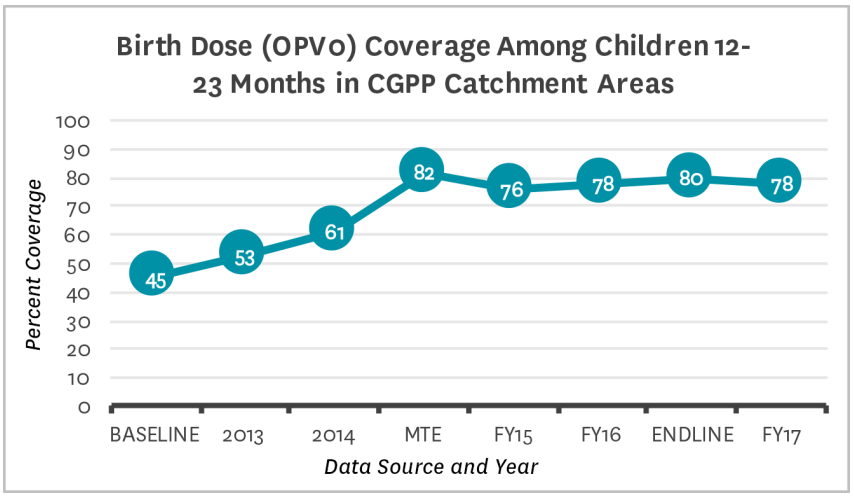
About 60 percent of women residing in Nai Basti and Qaziyra villages of Sitapur's Machhrehta block were delivering their babies at home. CMCs and ASHAs (community based health workers) jointly visited the area to counsel families of expectant mothers to promote institutional deliveries. They also provided phone numbers for ambulance service to the health facility. As a result of the improved outreach, all babies were delivered at a health facility during January 2017 and receiving the important birth dose of OPV.

IMMUNIZATION COVERAGE

OPV3 rates among children 12-23 months old reached 88% in FY17, according to the 2017 endline survey. Coverage rates by district vary from 81% in Muzaffarnagar to 96% in Sitapur. A recently published fact sheet of the 4th round National Family Health Survey (NFHS-4) reported that 68% of children age 12-23 months from Uttar Pradesh state were vaccinated for OPV3. Moreover, 9 of 12 CGPP districts reported 10 percentage points higher coverage than district level estimates provided by the national health survey.



Source: CGPP MPRs; NFHS-4



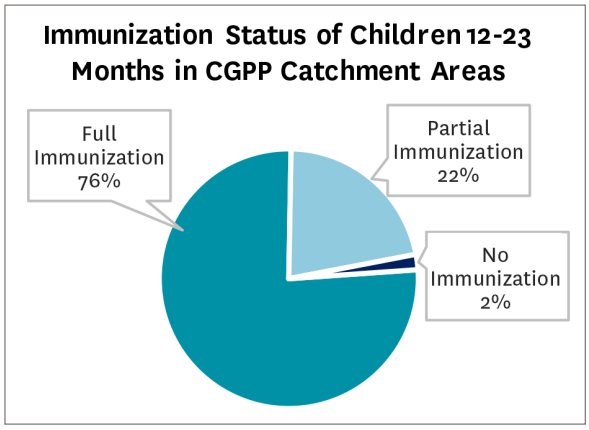
Source: CGPP Evaluations; CGPP MPRs

According to the final 2017 survey, 100% of children had received at least one dose of the polio antigen either during the SIA campaign or during routine immunization. There were no zero dose children. About 83% of children 12-23 months old received at least eight doses of oral polio vaccine during SIAs or RI. District coverage ranged from 76% in Muzaffarnagar to 92% in Sitapur. Birth dose coverage remained at 78% in September 2017 as compared to one year ago. Moradabad reported lowest coverage of all districts at 69%. Saharanpur reported highest coverage of 93%. There was a notable increase of 25% during the project period from 53% to 78%. Data reported in periodic evaluations (cluster-surveys conducted by external agencies) indicated higher coverage than program monitoring data (monthly progress reports shared by PVOs).

Since November 2015, IPV has been added to OPV3 in CGPP areas. In September 2016, children began receiving two fractional doses of IPV; fIPV1 with OPV1 and fIPV2/IPV with OPV3. IPV coverage has decreased among children under one and has increased among children aged 12-23 months from 19% in September 2016 to 69% in September 2017. IPV3 coverage rates do not match with OPV1 or OPV3 coverage rates. Among children 12-23 months, a 19% difference was observed between the coverage of OPV3 (88%) and fIPV2/IPV (69%).

A 50% increase in the fIPV2/IPV coverage between 2016 and 2017 is due to the eligibility criteria for IPV vaccination. At its introduction in November 2015, IPV was provided only to OPV-primed children under one year. More than half of the children aged 12-23 months in September 2016 were too old for IPV. Shortages of the IPV is the chief explanation for low or decreasing IPV coverage in the CGPP areas.

Coverage of second doses of fractional IPV (fIPV) or IPV for children 12-23 months old ranged from 48% in Muzaffarnagar district to 91% in Sitapur district, with a district-wide average of 69%. Variation of IPV coverage could be the result of IPV shortages and demand-related factors such as delayed vaccination of OPV1 or drop-outs from OPV1 to OPV3. Similar results were observed between RI and IPV coverage; for example, Mau, Saharanpur, Shahjahanpur and Sitapur performed well in OPV3 immunization (OPV3 >90%) and reported higher IPV coverage.



The percentage of fully immunized children remained unchanged from 2016 to 2017 at 83%, according to monthly progress reports. As per the entries in the vaccination cards or CORE congratulatory cards, the endline evaluation found that 76% of children from CGPP catchment areas are fully immunized and only 2% were left out from primary vaccination. Full immunization coverage in the CGPP India's catchment areas is 32% higher than NFHS-4 estimates of 51%.

TRAININGS

More than 1,100 CMCs were trained. In addition to CMC annual induction training, CGPP PVOs and partner NGOs trained all CMCs on skill building, field interventions, monitoring, and reporting. During FY17, CGPP India conducted 14 training sessions.

CGPP India also conducted trainings for Block and District Mobilization Coordinators on three categories – Monitoring and Evaluation, Training of Master Trainers, Training for Interventions and Activities.

		Trainings Type	Participants	Date	No. of Trainings	No. of participants		
						Male	Female	All
FY 2016-2017	1	Basics of Monitoring and Evaluation: Applications in CGPP India	All DMCs, MIS Coordinators and SRCs	March 2017	1	27	9	36
	2	Training of master trainers	Selected DMCs, DUCs and BMCs	June 2017	1	30	8	38
	3	Training for CGPP interventions & activities	All SRCs, DMCs, DUCs, MIS Coordinators, BMCs	July 2017	4	80	31	111

3

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

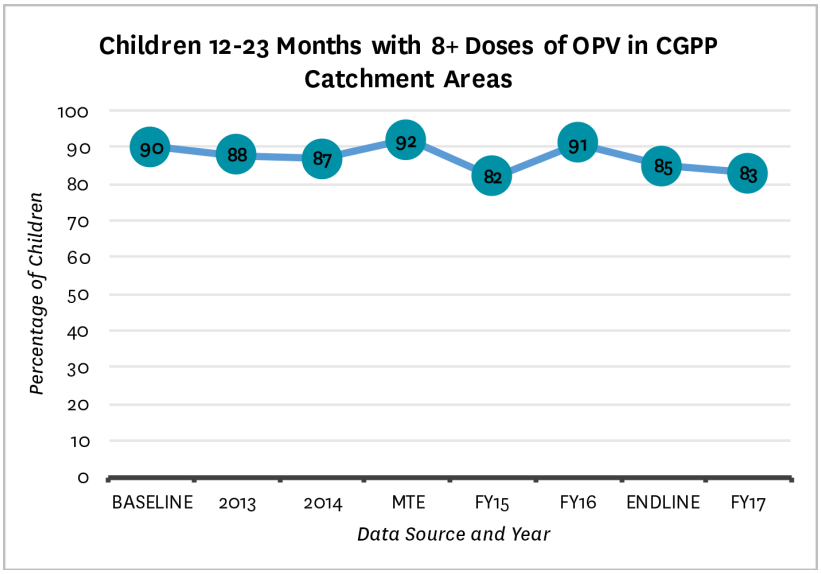
Date of Supplemental Immunization Campaign	% houses missed	
	CMC Area	Non-CMC Area
January 2017	4.7	5.0
April 2017	5.0	5.1
July 2017	4.0	4.5
September 2017	4.0	4.4
Overall Average FY17	4.4	4.7

During FY17, CORE Group India CMCs supported four supplementary immunization campaigns in January, February, July and September in social mobilization to improve booth coverage (fixed vaccination sites). In FY17, an average of 83% of children under five years received oral polio vaccine at 1,547 polio booths. District-wide booth coverage in project areas ranged from 77% in Sambhal to 94% in Mau. CMCs provided a tremendous boost to vaccination efforts, as is evidenced by 83.4% project booth coverage in CMC areas versus 44.2% in non-CMC sites.

In addition to booth vaccinations, vaccinators visited 500,600 households in the CMC areas, including 376,000 children under five years in each SIA. The total SIA coverage in CMC areas was 99.3%, ranging from 98.1% in Sambhal to 100.2% in Muzaffarnagar. (SIA campaign coverage was measured by two consecutive SIAs with the denominator being the numbers of children covered in the previous SIA.)

Over the last five years, the percentage of children with more than 8 doses of OPV has remained consistently above 80%, ranging from 76% in Muzaffarnagar to 92% in Sitapur.

About 8% of children were missed during each SIA, mostly due to migration. The April 2017 SIA reported the highest number of missed children at 8.8%. The district-wide proportion of missed children ranged from 2.8% in Mau to 11% in Muzaffarnagar.



Source: CGPP Evaluations; CGPP MPRs

Consolidated number of Social Mobilization activities in the field: October 2012 to September 2017

Project area districts	# IPC visits	Number of group meetings									Number of coordination meetings*		Participation in number of VHSNC meetings**	
		Mothers/ Adolescent girls meetings		Fathers/ Adolescent boys meetings		Interface/ Influencers/ Religious leaders meetings		Total						
	P	C	P	C	P	C	P	C	P	C	P	C	P	C
Baghpat	264551	246017	10048	9278	455	434	5064	4771	15567	14483	134	135	571	543
Bareilly	280134	267841	7100	6892	436	408	3524	3404	11060	10704	118	72	239	206
Rampur	219342	207482	9289	8713	220	211	894	818	10403	9742	95	74	452	270
Mau	89379	88613	8050	8008	1528	1527	1638	1604	11216	11139	87	81	303	302
Saharanpur	108393	101349	6416	6122	993	885	1564	1416	8973	8423	83	77	310	297
Shahjahanpur	137526	134934	6708	6621	348	346	1725	1719	8781	8686	106	100	706	704
Sitapur	161931	146141	12608	12307	819	736	2174	2114	15601	15157	133	119	493	384
Meerut	158770	151421	11496	11182	86	84	513	494	12095	11760	133	125	229	217
Moradabad	403312	376968	13139	12676	15	15	2005	1894	15159	14585	144	132	597	476
Muzaffarnagar	282971	263092	15014	13652	243	231	2094	2023	17351	15906	269	252	433	408
Sambhal	430768	361920	12436	11878	72	72	1583	1402	14091	13352	118	97	615	499
Shamli	73274	69949	4369	4281	0	0	1366	1353	5735	5634	77	75	91	84
12 CGPP districts	2610351	2415727	116673	111610	5215	4949	24144	23012	146032	139571	1497	1339	5039	4390

P=Planned C=Conducted

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

** Village Health Sanitation and Nutrition Committee (VHSNC) meetings are organized at the community level

*** Community meetings and Barbers initiatives were introduced in the FY 16 but the data is only available for FY 17.

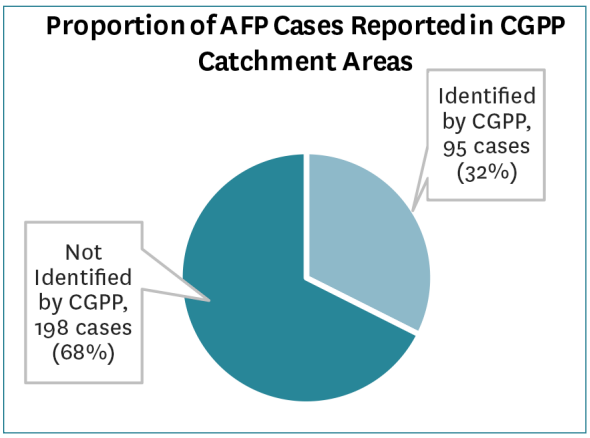
Project area districts	Number of special activities (in selected areas)				
	Community meetings***		Barbers' meeting***		
	P	C	P	C	
Baghpat	24	24	2	2	
Bareilly	24	20	2	2	
Rampur	21	17	2	1	
Mau	7	8	6	4	
Saharanpur	8	8	6	8	
Shahjahanpur	10	10	5	5	
Sitapur	12	12	6	6	
Meerut	68	64	2	2	
Moradabad	22	20	2	2	
Muzaffarnagar	29	24	4	2	
Sambhal	19	19	3	3	
Shamli	9	9	1	1	
12 CGPP districts	253	235	41	38	

4

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

Since the inception of CGPP, the number of WPV cases in India has dropped from a high of 1,934 in 1998 to zero in 2017. Surveillance and improved immunization coverage were key factors in stopping virus transmission in India. In India, surveillance is carried out by WHO and the MOH. CGPP also trains its CMCs to watch for and report any suspected AFP cases. CGPP India CMCs provided critical support in the field by detecting and reporting 32.4% AFP cases from CGPP catchment areas, or 95 of 293 total cases in FY17. The non-polio AFP rate in the 12 CGPP districts was 12.3 per 100,000 children under 15. All districts far exceeded the minimum threshold of 2, ranging from the lowest of 4.4 in Mau to the highest in Baghpat of 25.1. The aggregated adequate stool collection

Project district	Non-Polio AFP rate	% 2 stool samples are collected within 14 days of onset of paralysis
Baghpat	25.1	88.3
Bareilly	14.2	90.7
Rampur	15.9	90.8
Mau	4.4	88.9
Saharanpur	15.9	86.2
Shahjahanpur	16.9	85.0
Sitapur	18.5	87.9
Meerut	16.9	84.7
Moradabad	19.8	85.5
Muzaffarnagar	14.2	84.3
Sambhal	19.0	82.8
Shamli	15.8	81.8
Average Uttar Pradesh State	12.3	86.8
Data source: WHO - NPSP, AFP Surveillance Indicators; Data as on week No. 37, 16 September 2017		



Data Source: CGPP MPRs 1

rate for the state of UP was 86.8%, according to epidemiologic week 37. All CGPP districts maintained the minimum stool adequacy rate of 80% with district-wide rates ranging from 90.8% in Rampur to 81.8% in Shamli. There are no silent areas in CGPP project areas.

Photo: CGPP team member from ADRA conducts High-Risk Group (HRG) tracking and mapping to ensure coverage with OPV and routine immunization during SIA campaigns. This strategy is critical to prevent the re-introduction of WPV from neighboring countries. ADRA conducts robust tracking of HRGs at least twice a year and records the name of each eligible child in the micro-plan. During FY 17, the ADRA CGPP team conducted HRG tracking in December 2016 and January 2017 in three districts to visit 667 HRG sites across 15 blocks.

5

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

India has a well-developed health information system to monitor the project through the collection of data on project activities. In January 2017, CGPP India submitted an article to the Journal BMC Infectious Disease entitled "Demand-side determinants of timely OPV3 immunization among children aged 6-11 months in Uttar Pradesh, India: Evidence from a Doers and Non-doers survey conducted in the catchment areas of CORE Group Polio Project (CGPP)." The article was authored by Manojkumar Choudhary, Roma Solomon, Jitendra Awale and Rina Dey. Mr. Choudhary presented the paper at the 15th World Congress on Public Health in Melbourne, Australia in April 2017 during an oral presentation session on "Vaccination, Immunization and Vulnerable Populations." Ms. Dey developed a short film "Yes! It's Possible" that explores the role and journey of CORE Group and development partners in efforts to stop polio.

Photo: Fathers are the main decision makers in families, and are essential to ensuring timely immunization. Barbers' are an integral part of the Indian community, and can be found even in the smallest of villages. Barber shops not only provide services, but also act as important meeting places, where men participate in conversations about family life, village politics, cricket, and many other issues. They, therefore, represent an opportunity to reach large numbers of men with behavior change communication related to polio vaccination. Through the Barber Initiative, CGPP has built the capacity of barbers to impart knowledge about immunization, initiate discussions about the importance of polio immunization, and sensitize men to immunize their children during polio immunization and routine immunization campaigns.

6

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

Dr. Solomon is member of the Polio Transition Independent Monitoring Board (TIMB). CGPP India has developed a sustainable transition plan on several fronts:

- As India's frontline workers, CMCs have been trained and coached in Behavior Change Education and interpersonal skills and are equipped with Behavior Change Communication materials to encourage immunization uptake. CMCs share child tracking data with ASHAs (community based health workers) that are deployed by the MoH. Linkages with the National Health Mission will be strengthened to gradually scale down the project and transfer the work of the CMCs to ASHAs. BMCs will regularly meet with ASHAs to build their capacity. By year two, about 10% of existing CMC areas will be transitioned to ASHAs, and the number of areas will be increased in future years. This approach should maintain high levels of immunity among the target population and protect against any potential threat of importation.
- NGO staff will build on their linkages with the government health system and community leaders at the Ward and village level to ensure that children are immunized through an increase in demand and improvement in routine immunization supply services.
- Based on CGPP India's experience in West Bengal as part of the Emergency Preparedness and Response strategy to the single 2011 WPV case, CORE Group India prepared a Standard Operating Procedure (SOP) in response to any potential new case of WPV, which would be considered an emergency by WHO. CGPP will map NGOs and PVOs working in high-risk districts in the high-risk states outside of UP and educate them on the need for SOP. Rapid Response Teams (RRT) of experienced members of CGPP's UP team will be deployed to address communication challenges through training of local NGO partners and ASHAs. RRT members will work in coordination with local health officials and NPSP/UNICEF officials.

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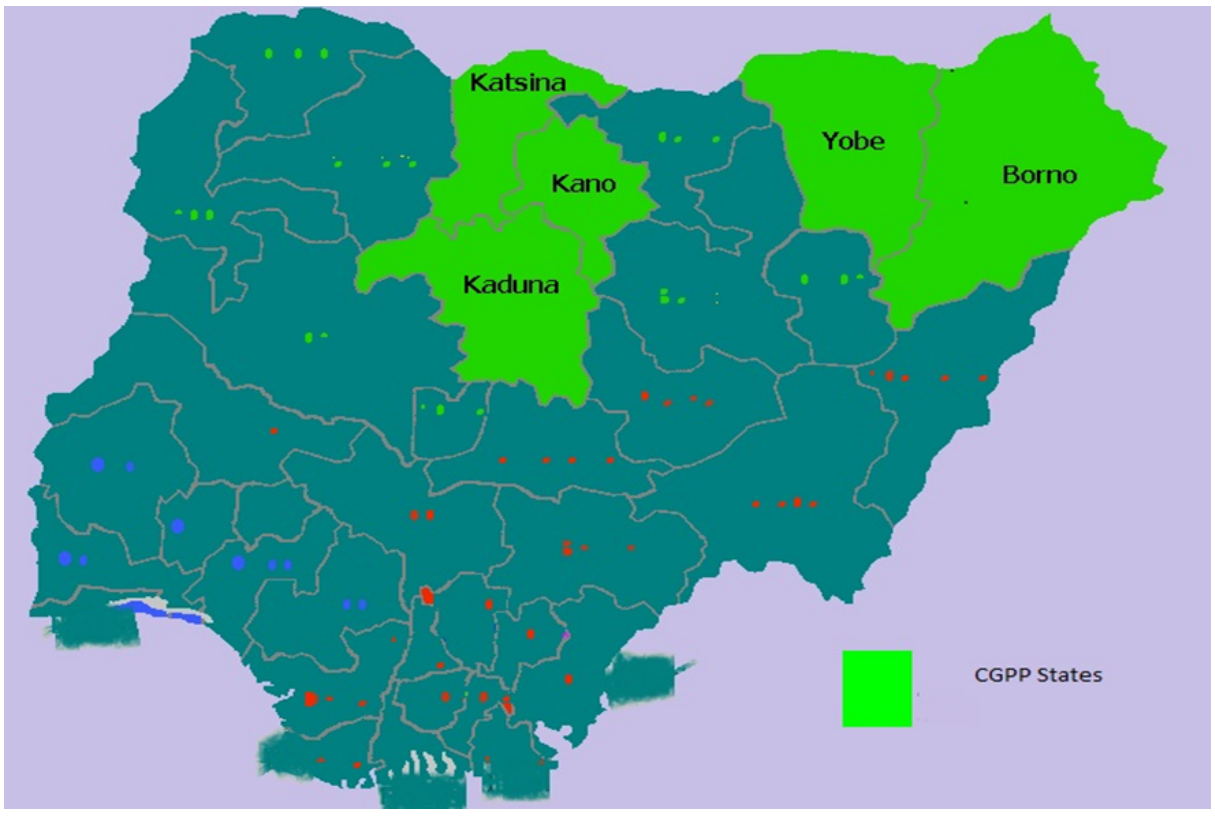
Country Report: **Nigeria**

Nigeria reported no new cases of wild polio virus in 2017 - a noteworthy success for the last endemic nation in Africa. This hard-fought battle was a significant comeback after the detection of four cases of WPV1 and two cases of cVDPV2c in July and August 2016 in security-challenged Borno state. The source of the Borno outbreak was wild polio virus circulating undetected for five years. Working in the highest-risk areas, 2,383 CORE Group Polio Project Nigeria-trained community volunteers reached nearly half a million children under five years old in FY17. Volunteers reported 281 cases of AFP through community based surveillance.

Vaccine refusal or non-compliance and poor access to vaccination in the most insecure areas of the country continued to pose a serious threat to Nigeria. CGPP Nigeria continued its work to reach unprotected, trapped children in areas impacted by the Boko Haram insurgency. At the request of the national Polio Emergency Operating Center (EOC), CGPP Nigeria will increase its coverage to severely under-immunized Sokoto state in far northwest Nigeria beginning in FY18; Sokoto's Routine Immunization rate stands at only 3 percent, the lowest in the country. In addition to continued violence and issues of inaccessibility in Borno state, CGPP Nigeria will work to dispel a new wave of anti-immunization rumors linking the Monkey Pox virus outbreak to vaccinations.



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

At the behest of the National Primary Health Care Development Agency (NPHCDA) and the EOC, CGPP targeted the very high-risk critical states of Kaduna, Katsina, Kano, Yobe, and Borno, reaching more than 500,000 children under the age of five and approximately 1.5 million children under the age of 15. In 2017, 2,132 Volunteer Community Mobilizers (VCMs) promoted campaign participation, routine immunization and AFP case detection. VCMs were directed by 216 Volunteer Ward Supervisors (VWSs) who were, in turn, supervised by 35 Local Government Area Coordinators (LGACs) positioned across the five focal states.

During FY17, the project partnered with three international NGOs: Catholic Relief Services, International Medical Corps, and Save the Children and seven local NGOs under their supervision. The seven community-based organizations were the Archdiocesan Catholic Healthcare Initiative (DACA) in Kaduna; Federation of Muslim Women Association of Nigeria (FOMWAN) and WAKA Rural Development Initiative in Yobe; Family Health and Youth Empowerment Organization and the Healthcare and Education Support Initiative (HESI) in Katsina; Community Support and Development Initiative (CSADI) in Kano, and African Healthcare Implementation and Facilitation Foundation (AHIFF) in Borno.

CGPP Nigeria participated in six regional and international forums to share knowledge and experiences and to learn from their peers in the field: the American Public Health Association (APHA) annual meeting in Denver, Colorado, October 2016; the Lake Chad Basin Technical Coordinating Task Team meeting in Abuja, Nigeria, November 2016; the Regional Immunization Technical Advisory Group (RITAG) meeting in Dakar, Senegal, December 2016; and the Expert Review Committee on Polio and Routine Immunization (ERC) meetings in January 2017 and September 2017.

The EOC selected CGPP Nigeria amongst other partners in the Nigeria PEI program to coordinate the outbreak response in the hard-to-reach Lake Chad area through the Lake Chad Technical Task Team (LCTTT). CGPP partnered with WHO, UNICEF, CDC and other leaders to work with the military to reach children living on more than 1,000 islands in the area. Additionally, CGPP and its partners supported the GPEI Out Break Response Assessment (OBRA) in July. As a result of its outstanding performance in reaching under-fives, CGPP was chosen to work in Sokoto state. CGPP Nigeria partners with the Northern Traditional Leaders Committee on Primary Health Care (NTLC) led by His Eminence the Sultan of Sokoto. The NTLC is a critical voice in refuting religious myths and misconceptions surrounding Nigeria's immunization program.

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

The progress of CGPP Nigeria was closely tied to the work of community mobilizers in promoting participation in campaigns and routine immunization. VCMs tracked pregnant mothers, newborns and defaulters by using well-developed tools and strategies. The VCMs line-listed all households within their settlement(s) and were responsible for identifying, tracking and engaging families classified as non-compliant. They listed the pregnant women and all under-five children. VCMs

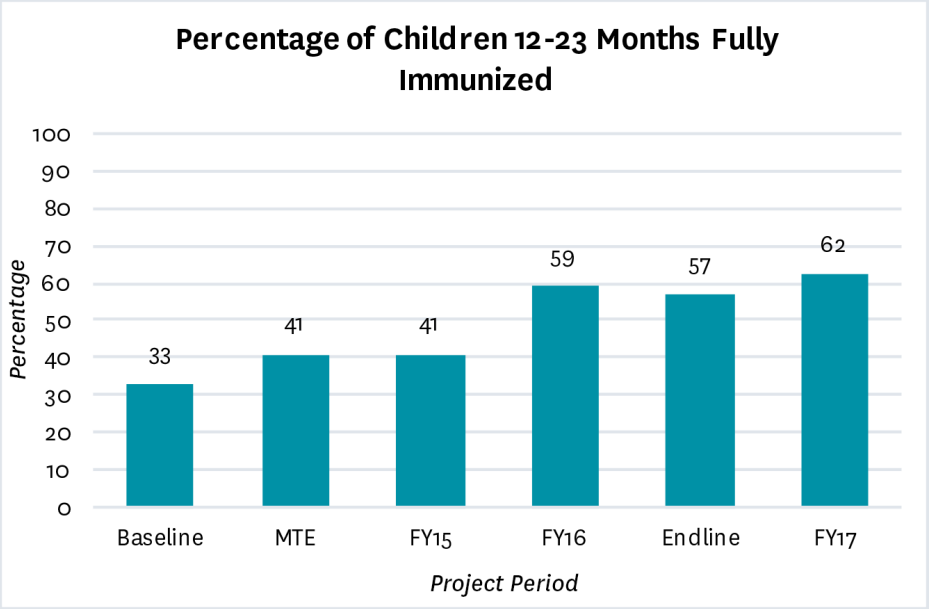
reached mothers on the 7th Day Naming Ceremony for newborns. VCMs used inter-personal communication (IPC) sessions with mothers to convey health education on vaccine preventable diseases, maternal health, hygiene and the dangers of polio disease to reduce vaccine hesitancy. VCMs were supervised by Volunteer Ward Supervisors (VWS).

Prior to IPDs, VCMs also conducted house-to-house visits to engage mothers on polio immunization. They also mobilized families for RI outreach/fixed sessions and ensured that all households were visited by the vaccination teams during the IPD or mop up sessions. These household visits were conducted with guidance and collaboration from local, religious and traditional leaders to reduce or minimize vaccine hesitancy, non-compliance or outright vaccine rejection. The total number of families covered by VCMs increased nearly 50,000 from 309,636 in FY16 to 355,197 in FY17. Additionally, the total number of children under 5 children increased from 400,157 in FY16 to 497,359 in FY17.

The percentage of children completing their Routine Immunization doses has increased due to tireless tracking of defaulters by VCMs. At baseline in 2014, 33% of children 12 to 23 months old were fully immunized. This percentage has steadily climbed to approximately 60% (according to 57% and 62% coverage found according to VCM registers and the 2017 Endline survey, respectively).

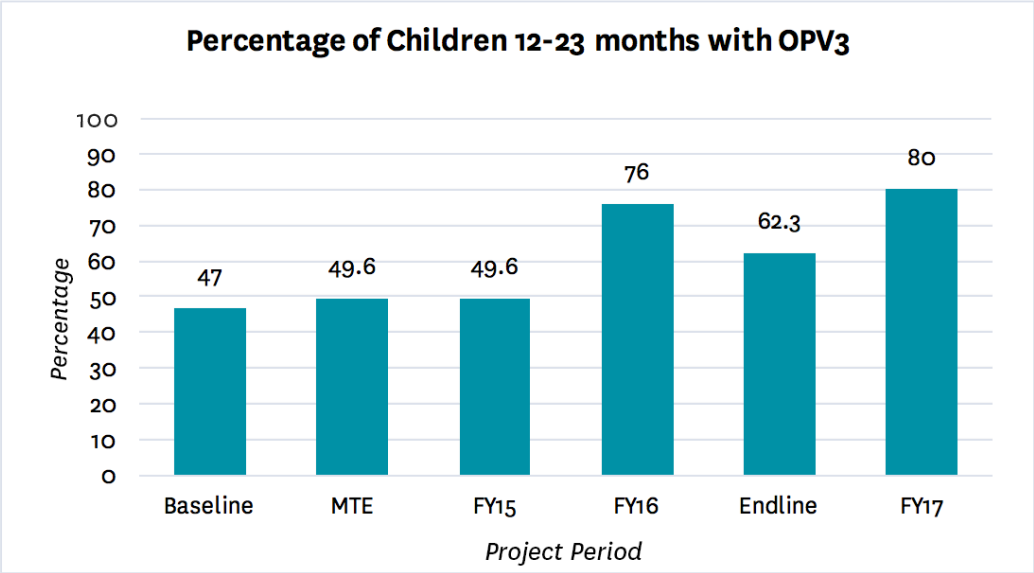
VCMs worked closely with their communities to ensure that parents understood the importance of repeated doses of polio vaccination beyond the initial birth dose. The 2017 endline survey found OPV0 or birth dose coverage of 98.6 percent; meanwhile, administrative data showed a lower birth dose rate of 92 percent in 2017, still a significant increase from 76 percent in 2016. VCMs tracked and vaccinated a total of 56,297 newborns in 2017. OPV3 rates in children 12 to 23 months increased to 62 percent in 2017 from 49 percent in 2015, according to midterm and final survey results. The percentage of children under one and older with seven or more doses of OPV dropped slightly to 93 percent in FY17 from 96.5 percent in 2016, most likely due to expansion to the hardest-hit areas in new LGAs in Katsina, Borno and Yobe states.

VCMs provided support to a frontline health worker in a facility located in Yobe,



Source: CGPP surveys, VCM Register

Health facility providers and community volunteers were trained to develop line lists of defaulters after each campaign session. VCMs were responsible for tracking and reconnecting defaulters to the health facility. Prior to SIAs, VCMs mobilized all households to promote the acceptance of immunization in CGPP catchment areas. If any child in the VCM settlement was missed due to absence, the VCM returned to the home, thus improving overall coverage rates. The breakdown by location and type of volunteer can be found below.



Distribution of VCMs, VWS and LGACs

State	# LGAs	# of VCMs	# of VWSs	# of LGACs
Borno	10	657	72	10
Yobe	10 +1FY17	780	78	10
Kano	6	320	30	9
Kaduna	2	100	10	2
Katsina	4 +1 FY17	275	26	4
Total 2,383	**32**	**2,132**	**216**	**35**

Source: VCM Line-list; Project Reports.

In addition to the involvement of religious leaders, young men have been engaged to mobilize and convince parents of the importance of Routine Immunization. The Male Peer Educators strategy was piloted in Kaduna state and has been expanded to Yobe state. This initiative trained prominent men in the community with information about the importance of vaccination. In turn, these men acted as influencers in their communities by supporting other heads of households to vaccinate their children.

CGPP Nigeria worked to improve the quality and timeliness of data collection across its five project states. As VCM registers are the critical tool of data collection in CGPP areas, CGPP trained community volunteers to provide full and accurate data on the registers and on the weekly reports of all immunized newborns and under-fives particularly at naming ceremonies.

Monitoring and evaluation efforts were strengthened in the areas of the collection, collation, analysis, interpretation and reporting of data. The Secretariat regularly visited the states to provide support to State M&E Officers and their teams.

CORE Group Nigeria collaborated with partners to provide 207 trainings (with a total of 8,465 participants) on microplanning, SIAs, AFP surveillance, social mobilization and additional strategies. All community volunteers and LGACs were trained before IPDs and on active AFP case search and Routine Immunization. Health workers at Ward and LGA levels were trained in numerous areas such as IPC and smart phone use. A total of 1,637 health staff were trained, an increase from 33 in FY16. The Secretariat designed supportive supervision checklists for LGACs and VWSs to support on-the-job mentorship; the results of this effort have yet to be measured. Renewed emphasis will be focused on Supportive Supervision and on-the-job mentoring of field staff to enhance accountability; staff who meet expectations will be rewarded while others will be sanctioned for any poor performance.

CGPP Trainings conducted across CGPP focal states in FY17

Type of Training	Number of Participants	Cadres (Persons trained)
Pre-IPDs trainings at State/LGA/Ward levels	2376	VCM/VWS/LGAC
AFP active case search (Surveillance) training	235	VWS/LGAC
Routine Immunization training	341	VWS/LGAC/RI Monitors, PHCCs, LIOs, CCOs, SMFPs, SFPs, LGACs
M & E training on RI	82	VCM/VWS/LGAC
BCC tools Training	48	VCM/VWS/LGAC
Social Mobilization training	31	VCM/VWS/LGAC
M & E	127	VCM/VWS/LGAC
Surveillance Training (for CI)	367	Community Informants
Health Management Information System (HMIS)	138	R.I Service Providers, Recorders and Clinic In-Charges from host communities
M&E Smart phone refresher training	278	VWSs, LGACs and M&Eos
Polio plus training (ICCM, WASH, CMAM, IMCI)	173	MCH, CMAM FPS and OTP in-charges
PEI (Micro planning, SM and M&E) training	50	SMCs, VWSs, and M&Es
Refresher training on the VCM register for VCMs	2348	VCMs and VWS
AFP surveillance training for DSNOs	52	DSNOs, LGACs, CGPP RI and Surveillance focal persons
RI training of PHCC, LIOs and CCO	132	PHCCs, LIOs, CCOs, SMFPs, SFPs, LGACs
Training on IPC skills	275	VCM and VWS
Peer Education training on RI, IPC and demand creation	114	VCM, VWS, LGAC, M&EO and STL
Maternal and Child Health Training	1130	VCM, VWS, LGAC, M&EO and STL
Training on Measles-Rubella for NSTOP supported LGAs	4	LGAC (2), M&E and STL
DHIS training	4	LGAC (2), M&E and STL
Grand total	**8,305**	

Source: CGPP Training Reports; CGPP Training Database

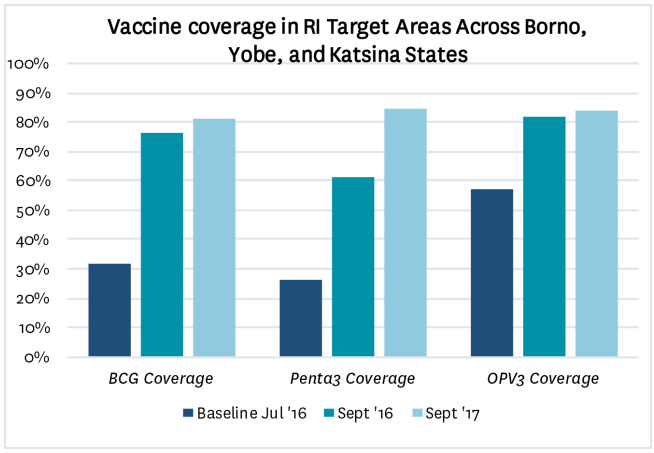
HEALTH SYSTEMS STRENGTHENING

Routine Immunization Services in Borno, Yobe and Katsina states

USAID's Nigeria Mission provided separate funding to improve Routine Immunization services through five health facilities within IDP camps in Borno state; 11 facilities bordering Nigeria and Niger Republic in three LGAs of Yunusari, Yusufari and Machina of Yobe state; as well as 20 health facilities within two LGAs in Katsina state. Implementing partners CRS in Yobe, IMC in Borno and Save the Children in Katsina conducted RI activities from December 2015 to September 2017.

The project recorded 84% coverage for Penta3 and 84.2% for OPV3 in the three target states at endline in 2017, compared to 26% and 57% recorded at baseline in 2013; these figures are significantly higher than the national RI coverage of 33% for both OPV3 and Penta3 (NICS/MICS, 2016). Regionally, RI coverage was 28% for Penta3 in the northeast and 14% for Penta3 in the northwest (NICS/MICS, 2016). Additionally, BCG coverage climbed from 32% at project baseline to 81% at project endline.

Baseline results showed RI card retention rate of 19%. In response, CGPP introduced and distributed an RI card holder for mothers and caregivers in the target areas. At endline, the RI card retention rate increased to 31%, an improvement over the 29% national rate (NICS/MICS, 2017).



CGPP VCMs supported a mother to immunize her child with a RI antigen during a compound meeting in Katsina LGA in Katsina state.

These achievements were credited to frontline workers responsible for mobilizing caregivers of eligible children, tracking and referring defaulters to RI facilities and ensuring consistent engagement of mothers and caregivers at the community level to build trust and sustain demand for immunization services, as well as AFP surveillance, WASH activities and nutrition.

A full report of these activities may be found in Appendix A. Information for this report was collected from the three implementing partners and edited by CGPP Nigeria Secretariat Director Dr. Samuel Usman.

Yobe Cross-Border Work

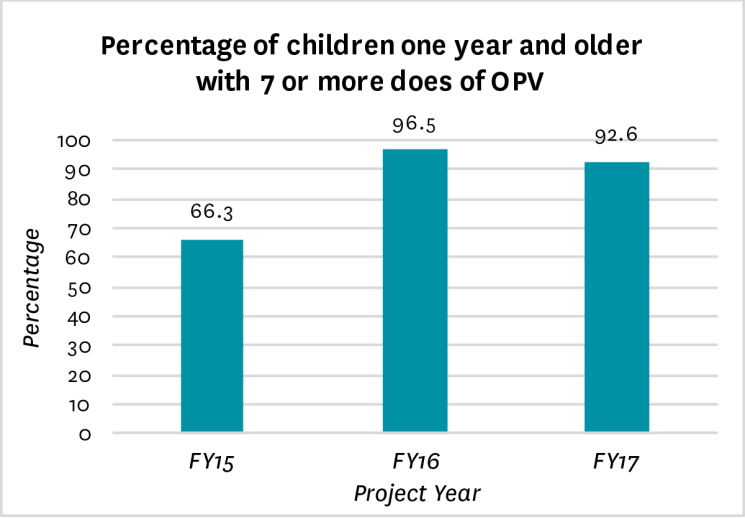
In the last quarter of FY17, CGPP began a cross-border intervention in Toshia and Sumbar settlements in Yunusari and Yusufari LGAs in Yobe state. The goal of the program was to create

demand for immunization services across international border communities, to increase herd immunity against WPV and to improve the nutritional status of children with a food supplement provided to mothers with children 6 to 59 months with Moderate Acute Malnutrition (MAM) and to mothers with children under 6 months to improve their breast milk. In the Toshia community, 248 children were enrolled in the community nutrition program: 40 were found to have Severe Acute Malnutrition (SAM) and were referred to the nearest health facility and 208 children were diagnosed with MAM. In the Sumbar community, 137 children were enrolled in the nutrition program: 49 were diagnosed with SAM and 88 with MAM. Of the children under one, 52 were immunized in Toshia and 65 in Sumbar. The nutrition program will be expanded in FY18 through a partnership with CRS-Niger that is leveraging other resources for financial support.

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

The detection of four cases of WPV1 and two cases of cVDPV2 set back Nigeria's timeline to reach polio-free status. The national polio EOC responded with an aggressive OBR plan to stop the transmission of WPV and the circulating virus. CGPP Nigeria and partners engaged in intensive microplanning, household enumeration, cold chain and vaccine logistical planning, social mobilization and behavior change communication to support IBR activities. CGPP Nigeria mobilized all its partners to support the OBR to immunize more than six million children under five years, 91.9%, including returned IDPS in Borno and Yobe states. These efforts to vaccinate every child during campaigns resulted in a dramatic downtick of "zero" dose children (those who had never been vaccinated) from 5.3% at the end of FY16 to 1.6% at the end of FY17.

CGPP Nigeria worked in areas that are strongholds of opposition to the oral polio vaccine. Non-compliant households were a major challenge in the most critical CGPP states. A recent outbreak of Monkey Pox virus further undermined the project's efforts to vaccinate children, with widespread vaccine refusals in numerous CGPP settlements. To address the most recent rumors that community volunteers were vaccinating children with Monkey Pox, NTLC countered with media messages to reinforce the importance of vaccinations. Community influencers such as religious leaders, community leaders, elders, decision makers, youth and women leaders were engaged to dispel rumors and myths.



The percentage of children missed in 2017 SIAs in CGPP target areas dropped to 1.5 percent, a significant drop from 4.46 percent in 2014. Persistent contact and house to house vaccination efforts by VCMs led to a significant drop in the percentage of missed houses in each SIA from 2.4% in FY15 to .07% in FY17. Katsina state remained stubbornly positioned at the top of the list for missed children; impactful compound meetings and community dialogues have been captured on video to encourage caregivers to accept immunization.

Average Missed Children during SIAS per State in CGPP target areas

	September 2014 (%)	September 2015 (%)	September 2016 (%)	September 2017 (%)
Borno	5.5	2	1.4	0.15
Kaduna	7	2.5	0.9	0.3
Katsina	5	3	3.7	5.4
Yobe	4.8	3.4	1.4	1.7
Kano	0	3.7	2.1	0.02
Average	**4.46**	**2.92**	**1.9**	**1.5**

Source: NEOC Lot Quality Assurance Sampling Data (LQAS)

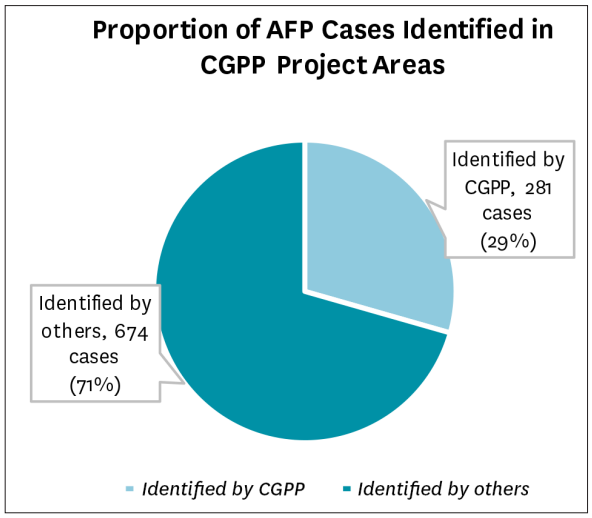
To resolve cases of non-compliance, regardless of the reason provided by the family, each household was revisited during the same day of the campaign and LGACs were deployed to intervene. Cases of refusals were revisited between rounds as well. A compound meeting or community dialogue was conducted to resolve cases of non-compliance. CGPP introduced a new strategy named Iftar to engage fathers, who are the heads of households in CGPP focal areas, during the Ramadan period. To encourage the acceptance of vaccination, CORE Group was reaching men at community mosques when Muslim men congregate for dusk prayer. Before the meetings, a list line of all non-compliant households was comprised. Following these meetings, 90% of the Non-compliance cases, or a total of 905 children, were immediately immunized.

There were still silent portions of some LGAs with significant security related access restrictions including inaccessible areas in Borno and Lake Chad Basin. Two LGAs, Abadam and Marte, were completely inaccessible due to the presence of Boko Haram. In FY17, CGPP added two LGAs in Katsina and Yobe states. Furthermore, the national EOC has requested that CGPP increase its work to six states from five states to include Sokoto, which has the lowest RI coverage of 3 percent, according to the 2016 NICS/MICS survey. Military personnel will continue to be used to reach inaccessible children in hard to reach areas.

To improve access and equity, CGPP and partners were implementing the IMB-developed Resilience Strategy, which is a set of activities that minimize the risk of a resumption of transmission through maintaining constant vigilance for weakness and vulnerability in the polio eradication system.

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

To support community based surveillance, CGPP-trained Community Informants (CIs) assisted VCMs to identify and report suspected AFP cases within their settlements. CIs included Traditional Birth Attendants (TBAs), Patent Medicine Vendors (PMVs), bone setters and herbalists. VWS received reports of suspect AFP cases and referred them to the CGPP LGA Coordinator. In turn, the LGA Disease Surveillance Notification Officer (DSNO) began a case investigation.



CGPP VCMs and CIs played a key role in AFP surveillance. In FY17, there were 674 AFP cases reported across CGPP focal LGAs. Of these, 281 cases were reported by CGPP VCMs/CIs. The Non-Polio AFP rate in 2017 was 19.6, a slight increase from 19.5 in 2016 and 15.7 in 2015. The reported stool adequacy rate was 98%, which has remained consistent since the program began. The only silent areas in Nigeria are two inaccessible LGAs in Borno state.

In addition to training of CGPP volunteers and staff, CGPP and partners trained health workers in health facilities on AFP case definition, detection and the reporting system.

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

CGPP Nigeria hired a consultant to conduct the endline program evaluation of the first four years of the project. A 30-cluster KAP survey was administered to mothers/caregivers. Data on the knowledge, practices, and immunization coverage were collected. This data was compared to the baseline survey in 2014 and the midterm assessment in 2015 to understand program impact. Additionally, qualitative data was collected through interviews and focus groups from community members, VCMs, religious leaders, and CGPP staff. This data will be used to inform and adjust future activities.

QUOTES FROM THE FIELD:

> *I am so happy with the kind of support I get from Mama Asabe. I thank God for making her VCM in my ward. Whenever there is noncompliance, Mama Asabe will go and resolve it no matter how stubborn the parents are. She has a way with parents.*

- Ward Focal Person, Igabi LGA, Kaduna state

From now on, no immunization will be missed in this house. I didn't know immunization has benefits. I just thought government is forcing it on us.

- Former Non-Compliant Mother, Yobe State

Before CGPP intervention in our communities, we were battling with pregnancy related deaths and our children suffering from different afflictions.

- Community Leader, Funtua LGA Katsina

The 2017 survey showed increased knowledge about the polio vaccine across states; 86 percent of households understood when a newborn required his or her first oral polio dose, compared to 68 percent reported during the 2015 midterm survey. The final survey showed a 31 percent vaccination card retention rate, compared to the 19 percent survey results in 2014 and compared the current national rate of 29 percent. Furthermore, survey results showed improved relationships of caregivers with CGPP community volunteers at 72 percent in 2017 over 54 percent at 2014, and caregivers with health workers, 24.4 percent at baseline compared to 29 percent at endline.

In FY17, CGPP Nigeria supported a Peer Review Assessment in Jigawa, Sokoto, Kebbi and Nasarawa states. Results of the review were developed into an abstract and paper submitted to a peer-review journal for publication. Additionally, an abstract entitled ***"Improving Access to Quality Care through Utilizing Community Based Strategies and Resources"*** was accepted for publication and presentation at the Acting on The Call: Overcoming Critical Barriers to Maternal and Child Survival conference in Addis Ababa, Ethiopia. The paper highlighted the success stories of CGPP Nigeria's model of implementing BCC and CM. In addition to the Ethiopia conference, staff from CGPP Nigeria attended six other international and regional conferences.

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

CGPP is aligned with the Nigeria Polio Legacy plan to transition the polio infrastructure to support Primary Health Care services. CGPP Nigeria has mapped and estimated the cost of its resources. A new cadre of community workers, called CHIPS for Community Health Influencer, Promoters and Services, will work at the community-level to improve access to healthcare as part of the Government of Nigeria's effort to improve access to care and the revitalization of 10,000 primary health care centers. The CHIPS workers will work to influence, promote and offer front-line treatment of common diseases and support community-based primary health care. All VCMs, TBAs, and other community-level workers will be included under the umbrella of CHIPs, including UNICEF-recruited VCMs. The ultimate goal is to recruit 200,000 CHIPS workers across the country under the direction of six criteria to work with traditional, community and religious institutions.

Country Report:
South Sudan

The civil war in South Sudan has created Africa's largest refugee crisis; driving more than two million people into neighboring countries and forcing more than 1.8 million internal refugees to flee their homes. Hundreds of thousands of children lack access to health services and vaccination campaigns due to the impact of widespread fighting. Despite these challenges, CORE Group South Sudan conducted national independent campaign monitoring (ICM) for four polio campaigns and targeting approximately 2.6 million children under the age of five.

Three cases of circulating vaccine-derived polio virus (cVDPV2) in 2014 and 2015 exposed South Sudan's high vulnerability to another polio outbreak. The government health infrastructure has continued to remain weak and reliant on assistance from NGOs and UN agencies to provide basic services, including routine immunization.

CORE Group Polio Project has worked in South Sudan since 2010. In FY17, the Bill and Melinda Gates Foundation funded community based surveillance in 34 counties in three states; UNICEF funded social mobilization activities through community mobilizers and USAID funds were used to conduct independent campaign monitoring in the entire country.

At the request of the national EPI Technical Working Group (EPI TWG) CGPP began conducting post-campaign evaluations in 2014. In FY17, CORE Group identified, trained and deployed more than 550 data collectors who assessed the quality of the country's four annual SIAs. These efforts resulted in a more reliable and accurate picture of campaign coverage. More specifically, data collected by monitors contributed to developing and planning campaigns that resulted in increased numbers of children who received oral polio vaccine for the first time.

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

CGPP South Sudan has built strong relationships with a broad range of partners and stakeholders. CORE Group continued to work closely with the MoH, WHO, UNICEF, JSI and CDC-Afenet as a member of the national EPI TWG. This working group met weekly and deliberated on technical matters regarding all EPI activities in South Sudan, including evaluation of monthly performance, plan development for NIDs and follow up on policy issues. Through this working group, CGPP represented the voice of CSOs and their contributions to polio eradication efforts.

CGPP South Sudan is an active member of the national ICC and participated in all quarterly meetings. The South Sudan Secretariat in addition attended the 16th Horn of Africa Technical Advisory Group (HoA TAG) working group meeting from May 10-12, 2017 in Nairobi at which CORE Group Polio Project Secretariats from South Sudan, Ethiopia and Kenya/Somalia provided an update on its cross-border work and were recognized for their important contribution to global polio eradication efforts in the Horn of Africa, including community surveillance, cross-border activities and independent campaign monitoring.

Additionally, CORE Group South Sudan convened and chaired monthly partners meetings to discuss lessons learned and to review progress or challenges during field implementation. Topics ranged from standard operating procedures for quality improvement to vaccine shortages. Outcomes of the meetings were recorded and immediately shared with partners to improve accountability and ensure more timely response to pressing issues.

The South Sudan Secretariat is hosted by World Vision and works through three local NGOs - Bio Aid, Universal Network for Empowerment Agency (UNKEA) and Support for Peace and Educational Development Program (SPEDP to conduct community-based AFP surveillance in three conflict-affected states and one southern state.

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

South Sudan has a very weak health system with little support from the government. The country has depended on outside help to provide basic health services including routine immunization services. In the reporting year, South Sudan conducted three national and one sub-national immunization campaign (NIDs and SNIDs) in November and December 2016 and in February and

March 2017. The national campaigns targeted 3.5 million children under five through house-to-house vaccination.

County health departments selected volunteer vaccinators to conduct vaccinations. EPI supervisors and WHO field assistants provided one-day training to the volunteers, equipped them with vaccine carriers and other supplies, and deployed them to the field. UNICEF provided a series of social mobilization activities prior to the campaigns. Each of the CGPP partner NGOs provided transportation, training, social mobilization, supervision and planning support for the annual NIDs and SNIDs.

Geographic Coverage by County of ICM			
Rounds	# of Counties Campaign Implemented	# of counties ICM implemented	% coverage of ICM
Nov 2016	69	38	60
Dec 2016	51	30	59
Feb 2017	67	53	79
March 2017	42	26	62

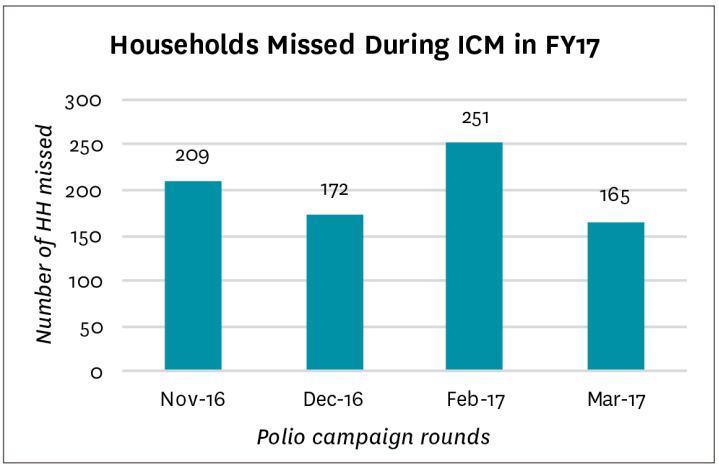
Considering South Sudan's low routine immunization coverage, maintaining high quality coverage through these immunization campaigns is critical to preventing re-importation of the wild polio virus. Independent campaign monitoring, therefore, provides a measurement of vaccination coverage and the proportion of missed children in high-risk settlements. Specifically, CGPP seeks to obtain reliable data on missed children to help guide mobilization and programming, assess the quality of NIDs/SNIDs (including coverage, awareness on SIAs, reasons for missed children and reasons for zero dose children), and to guide immediate mop-up campaigns for poorly covered areas (<10% missed children).

The campaign monitoring process is conducted and supervised by independent monitors and interviewers. The monitors are not part of the polio implementation team or part of the health system. Sources of monitors include teachers, NGO/UN staff, and university students. They are responsible for collecting the data during (in –process) and after the NIDs (end-process). For each round, the Independent Monitors are trained for one full day by the State teams (Ministry of Health and Partners) on data collection procedures.

CGPP South Sudan recruited, trained and deployed a total of 18 central supervisors in each state to identify, train and manage 550 data collectors to conduct ICM. Supervisors provided transportation to the field, ensured that collectors were compensated with incentives and submitted forms to Juba for entry and analysis. Independent campaign monitoring data was used to review vaccinator success and problems during review meetings at the end of each day's work and evaluated the percentage of children missed at the end of each campaign. Full independent monitoring results were available 14 days following campaign completion. CORE Group South Sudan conducted post-campaign evaluation in more than 50% of counties where campaigns were implemented.

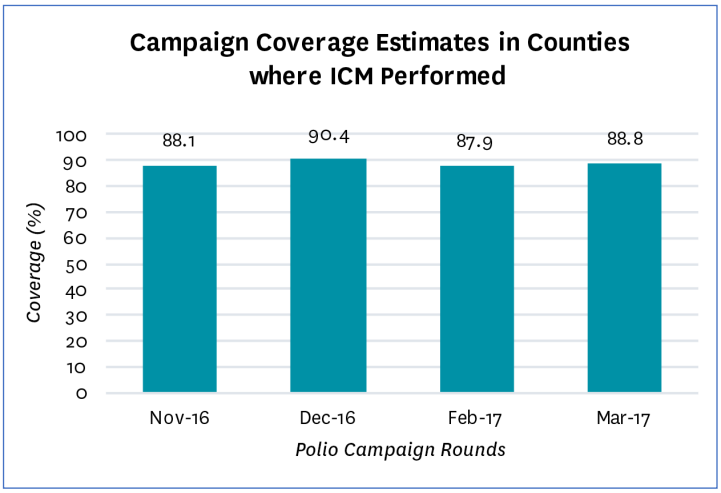
CGPP ICM data collection follows procedures and guidelines from WHO which dictate a convenience sampling methodology without specific random sampling. Which is to say that the results are not statistically valid but they are very helpful in identifying areas of concern and the methodology ensures limited convenience sampling in every county so that no counties are missed. The areas

identified for ICM were selected by WHO IFP/NFP in consultation with County/Field Supervisors. High risk areas are prioritized, including border areas, or areas that have been known to have been missed in the past. For larger areas (200 houses or more), sub-areas were identified, and selected randomly, to avoid only monitoring the town center. ICM utilizes a cross-sectional study design with cluster sampling to select payams/bomas. Four accessible payams per county are selected (with the exception of Juba with 6 selected payams), and 4 accessible clusters per payam are chosen. A total of 10 households in each cluster are then selected. The first household is randomly selected, and each household after is systematically selected using a selection paradigm. When a household is selected, all eligible children present at the time of the survey are included. The monitor then checks for finger markings, indicating vaccination during the campaign.



During the November 2016 campaign, monitors reached 4,650 households in seven states and missed 209 (4.5%) households; in December 2016, monitors surveyed 4,880 households in seven states and missed 172 (3.5%) households; in February 2017, monitors reached 8,180 households in all 10 states and missed 251 (3.1%); and in March 2017, campaign monitors surveyed 3,590 households and missed 165 (4.6%). Once the security situation in the country improves, the use of mobile phone technology could be re-introduced to improve data collection and transmission.

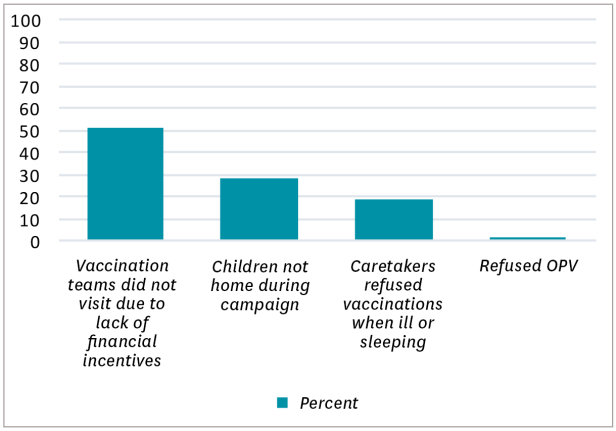
Based on CGPP Independent Campaign Monitoring data, most project counties did not meet the 90% benchmark or pass rating for campaign quality. During the November 2016 campaign, 24 counties met the 90% benchmark, while 14 counties failed to meet this benchmark. During the December 2016 campaign, 18 counties met or exceeded the benchmark, while 12 counties failed to do so. During the 2017 campaigns, in February, 29 counties met or exceeded the 90% benchmark, while 24 counties failed to meet the benchmark; in March, 13 counties met the pass rate, while 13 did not reach the benchmark. Overall, three of the four campaigns did not meet the 90% benchmark for coverage. Only the sub-national campaign in December 2016 exceeded the threshold at 90.4%.



Independent monitors cited the following reasons for missed children: vaccination teams not visiting the house holds due to lack of financial incentives (51%); children not at home during the visit due to traveling or lack of notice of the campaign (28%), and caregiver of vaccinations when

children were ill or when newborns were sleeping (19%). Issues of vaccine stock and insecurity were also mentioned. CGPP South Sudan will continue to provide useful data on "missed children" during each campaign to improve campaign results.

Main Reasons for Missed Children in South Sudan (FY17 Campaigns)



UNICEF supports the social mobilization and communication component of the various polio supplementary immunization activities in South Sudan. This is normally done through training and deployment of social mobilizers to the communities in the various parts of the country to inform the caretakers about the dates, campaign strategies, type of antigen to be used, importance of the oral polio vaccines to their children for any upcoming polio campaigns. The ICM conducted in all the four rounds revealed that, except for the December round, social mobilization coverage did not reach the target of 90%. This low social mobilization coverage had generally resulted into low vaccination coverage in the same rounds.

Campaign Month	Percent of Zero Dose Children	Social Mobilization Coverage
Nov 2016	4.2%	87.4%
Dec 2016	3.7%	95.2%
Feb 2017	7.1%	88.0%
Mar 2017	5.5%	86.0%

ICM data indicated strong gains in the numbers of children who received the oral polio vaccine for the first time. During the February 2017 campaign, independent campaign monitoring activities were expanded to cover the entire 10 states of South Sudan, including three conflict-affected states that were previously unreachable. ICM results indicated that vaccinators reached the highest number of zero-doze children in the three high-risk areas without functional health facilities.

SPECIAL VACCINATION POSTS

The South Sudan Secretariat continued to build close relationships with WHO, UNICEF and the MoH to lead cross-border collaboration efforts with Uganda, Kenya, Ethiopia and DR Congo. CGPP South Sudan organized and conducted meetings with neighboring countries to establish Special Vaccination Posts (SVPs) at heavily travelled cross-border sites. The meetings were held to strengthen collaboration and coordination among countries at the subnational level and to share information on immunization, surveillance and social mobilization to mitigate cross border transmission of the wild polio virus and to respond quickly in case of any outbreak.

On December 16, 2016, CGPP in partnership with SPEDP, the local government of Koboko in Uganda, and DR Congo Health Department organized a cross border meeting in Arua district in Uganda. Thirty-three participants from South Sudan, DR Congo and Uganda discussed routine immunization, surveillance and social mobilization efforts. In response to the influx of South Sudanese refugees into Uganda and DR Congo, meeting participants proposed that the cross-border vaccination posts be extended to include all crossing points and districts in Uganda through mapping of key informal routes and settlements.

CGPP established eleven Special Vaccination Posts at the following cross-border sites: Mingkaman,

Kirynumbo, Attit, Kuda, Nadapal, Mogos and Joda Junub, Nimule, Panjala, Biemkat, and Buribie. Mogos, Nadapal and Buribie SVPs were not operational due to lack of cold chain facilities and vaccine stock outs.

During the reporting year, vaccinators reached 39,770 children under 15 years old with one dose of oral polio vaccine at SVPs. Of the children vaccinated, 11.6 % were zero dose - above the acceptable level of zero dose children of 10%. Most of these children were not immunized previously due to either destruction of health facilities or were noted to be members of nomadic families.

In South Sudan, UNICEF trained social mobilizers to inform caretakers of the dates of upcoming campaigns, antigens to be used and the importance of oral polio vaccines. ICM results indicated insufficient social mobilization coverage rates that consequently impacted vaccination coverage rates; ICM data showed that only one round of social mobilization activities reached the 90% threshold.

Children under 15 vaccinated at SVPs from October 2016-September 2017

Vaccination Status	Male	Female	TOTAL
Vaccinated before	17,740	17,427	35,167
Vaccinated for the first time (Zero dose)	2,297	2,306	4,603
TOTAL	**20,037**	**19,733**	**39,770**

Source: CGPP SVP monthly reports

Training participants learn about the cold chain at the Juba teaching hospital.

From September 11-14, 2017, the CGPP Secretariat, UNICEF and MoH conducted a training based on the Immunization in Practice Manual for South Sudan for 45 participants from CGPP field locations in Jonglei, Upper Nile and Eastern Equatoria states.

3

Support PVO/NGO efforts to strengthen acute flaccid paralysis detection

In addition to campaign monitoring and cross-border work, CGPP South Sudan received financial support from BMGF to conduct community-based AFP surveillance in three conflict-affected states and one southern state. During the reporting period, CGPP South Sudan partnered with three national organizations: Bio Aid, Universal Network for Empowerment Agency (UNKEA) and Support for Peace and Educational Development Program (SPEDP).

SURVEILLANCE INDICATORS PERFORMANCE

During FY17, all states achieved the national target of non-polio AFP rate equal or more than 2 per 100,000 children under the age of 15 years old. Stool samples arrived at the national laboratory in Juba and were validated within 14 days of case detection, reaching 96% and 90% adequacy in Jonglei and Kapoeta East respectively. Stool adequacy did not reach targets in Unity and Upper Nile counties, where challenges with violence, fighting, and cold chain remain.

States	Population <15	Stool Adequacy	NPAFP Rate
Jonglei	982,693	96%	3.53
Unity	864,152	72%	3.86
Upper Nile	895,541	42%	2.38
Kapoeta East	109,709	90%	4.6

Source: WHO South Sudan weekly updates 2016

NUMBER OF AFP CASES FROM OCTOBER 2016-SEPTEMBER 2017

A total of 233 suspected AFP cases were reported through the community based surveillance network and line listed during this reporting period. All 100% of these suspected cases were investigated by either a county supervisor or WHO filed supervisor. Of these, 82** (35.2%) were found to be true AFP cases, had stool samples collected and were reported in WHO weekly surveillance data; **90.7%** of these validated AFP cases from the CGPP project areas were reported through CGPP's community based surveillance. This demonstrates the sensitivity of community-based surveillance and the critical importance of CBS due to wide-spread destruction of health facilities across the country.

Quarter	Number of suspected/ investigated AFP cases	Excluded cases as not AFP	AFP cases validated by WHO with stool samples collected
Oct-Dec 16	24	8	16
Jan-Mar 17	71	51	20
April-June 17	61	42	19
July -Sep 17	77	50	27
Total	**233**	**151**	**82****

Source: CGPP CBS Surveillance line-list 2016-2017

** Of the total AFP cases referred to WHO field supervisors for validation, 82 cases were found to be true AFP cases with stool samples collected and sent to Juba for further laboratory analysis. However, WHO recorded four stool samples from AFP cases from Nyirol in February 2017 as community samples and, therefore, were not included in the weekly surveillance due to inadequate information on the initial reporting form. This decreased the total number to 78 AFP cases reported by WHO.

REDUCTION IN THE NUMBER OF SILENT COUNTIES

CORE Group South Sudan reported suspected AFP cases in 30 of 34 (88.2%) counties during the reporting period. Four counties remained silent due to repeated conflict in areas of Panyikang in Upper Nile, and Koch, Panyijar and Leer in Unity.

Partner	Number of counties	# of counties that reported suspected AFP cases
UNKEA	7	7
SPEDP	11	11
Bio AID	16	12
Total	**34**	30

Source: CGPP Reports 2016-2017

Per week 52, WHO cited that 4 of 34 counties did not report any true AFP cases. Though true AFP cases were reported from Nyirol in 2017, these cases were submitted as community samples and not reflected in the WHO weekly surveillance report due to a lack of information on the initial reporting form. Another true AFP case was also reported in Piggi county in September 2017 but the samples were not submitted due to lack of cold chain facilities. Thus, further decreasing the number of silent counties to 2 of 34 counties supported by the project during the reporting period.

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

CGPP South Sudan participated in an external evaluation in August 2017 to document CGPP's contributions in Independent Campaign Monitoring, Cross Border Work, and Community Based Surveillance. The evaluation team reviewed key documents and reports (for quantitative and qualitative data) and conducted interviews and focus group discussions. Consultants conducted interviews in six randomly selected counties with county health officers, county supervisors, payam assistants and community informants. Evaluators also interviewed officials with UNICEF, WHO, MoH and BMGF staff in Juba. The findings from this evaluation will be used to inform and adjust future activities lead by the MoH and WHO.

South Sudan's CORE Group Polio Project Pibor County Supervisor Koma Samuel of Bio Aid investigated a case of Acute Flaccid Paralysis (AFP) in Moloktoch village in hard-to-reach and conflict-affected Pibor County in August 2017.

KEY FINDINGS FROM THE EVALUATION:

- ICM data collectors were well trained and collected accurate, complete information. ICM data collected by CGPP is reliable and relied upon for planning and targeting social mobilization campaigns by the MoH and WHO in South Sudan.
- Cross-border meetings facilitated by South Sudan enabled more children to be vaccinated and have made significant contributions to building relationships with neighboring state health systems, thus directly reducing the risk of polio cases being imported from neighboring states.
- The delivery of polio vaccination was impeded by the vastness of the area, limited time to complete the campaign and a lack of social mobilization.
- The evaluators recommended that CGPP ensure that ICM data be widely shared and that feedback on the ICM reports and data be solicited by stakeholders and consumers of the data. They also recommended a focus on strong supervision and reporting within the ICM system.

CGPP will continue to ensure the surveillance system remains timely, efficient, and accurate and that the data from ICM is shared with decision makers and key stakeholders quickly and frequently. CGPP will also to work closely with neighboring countries on cross-border activities, and with WHO and MoH to harmonize field plans, understand challenges, and ensure close working relationships.

5

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

In support of the 66th World Health Assembly's Polio Endgame Strategic Plan 2013-2018, CGPP South Sudan made several important steps towards documenting and transitioning knowledge, lessons learned, and assets/infrastructure to address other health goals and priorities.

- CGPP South Sudan participated in a polio simulations workshop organized by UNICEF and the government of Ethiopia from April 9-14, 2017 in Addis Ababa. South Sudan's CGPP Polio Project Manager Dr. Samuel Rumbe, WHO, UNICEF and staff from the South Sudan MoH worked with participants from Sudan, Angola, Ethiopia, Nigeria and Somalia to develop a polio transition plan for Ethiopia.
- As a follow up to the April workshop, CGPP South Sudan participated in a polio simulation workshop on May 29 and May 30, 2017 and explored the upcoming funding ramp down and its impact on public health in Sudan. Participants at the UNICEF-sponsored workshop identified critical risks to the future loss of polio funding.

CCPP South Sudan has mapped its assets, including human resources, vehicles and computers to determine which assets can be transferred to support other government functions. As a member of the technical committee for the Polio Transition Plan, CORE Group participated in preparing technical documents to identify the twelve best practices from South Sudan. CORE Group identified several strategies including community-based structures to strengthen community surveillance for Acute Flaccid Paralysis (AFP) surveillance, international and national vaccination and transit vaccination posts and monitoring the quality of polio campaigns through nationwide post-campaign independent monitoring.

Appendix A:
Annual RI Report: FY17
CGPP Nigeria RI Programme

Acronyms

AFP	Acute Flaccid Paralysis
BCC	Behavior Change Communication
CGPP	Core Group Partners Project
CRS	Catholic Relief Services
EIM	End-process Inside Monitoring
EOC	State Emergency Operations Centre
GON	Government of Nigeria
H2H	House-to-House
HTR	Hard To Reach
iCCM	Integrated Community Case Management
IEC	Information Education and Communication
IMC	International Medical Corps
IMCI	Integrated Management of Childhood Illnesses
IPC	Inter-Personal Communication
IPDs	Immunization plus Days
IPV	Inactivated Polio Vaccine
LGA	Local Government Area
LGAC	Local Government Area Coordinator
LIO	Local Immunization Officer
MEAL	Monitoring, Evaluation, Accountability and Learning
MICS-NICS	Multi-Indicator Cluster-Nigeria Immunization Coverage Survey
M&E	Monitoring and Evaluation
MEO	Monitoring and Evaluation Officer
MOH	Ministry of Health
MMC	Maiduguri Metropolitan Council
MST	Management Support Team
NC	Non-Compliance
NGO	Non-governmental organization
NEOC	Polio Emergency Operation Centre
NPEEP	Nigeria Polio Eradication Emergency Plan
NSTOP	National Stop Transmission of Polio (CDC consultant)
NPCDA	National Primary Care Development Agency
OPV	Oral Polio Vaccine
PEI	Polio Eradication Initiative
PHC	Primary HealthCare

IMC	Public Health Services and Solutions
PM	Project Manager
PEI	Polio Eradication Initiative
RI	Routine Immunization
RIO	Routine Immunization Officer
RIWG	Routine Immunization Working Group
SD	Secretariat Director
SIAs	Supplementary Immunization Activities
SMoH	State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
SPHCMB	State Primary Health Care Management Board
SCI	Save the Children
UNICEF	United Nations Children's Fund
VCM	Volunteer Community Mobilizer
VPD	Vaccine Preventable Diseases
VWS	Volunteer Ward Supervisor
VVHR	Very, Very High Risk
WASH	Water, Sanitation and Hygiene
WFP	LGA Ward Focal Person
WHO	World Health Organization
WPV	Wild Polio Virus

Introduction, State Background, and Summary of Key Achievements and Challenges

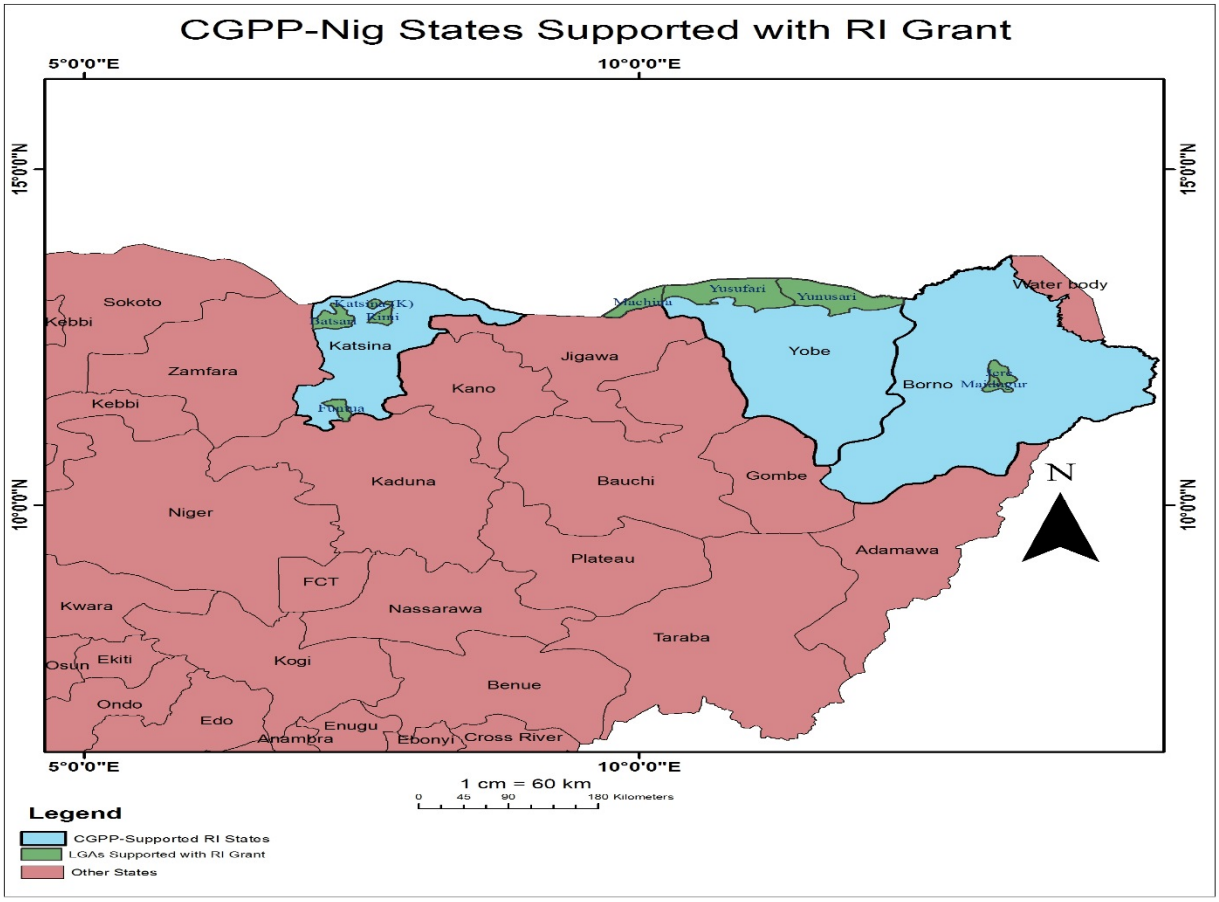


Figure 1: Map showing CGPP focal states

The 2016 MICS/NICS shows a national Penta 3 coverage of 33%, against the 2015 administrative coverage of 98%. Some States have reported up to 140% admin DPT3 coverage and yet there are outbreaks of VPDs. From 2016 MICS/NICS, about 4.3 million children were un-immunized in the country in 2015 alone. These data variances show a state of poor data quality that has also become unacceptable to the National Immunization program. And because of the very high number of un-immunized children, a State of Public Health Concern on Routine Immunization was declared by the National Primary Health Care Development Authority on 17th June 2017. After this declaration, CGPP and other partners have had to return to the drawing Board to re-strategize on how to improve Nigeria's RI program.

With a grant from USAID in 2016, CGPP has been supporting Borno, Katsina & Yobe to improve RI services. In August, 2016, the situation in Borno State where four cases of type 1 WPVs were reported after more than a year of no transmission of WPV brought about a new challenge to the immunization

program. Being the first pillar of Polio eradication, RI regained a new focus from government and partners which led to the formation of the National Routine Immunization Emergency Coordination Center (NERICC).
States were also mandated to set-up the State Emergency Routine Immunization Coordinating Center (SERICC) which was to drive the NERICC agenda at the state level. And since Sokoto State has the lowest RI coverage of 3% in Nigeria, NPHCDA set up the first state Emergency RI Coordinating Center (SERICC) in Sokoto state. Presently, CGPP is supporting the set-up of SERICC in Borno and Kano State.

However, as mandated by the USAID RI grant, CGPP focused more on ensuring immunization coverage is improved in its target areas of focus using the best, fastest and cheapest means possible. This explains CGPP focus on Outreaches in the RI focal states of Borno, Yobe and Katsina where CGPP is focused on five health facilities within IDP camps in Borno State, eleven facilities bordering Nigeria and Niger Republic in three LGAs of Yunusari, Yusufari and Machina of Yobe state; as well as 20 health facilities within two LGAs in Katsina state. It has been proven that Outreaches bring immunization services close to the people in a manner that with consistent supportive supervision, there is improved coverage within the shortest time possible.

During the period under review of, the project recorded 84% coverage for Penta3 and 84.2% for OPV3 in the three RI focal states. This remarkable progress was against 26% and 57% recorded for Penta3 and OPV3 respectively at Baseline. This achievement is far above national RI coverage of 33% for both OPV3 and Penta3 (NICS/MICS, 2016). Regionally, RI coverage is 28% for Penta3 in the NE and 14% for Penta3 in the NW (NICS/MICS, 2016). Compared to the relatively lower national and regional averages, this achievement in CGPP focal areas was as a result of the high commitment of CGPP team especially frontline workers like VCMs and VWS who are constantly mobilizing caregivers of eligible children, tracking and referring defaulters RI facilities and ensuring consistent engagement of mothers and caregivers at the community level to build trust and sustain demand for immunization services. Another key achievement was coverage of BCG that grew from 32% at project baseline to 81% at project Endline conducted during the year under review. Despite the challenges of cultural and religious norms and practices which disallow newborn to be brought out until 40 days after birth, CGPP-supported outreaches were consistent enough to report high coverage.

In Yobe State, CGPP introduced cross-border nutrition integration into routine immunization. Although implementation commenced in the last quarter of the FY17, the immediate result of the nutrition integration was phenomenal. Women in border communities were taught how to prepare *Tom Brown* to boost the nutrition status of their children and family. In line with the National Polio Eradication Emergency Program (NPEEP, 2017) strategy, CGPP aligned its activities to increase access to immunization services and improve the immunization coverage across border communities. This integration of locally made nutrient-dense supplementary food will help to improve the nutrition status of children at border communities and increase demand for RI services.

In the year under review, a total of 1,824 people was trained. These included CGPP staff and community volunteers (VWS & VCM) and the LGA Coordinators. In addition, the capacity of front line

health workers was built in cold chain management, Reach Every Ward (REW) microplanning, vaccine administration, using monitoring chart as well as understanding Adverse Event Following Immunization (AEFI) among others. Other classes of health workers who participated in these trainings were Cold Chain Officers (CCO), LGA Immunization Officer (LIO), Disease Surveillance and Notification Officer (DSNO), M&E Officers, Health Promotion Officers (HPO), and Community Health Officers (CHOs)**.** All these were trained on implementing proper RI services at LGA and ward levels with CGPP support.

At the commencement of the project in 2014, baseline assessment showed that RI card retention was 19%. In order to address this challenge, CGPP introduced the innovative RI card holder. The RI card holder is for mothers and caregiver to keep the RI card safety and be able to present the card at the RI Health Facility as at when due. These RI card was distributed in the three RI states of Katsina, Yobe and Borno. At Endline, RI cards retention increased to 31% while the current national RI card retention rate is very low at 29% (NICS/MICS, 2017).

In the year under, RI Supportive Supervision was conducted at all levels. The Secretariat worked closely with the RI Officers across the three states providing overall guidance in support of the delivery of quality RI services. CGPP primarily supported Fixed Post and outreach sessions in areas of mobilization by VCM, recording of Defaulters or clients lost to follow-up, crowd control during session, defaulter tracking and referral. During this reporting period, in Borno State CGPP has strongly supported the implementation of routine immunization services in health facilities within five IDP camps. Across the RI focal states, the focus is to consistently ensure reduction in Drop-out Rate. Through close supportive supervision of fixed and outreach sessions, capacity of RI in-charges was strengthened and on-the-job mentorship implemented. Since the RI In-Charges manage the RI clinic in the Health Facility, building their capacity is critical to the delivery of quality RI services especially at the Primary Health Care facility level. This is one of the success factors of CGPP support to the RI focal states.

The entire immunization program in Nigeria is presently facing one of its most significant challenges of misinformation ever. Across many states in Nigeria today, rumors have been maliciously spread that vaccinators are injecting vaccine eligible children with Monkey Pox virus which is of course, not true. The country immunization program is currently working closely with stakeholders to educate the populace and resolve this issue. The National Traditional Leaders Committee on Primary Health Care (NTLC) is also working with CGPP and other partners to raise awareness on and dispel these malicious rumors that now threaten the program.

The impact of the CGPP RI interventions to its target beneficiaries is also evident in the following testimonies:

"Indeed, CORE Group Partners Project has done a lot in gathering all stakeholders in routine immunization, the support provided by VCM and others is phenomenal"

Chief Health Officer (CHO) Machina LGA, Yobe State

"We enjoyed how Core Group is supporting this LGA to overcome many immunization obstacles including resolving of block immunization rejection in Malahasanti settlement of Mazogun/Kujari ward of Yunusari LGA by the effort of CGPP LGAC"

Chief Health Officer Yunusari LGA Yobe State

The Incident Manager (IM) in Yobe State also commended CGPP's efforts and challenged the Local Government Chief Health Officers present at the meeting to take a cue from CGPP supported health facilities. He also encouraged them to intensify supervision of the health facilities in their LGAs. Likewise, development partners supporting routine immunization and Polio activities were encouraged to show more commitment to conducting supportive supervision visits to health facilities during immunization sessions and mentoring of the routine immunization providers on data quality like CGPP does. This makes CGPP a role model in the state.

About 242 settlements where CGPP has VCMs directly support RI interventions across the three RI states. These VCM ensure that mobilization is carried out for outreaches while their direct supervisors (VWS) participate in both fixed and outreach sessions. Table 1 shows the total number of health facilities supported including those in IDP camps in Borno state.

Table 1: Human resources for RI Intervention in CGPP focal states

S/N	State	LGAs	Number of VCMs	Number of VWS	Number of LGACs	Number of HF supported
1	Yobe	Machina	14	4	1	4
2	Yobe	Yunusari	21	2	1	3
3	Yobe	Yusufari	19	2	1	4
4	Borno	Bama	0	0	0	4
5	Borno	Monguno	23	2	1	2
6	Borno	Ngala	25	2	1	2
7	Katsina	Katsina	70	7	1	8
8	Katsina	Funtua	70	5	1	12
TOTAL			**242**	**24**	**7**	**39**

Source: CGPP Focal State immunization report

Table 2: Fixed and Outreach sessions conducted

Indicator		Baseline July. 2016	Project Year Ending Sept. 2016	Project Year Ending Sept, 2017
1.1	% of fixed sessions conducted	51%	93%	98%
1.2	% of outreach sessions conducte	35%	95%	95%

Source: Admin data (CGPP-Supported Health facility)

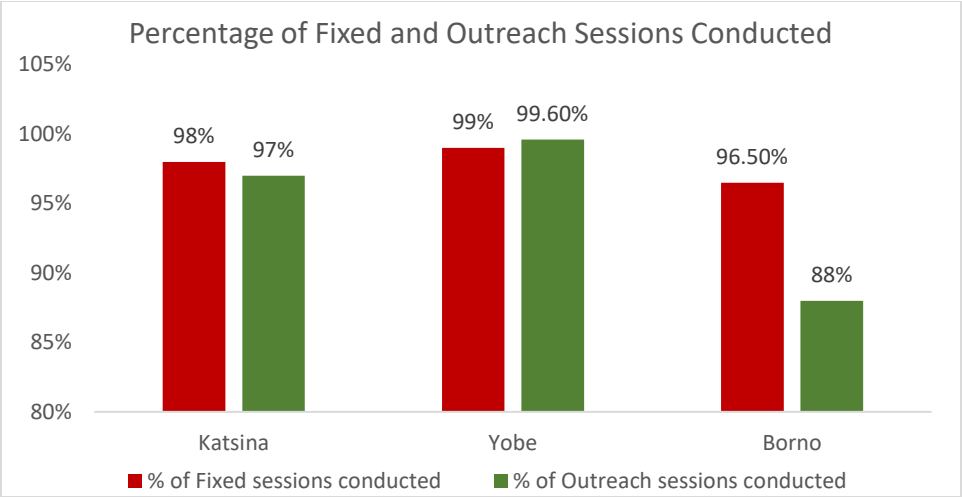


Figure 2: Percentage of fixed and outreach sessions planned and conducted

Table 2 above shows the percentage of fixed and outreach session planned and conducted. In FY17, 98% fixed sessions were conducted compared to 93% in FY16. This is an improvement on the result of the previous year and its due to improved supportive supervision by CGPP team at the health facility providing RI. However, percentage of outreach session in FY17 remains same as that of FY16 which could be attributable to the similar challenges that have persisted in terms of insecurity, difficult, hard-to-reach terrain among others.

ACTIVITIES:

Percentage of fixed and Outreach sessions conducted

- In all the states, VCMs supported the conduct of RI fixed sessions to achieve 98% and 95% outreach sessions and planned fixed sessions respectively. Other support provided include RI defaulter tracking, health education sessions during fixed session, support RI providers during immunization by ensuring crowd control and support the care givers in holding the children during immunization.
- CGPP VCMs also conducted newborn tracking and referred them for RI sessions. The compound meeting conducted by VCMs helps in ensuring mothers are fully aware of the RI sessions schedules and the need to complete immunization. CGPP supported the conduct of at least one Outreach sessions per week (4 sessions per months). VCMs mobilizes mothers during House to house mobilization visits by providing information on RI Outreach (where and when it will be conducted) and ensure they attend the sessions

Table 3: Vaccines coverage

Indicator		Baseline July. 2016	Project Year Ending Sept. 2016	Project Year Ending Sept, 2017
2.1	% of Children 12-23 months who received BCG	32%	76%	81%
2.2	% of Children 12-23 months who received OPV0	71%	94%	96%

2.3	% of Children 12-23 months who received Penta 1	34%	72%	88%
2.4	% of Children 12-23 months who received Penta3	26%	61%	84.2%
2.5	% of Children 12-23 months who received OPV3	57%	82%	84%
2.6	% of Children 12-23 months who received IPV	NA	NA	78%
2.7	% of Children 12-23 months who received Measles	47%	88%	81%
2.8	% of children 12-23 fully immunized	NA	37%	61%

Source: Admin data (CGPP-Supported Health facility)

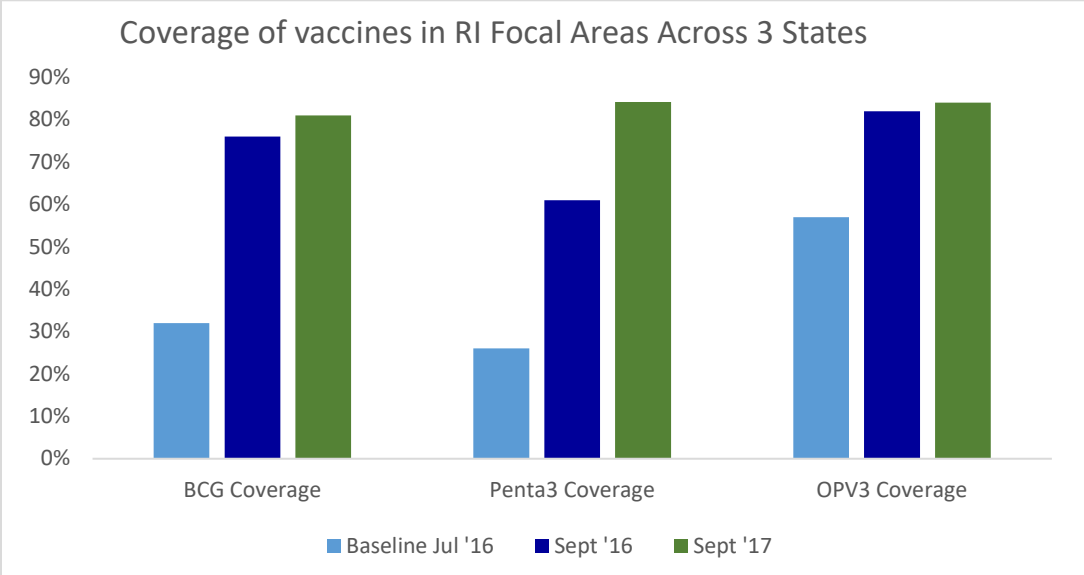


Figure 3: Average vaccine coverage in CGPP RI focal states of

Percentage of children 12 to 23 months with BCG

- Mothers were tracked by CGPP VCMs from the beginning of pregnancy up to delivery. Mothers are continuously mobilized during in-between round activities especially house to house mobilization on the need to ensure their children receive BCG vaccine at birth. There was increase in BCG coverage from 76% in FY16 to 81% in FY17.
- CGPP VCMs track all newborn within their catchment areas on weekly basis to ensure they all get BCG at birth and other Routine antigens.

Percentage of children 12 to 23 months with OPV

- CGPP VCMs tracked pregnant mothers in their register till child birth and ensure that OPV0 is received immediately after birth. The VCMs attend Suna (naming ceremony) immunization in order to ensure the newborn get OPV 0 since some of the newborns are not allowed to come out of the house until after 40 days.

- Compound meetings are also organized by VCMs to educate mothers about the importance of immunization. Those who defaulted are tracked by VCM and ensured the caregiver brings back their children for all the doses of OPV aside the doses received during campaign.

Percentage of children 12 to 23 months with Penta

CGPP VCMS continuously mobilizes mothers during in-between round house to house mobilization on the need to ensure their children receives Penta 1 at 6 weeks of birth plus other antigens

- VCMs track all children that are due for Penta 1 within their catchment areas on weekly basis to ensure they all went to the health facility to receive Penta 1 and other Routine antigens
- Those who defaulted, were tracked by CGPP VCMs and ensure the caregiver brings back their children for Penta 1 injection.
- CGPP VCMs used their register to develop line list of those due for Penta 1 and make follow-up visits to ensure the child is immunized.
- During compound meetings, mothers were reminded on the RI schedule and time due for Penta 1 and the importance of going back to health facilities to complete Routine immunization for their children.

Percentage of children 12 to 23 months with Penta 3

- CGPP VCMS continuously mobilizes mothers during in-between round house-to-house visits on the need to ensure their children receives Penta 3 at 14 weeks of birth plus other antigens. VCMs were allocated to the health facilities within their Wards to provide support on mobilization for immunizations, tracking and reconnecting of defaulters, and to conduct health talks during immunization sessions focusing on the benefits of immunizations, etc. This measure led to the significant increase observed in FY17.
- Those who defaulted, were tracked by CGPP VCMs and ensure the caregiver brings back their children for Penta 3.
- CGPP VCMs used their register to develop line list of those due for Penta 3 and make follow-up visits to ensure the child is immunized.
- During compound meetings, mothers are reminded on the RI schedule and time due for Penta 3 and the importance of going back to health facilities to complete Routine immunization for their children.

Percentage of children 12 to 23 months with IPV

- CGPP VCMS emphasize to mothers and other caregivers during in-between round house-to-house visits on the need to ensure their children receive IPV at 14 weeks of birth plus other RI antigens
- CGPP VCMs used their register to develop line list of those due for IPV and make follow-up visits to ensure the children receive IPV at 14 weeks of birth
- During compound meetings, mothers are reminded of the benefits of Immunization and the importance of taking their children to health facilities to receive IPV and other RI antigen.

Percentage of children 12 to 23 months with Measles

- CGPP VCMS educate mothers and other caregivers during in-between round house to house visits on the need to ensure their children receives Measles at 9 months of birth
- VCM register is used to identify eligible children due for Measles vaccination and VCMs make follow-up visits to ensure the children receives Measles vaccination
- During compound meetings, mothers were reminded on the benefits of immunization and the importance of taking their children to receive Measles vaccine.
- CGPP VCMs uses Compound meeting as an opportunity for RI provider to immunize large number of eligible children with Measles vaccine.

Percentage of children 12 to 23 months fully immunized

- VCMs track pregnant Mothers in their register till child birth, they continue to mobilize the mother/caregiver for Routine Immunization until the child is fully immunized.
- CGPP VCM educate mothers and other caregivers during in-between round house-to-house visits on the importance of ensuring their children are fully immunized.
- Compound meetings are conducted with the aim of educating mothers on the need to complete RI antigens, immunize defaulters tracked by CGPP VCMs and to ensure children in CGPP intervention areas are fully immunized.
- The effort of these CGPP VCMs led to improved RI coverage to 63% in CGPP intervention areas.

Table 4a: Demand Creation Activities

Indicator		Baseline July. 2016	Project Year Ending Sept. 2016	Project Year Ending Sept, 2017
3.1	% of Health Education Sessions Conducted	66%	82%	98%
3.2	% of Community link activities conducted	-	85%	96%

Source: Admin data (CGPP-Supported Health facility)

ACTIVITIES

Percentage of Health Education Sessions conducted

- CGPP VCM / VWS supported RI intervention health facilities during RI sessions to provide Health education focusing on immunization schedules, importance and benefit of immunization to their children and what they should do in case of AEFI.
- Compound meetings serves as an avenue for VCMs to provide health education especially to Non – compliance / defaulting mothers who doesn't visit health facility regularly and mothers that do missed sessions.

- CGPP VCMs provides Health talks during RI Outreach sessions for mothers and caregivers that could not access health facilities.

Percentage of Community link activities conducted

- CGPP VCMs conducted compound meetings as part of community engagement activity to link the community to the health facility; health education/talks is conducted stating the needs for mothers/caregivers to be visiting health facility from pregnancy to delivery and also to ensure their children receives full complementary of Routine immunization antigens.
- Community dialogues are conducted to address health care myth, RI defaulter tracking and Noncompliance among households, the outcome links the community members with health facility to access immunization services
- CGPP VCMs conducted House to House mobilization to mobilize mothers and caregivers to visit health facility for ANC, RI and other health care services.

Table 4b: Demand *Creation Activities*

Indicator		Baseline July. 2016	Project Year Ending Sept. 2016	Project Year Ending Sept, 2017
4.1	Total No. of under 1 children referred f by community mobilizers	-	4900	94,373
4.2	No. of newborns referred for RI by mobilizers	-	2984	14,060
4.3	No. of newborns referred to RI and vaccinated	-	2571	13,976
4.4	No. of zero dose referred for RI by mobilizers	-	2571	3,981
4.5	No. of zero dose referred by communit mobilizer and vaccinated	-	2571	3,943

Source: Admin data (CGPP-Supported Health facility)

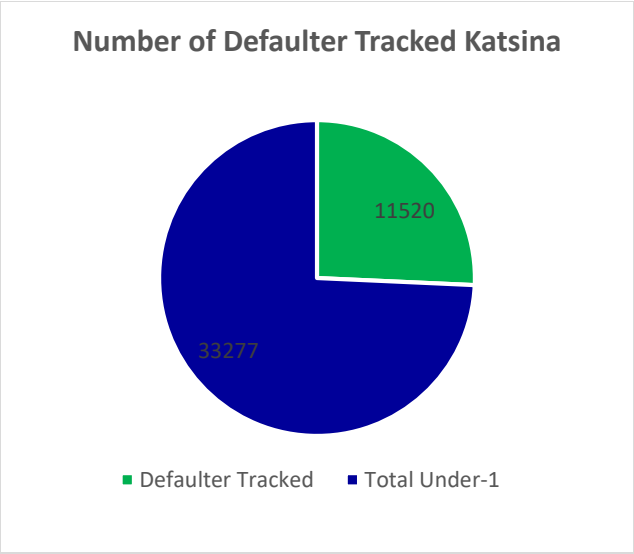


Figure 4: Number of RI defaulters tracked in Katsina State

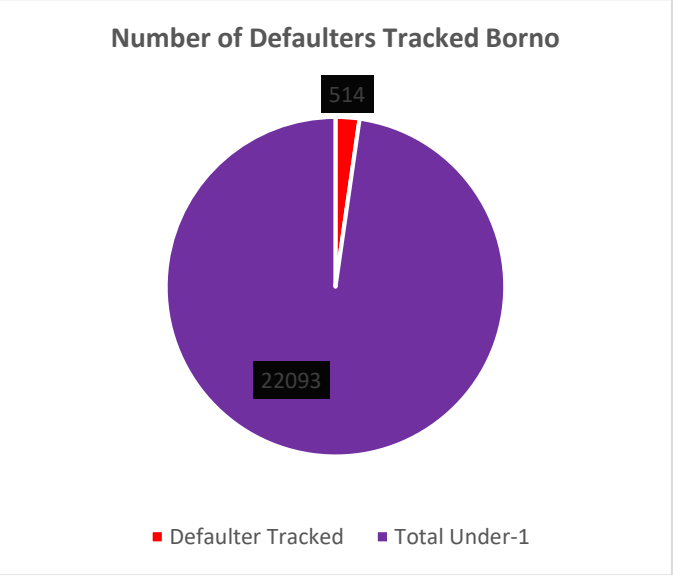


Figure 5: Number of RI defaulters (children) tracked in Borno State

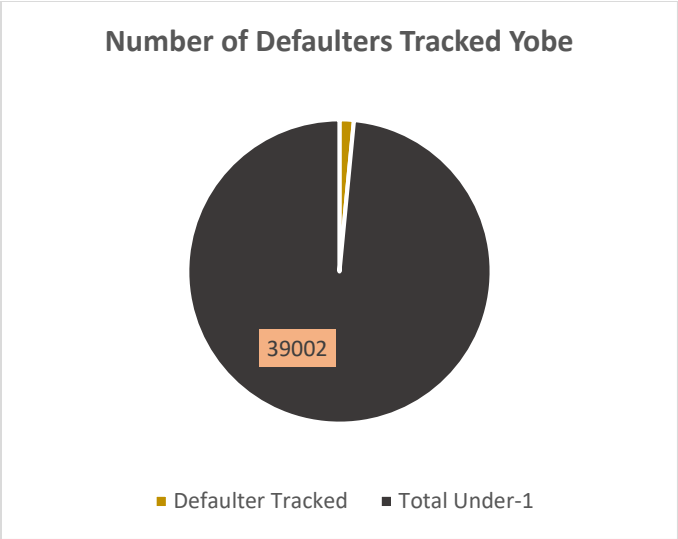


Figure 6: Number of RI defaulters tracked in Yobe State

ACTIVITIES

Total No. of children referred for RI by community mobilizers

- CGPP VCMs conducted House to House mobilization during in-between round visit and refer 39,002 under 1 children for Routine Immunization services to the CGPP supported health facility

No. of newborns referred for RI by mobilizers

- CGPP VCMs conducted House to House mobilization during in-between round visit and were able to refer 14,060 newborns for Routine Immunization.
- Newborn tracking is also conducted during IPDs as the VCMs go house to house for the campaign.

No. of newborns referred to RI and vaccinated

- CGPP VCMs conducted House to House mobilization during in-between round visit and were able to reach and refer 14,060 new born for Routine Immunization and vaccinated 13,976

- CGPP VCMs track all newborn within their catchment areas on weekly basis to ensure they all get OPV 0 at birth and all other Routine antigens

- CGPP VCMs attended Suna (Naming ceremony) immunization in order to ensure the newborn are immunized with BCG, HBV0 & OPV0

No. of zero dose referred for RI by mobilizers

- CGPP VCMs conducted House to House mobilization during in-between round visit which includes tracking children that has never received doze of OPV and are below the age of 5.
- CGPP VCMs were able to detect 3,981 children that has never received a single dose of OPV and refer them to the nearest health facility.

No. of zero dose referred by community mobilizer and vaccinated

- CGPP VCMs were able to detect 3,981 children that has never received a single dose of OPV and refer them to the nearest health facility, out of which 3,943 were vaccinated with OPV.

- CGPP VCMs attended Suna (Naming ceremony) immunization in order to ensure children below the age of 5 are immunized including zero dose.

Table 4c: Demand Creation Activities

Indicator		Baseline July. 2016	Project Year Ending Sept. 2016	Project Year Ending Sept, 2017
5.1	No. of RI defaulters tracked from the healtl facility register	-	542	2,883
5.2	No. of RI defaulters identified from the catchment area by community mobilizers	-	1819	12,762
5.3	No. of defaulters referred to HF for RI by th Community mobilizers	-	1819	12,677
5.4	No. of trained Health Workers	-	34	270
5.5	No of health facilities with up to date REW micro plan	0	26	39

Source: Admin data (CGPP-Supported Health facility)

ACTIVITIES

No. of RI defaulters tracked from the health facility register.

- CGPP VCMs harmonized defaulters in their register and that of Health facility register to line list all the defaulters and to ensure no child is missed during RI defaulter tracking activity.
- CGPP VCMs conducted House to House mobilization during in-between round visit which includes RI defaulter tracking, as such they were able to track 2883 RI defaulters and refer them all to the health facility for RI services (see Fig. 4, 5 & 6).

No. of RI defaulters identified from the catchment area by community mobilizers

- CGPP VCMs conducted House to House mobilization during in-between round visit which includes RI defaulter tracking, as such they were able to identify 12,762 RI defaulters in their catchment area (See Fig. 4, 5 & 6).

- The high defaulter rate is as a result of stopping the NPHCDA RI intensification program in Katsina State in June 2016
- CGPP VCMs conducted massive RI defaulter tracking in areas/settlements where RI intensification has stopped and were able to refer all the defaulters to CGPP supported health facilities.

No. of defaulters referred to HF for RI by the Community mobilizers

CGPP VCMs conducted House to House mobilization during in-between round visit and they were able to identify and referred 12,677 RI defaulters to CGPP supported health facilities.

No. of trained Health Workers

CGPP trained the following cadre of health workers providing RI and RI support services as follows:

- RI Providers – Under this grant, we have trained 270 RI providers
- Facility In-charges – Under this grant, we have trained 20 HF in-charges to support RI implementation in their respective HFs
- LGA Team – Under this grant, we have trained LGA team (DPHC, LIO, CCO, Health Educator & DSNO) on RI supportive supervision and RI best practices aimed to provide high level RI supportive supervision at the LGA and provide input/quality to state Joint RI supportive supervision

No of health facilities with up to date REW micro plan

- All the 39 CGPP supported health facilities have updated REW micro plan, which is updated every quarter with CGPP support throughout the reporting period.

- CGPP supervisors (VWS, LGAC, M&E, RI Monitors & RI Officers/Focal Persons) ensured the availability and proper utilization of the updated REW micro plan in all CGPP supported health facilities.

Table 5: CGPP RI- Specific Trainings conducted across focal states in FY17

Type of Training	Number of Participants	Cadres (Persons trained)	Date of Training
RI and Reaching every ward (REW) strategy	727	LIOs, CCOs, DSNOs, M&Es, HPO, CHOs, VWSs, VCMs, RI in charges, a LGACs.	November, 2016, Febru 2017
RI Training	66	RI Service Providers & Clinic In-charg	October 2016
RI Training	59	LGACs, VWS, R.I Monitors & AHIFF Management	October 28-29, 2016
M & E training on RI	59	LGACs, VWS & RI Monitors	December 14-15, 2016
Routine Immunization	89	R.I Service Providers & Clinic In-char	July 13-14, 2017
Routine Immunization	149	VWS/LGAC/RI Monitors	August 9-10, 2017
Health Management Information Systen (HMIS)	245	RI Service Providers, Recorders and Clinic In-Charges from host communit	September 25-27, 2017
RI providers refresher training	63	RI Providers, VWS and RI monitors	Dec 2016
RI service delivery training	36	VWS, RIOs and LGAs	Feb, 2017
Monthly RI Refresher Training	122	RI providers	Feb, 2017
Refresher training on RI service deliver	155	VCMs, LGACs, RIOs	May, 2017
Health promotion – on RI	54	VWs, LGACs M&Es	July, 2017
Grand total	**1824**		

Source: CGPP Focal State immunization report

KEY ACHIEVEMENTS:

Despite a National RI coverage of 33% for both OPV3 and Penta3, CGPP recorded 84% coverage for Penta3 and 84.2% for OPV3 in the three RI focal states (NICS/MICS, 2016). This remarkable progress was against 26% and 57% recorded for Penta3 and OPV3 respectively at CGPP Baseline (see Fig.3 above). Compared to the relatively lower national and regional RI coverages in Nigeria, this achievement in CGPP focal areas was as a result of the high commitment of CGPP team especially frontline workers like VCMs and VWS who constantly mobilize caregivers of eligible children, tracking and referring defaulters RI facilities and ensure consistent engagement of mothers and caregivers at the community level to build trust and sustain demand for immunization services.

Another key achievement was in the coverage of BCG that grew from 32% at project baseline to 81% at project Endline conducted during the year under review. Despite the challenges of cultural and religious norms and practices which disallow newborn to be brought out until 40 days after birth, CGPP-supported outreaches were consistent enough to report high coverage.

In addition, the project has improved community linkage through improved participation in Village Development and Ward Development Committees across the focal settlements and Wards. In addition, there is improved community engagement through better conduct and participation in community engagement activities such as compound meetings and community dialogues. It is this improved community engagement that had driven vaccine coverage upwards in the focal areas.

CGPP improved the capacity of VCMs and VWS in mobilizing mothers and caregivers on the importance of Routine Immunization, Community AFP Surveillance, Nutrition, and WASH. The quality of VCMs data collection and reporting has also improved as noticed in the VCM register and the ODK. This is through the intensive training, mentoring and supportive supervision deployed by CGPP during the year under review (see Table 5)

CGPP strengthened the capacity of RI providers, facility in-charges and Ward Focal Persons through conducting refresher trainings and providing on the job trainings aimed to improve the quality of RI services in CGPP intervention areas (see Table 5 above).

Card Retention has also improved across the CGPP focal areas. In general, the RI card retention rate among all surveyed caregivers during the Endline showed an increase. At Endline, Card Retention was 31% compared to 19% at Baseline and a current National Card Retention rate of 29% (MICS, 2016/17). This increase at Endline compared to both the Baseline/MTE and the National rate can be attributable to the RI Card Holders that were deployed by CGPP to improve Card Retention.

In Yobe State, advocacy visits resulted in two major results as the Machina LGA chairman allocated a primary school classroom to serve as health facility after an advocacy visit by CGPP. The class room was demarcated into the office of RI provider, waiting room and cold chain room. Also, after follow-up by CGPP with the State Primary Health Care Management Board considering that most of the CGPP RI focal health facilities were hard to reach and had difficulties in vaccine collection, the State in turn allocated Solar direct drive refrigerators to Taganama PHC in Machina LGA, Kujari PHC in Yunusari LGA, Bulatura PHC and Mayori PHC in Yusufari LGA.

The Cross-border CGPP RI intervention within settlements in Yunusari and Yusufari LGAs of Yobe state resulted in 248 children of Toshia community to be enrolled into the community nutrition program where 40 were detected to have Severe Acute Moderate (SAM) malnutrition and were referred to the nearest health facility and of them 208 were MAM (Moderate Acute Malnutrition) cases. In Sumbar community, 137 children were enrolled into the nutrition program where 49 were SAM cases and 88 MAM cases. Total

number of children under 1 immunized in Toshia and Sumbar communities were 52 and 65 respectively. The Yobe State Government has commended CGPP for this RI intervention.

LESSONS LEARNT

1. Effective and efficient Routine Immunization is vital to eradicate Polio and other child killer diseases.
2. Listening and responding to community needs builds trust for the programme
3. Health camps providing integrated services & linking community with fixed Post RI Health Facilities is a Best Practice.
4. Integration of vaccination with nutrition improves the outcome of infants and children
5. Routine intensification in high risk polio LGAs. High rate of awareness does not translate to high demand for services.

MAJOR CHALLENGES

- **No felt need**: Demand for other felt needs e.g., roads, schools, water, power, etc. has consistently led to parents and caregiver's rejection of immunization of their children
- **Insecurity across the states**: Insurgents continue to target vaccination team members, religious and traditional leaders thus making community engagement difficult and sometimes impossible. Two LGAs in Borno state (Abadam and Marte) are still inaccessible due to the presence of Boko Haram insurgents. Kidnapping, Armed Robbery, and Cattle Rustling also affects RI Outreaches and Supportive Supervision in some intervention settlements of the states e.g. Katsina State.
- **Risk perception**: Low risk perception at all levels (e.g. community, program managers, political leadership)
- **Political commitment**: Waning support of Governors & LGA Chairmen for counterpart funds
- **Human Resource**: This remains a major problem across the states. For example, most of the RI providers in Katsina State are casual staff which affects their commitment and dedication in RI service delivery

NEXT STEPS/FUTURE PLAN

1. Review and update CGPP Nigeria RI strategy so it aligns with the Resilience Strategy
2. CGPP to produce additional RI Card holders to improve card retention in the community.
3. Scale up the engagement of the Male Peer Educators intervention piloted in Kaduna to two LGAs in Yobe.
4. Refresher training for RI Service providers, other Health workers and VWS on Routine Immunization services / best practices
5. Provision of additional pluses to encourage mothers in ensuring their children complete RI schedules.
6. Intensify Social Mobilization / Community engagement activities aimed to reduce RI drop-out rate

7. Strengthening of community structures (VDCs and WDCs) aimed to support RI services, improve RI defaulter tracking and win community buy-in aimed to strengthen CGPP RI support
8. CGPP to continue supporting quarterly RI review meeting involving community leaders and the Chairmen of the Health Facility Management Committees (HFMC) with the aim of improving demand and ownership by the community members.
9. Strengthen VCM in-between round activities aimed to mobilize mothers on the importance of completing RI schedules, prevention of dropout and improve birth tracking and referrals
10. Refresher training for VCMs and RI providers on IPC skills and AFP surveillance.
11. Work closely with state RI TWG to ensure harmonization of RI activities in the state.
12. Production of more RI Cards aimed to improve documentation and improve coverage

Data Sources:

National Coverage data (NICS/MICS, 2016)
Health facility routine immunization data tool

VCM registers
Quarterly and annual partner reports

Annexes

CGPP VCMs support a Mother to immunize her child with RI Antigen during compound meeting in Katsina LGA, Katsina State.

CGPP VCM supporting an RI Fixed post session in Borno State

Sensitization of Mothers and Caregivers on the benefit of RI by CGPP RI/PIO, STL, CBO Coordinator, M&EO, LGAC, VWS and VCMs in Kofa IDP Camp, Borno State

Mothers displaying RI Cards holders provided with CGPP support after completing RI schedules for their children in one of the CGPP focal Settlement of Katsina State

RI Provider issuing RI card inside the RI Card holder at Rugar Fulana settlement of Jabire Ward of Funtua LGA Katsina State

Caregivers holding their RI card holders supported by CGPP at Kalgidi health facility in Machina LGA, Yobe State

Outreach session conducted by Tulotulo RI in charge at Bula jullu settlement of Tulotulo ward of Yusufari LGA, Yobe State

A CGPP VCM explaining the importance of RI Card Holder to a mother during the outreach immunization session in Kudu II ward of Katsina LGA.