

## EVALUATION REPORT

# Core Group Polio Project South Sudan Surveillance System and Independent Campaign Monitoring



Prepared by

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## List of Acronyms

<b>AFP</b>	Acute Flaccid Paralysis
<b>BMGF</b>	Bill and Melinda Gates Foundation
<b>C4D</b>	Communication for Development
<b>CBS</b>	Community Based Surveillance
<b>CGPP</b>	Core Group Polio Project
<b>CS</b>	County Supervisor
<b>DRC</b>	Democratic Republic of Congo
<b>EPI</b>	Expanded Program on Immunization
<b>FGD</b>	Focus Group Discussions
<b>IDPs</b>	Internally Displaced Persons
<b>IEC</b>	Information Education and Communication
<b>IRF</b>	Initial Reporting Format
<b>KI</b>	Key Informants
<b>KII</b>	Key Informant Interviews
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MFUP</b>	Measles Follow up Updates
<b>MIS</b>	Management Information System
<b>MOH</b>	Ministry of Health
<b>NGO</b>	Non-Governmental Organization
<b>NIDS</b>	National Immunization Days
<b>NNTS</b>	Neonatal Tetanus Surveillance
<b>PA</b>	Payam Assistant
<b>PCE</b>	Post Campaign Evaluation
<b>SIAs</b>	Supplementary Immunization Activities
<b>SNIDS</b>	Special National Immunization Days
<b>SPEDP</b>	Support for Peace and Education Development Program
<b>SVPs</b>	Special Vaccination Posts
<b>SVPs</b>	Special Vaccination Posts
<b>TB</b>	Tuberculosis
<b>TWG</b>	Technical Working Group
<b>UNICEF</b>	United Nations Children's Fund
<b>UNKEA</b>	Universal Network for Knowledge & Empowerment Agency
<b>WHO</b>	World Health Organization
<b>WPV</b>	Wild Polio Virus

## Acknowledgment

I would like to thank the Core Group Polio Project team for the opportunity to conduct the evaluation of the community-based surveillance system, post campaign evaluation and cross border campaigns in South Sudan. Additionally, my sincere thanks to the following organizations and individuals for their critical contributions:

- The Ministry of Health(MOH), World Health Organization(WHO), UNICEF, the Bill and Melinda Gates Foundation (BMGF), BIO AID, Universal Network for Knowledge & Empowerment Agency (UNKEA) and Support for Peace and Education Development Program(SPEDP) for their support and cooperation.
- The team at the South Sudan Secretariat composed of the Project Director, Project Manager, M&E Officer and State Surveillance Coordinators for coordinating the evaluation and providing important documentation and other essential information.
- World Vision National M&E team and supplies chain for coordinating this review.
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- The data collection team from South Sudan for conducting focus group discussions and key informant interviews.

Lastly, the consultants team composed of Samson Omongot and Jude Muyomba for ensuring a high-quality evaluation. Both worked tirelessly to train the evaluation team, organized and consolidated in puts from evaluation respondents.

Peter Walyaula  
Lead Consultant

## Executive summary

### Overview

South Sudan's prolonged civil war has led to the destruction of health facilities, a decline in surveillance, an increase in the number of silent counties, and scanty immunization services. The project has been providing interventions aimed at eradicating polio through supporting the community-based surveillance system and conducting post campaign evaluation and cross border activities. The main purpose of this consultancy was to evaluate the Core Group Polio Project (CGPP) activities implemented in South Sudan.

### Methodology

Qualitative methodology was mainly employed for this evaluation. Qualitative data was collected through interviews and focused group discussions held with key CGPP partners and stakeholders, qualitative interviews were conducted with more than 118 respondents. Quantitative data was collected through document review; the evaluation team reviewed key Core Group Polio Project (CGPP) documents and reports. Qualitative data was analyzed manually through content analysis by coding themes.

### Key findings and conclusions

- The Core Group Polio Project's Community Based Surveillance system has resulted in an impressive upswing in the reporting of Acute Flaccid Paralysis (AFP) cases. From January 2016 to June 2017, 67 of 176 AFP cases (38 percent) were detected by the project's community volunteers. Driving this success is a well-developed network of 2,366 men and 991 women that work as key informants, Payam Assistants and County Supervisors.
- Community Based Surveillance (CBS) efforts complement the formal WHO surveillance system. To further support surveillance efforts, CGPP has established strong partnerships with UNICEF, BMGF, the MOH, three national organizations (SPEDP, UNKEA, BIO AID) and cross border networks and local authorities at the State and County levels.
- Post-campaign evaluations (PCE) cover the entire country. Campaigns are conducted four times a year during the dry months of February, March, November and December. Post – campaign evaluations provide reliable data on vaccination coverage and missed children; this data is utilized by the MOH, WHO and UNICEF to shape subsequent polio campaigns. Useful data has also been provided on the quality of NIDs/SNIDs (including coverage, awareness of SIAs, reasons for missing children and reasons for zero dose). The PCE also detects whether all areas were reached through social mobilization.
- The CGPP-led cross-border meetings direct discussion of critical issues on child vaccination and surveillance and built relationships with neighboring State health systems. A total of 91,650 children were vaccinated from May 2016 to June 2017 with at least one dose and 5.6% were given zero dose.
- Partner project data contributes to the CGPP's reporting and documentation needs, accountability, learning and decision making. At the partners level, quantitative, systematic and rigorous data collection procedures are employed for collecting evidence to support decision-making. All data is carefully reviewed for quality by the Secretariat, partners and WHO.

## Key lessons learned

1. It is important to work with all partners towards a common agenda. Despite differing priorities and power dynamics, it is essential that the CGPP and partners build meaningful and effective relationships.
2. The CBS focus on AFP is a sound approach to reporting and handling cases. However, integrating another approach that focuses on disability or networks on disability will have far reaching benefits compared to conducting only CBS.
3. Conventional formal surveillance methods are not guaranteed due to a variety of challenges. Community based surveillance is a very effective approach in fragile context, when communities cannot be accessed by formal systems.
4. Multifaceted challenges require different approaches. The wet season's impassable roads and the dry season's pastoralist migration call for unique strategies, for example, to reach children and families on the move.
5. Partnerships built with organizations with shared values, common standards and principles are more sustainable; most CGPP partnering organizations strongly focus on child health and thus building synergies around such common priorities will have far reaching benefits.
6. Without frequent social mobilization, communities easily forget about the importance of routine vaccination and become complacent. Systematic and sustained messaging on EPI for a long period will keep communities and families aware of the need to have their children vaccinated
7. Well-balanced projects that integrate development and support activities with strong preparedness plans to respond to emerging diverse beneficiary populations have more far reaching impact compared to those projects focused on just one or two priorities.
8. The CGPP has developed very clear tools and guidelines to direct how the project should be implemented and tracked. However, there are concerns that these guidelines are frequently updated before the prior version is internalized. While innovations and changes are beneficial, updated tools and guidelines cost the ability to consistently track progress based on different standards emerging at short intervals.

## Opportunities

1. The CGPP has a well-established structure from the national level to the Boma level that has managed to bring services closer to the community. This unique structure allows a comparative advantage over other partners and the government. The project is positioned to use these structures to help it carry out other interventions like social mobilization, PCE, WASH, etc.
2. Partnership with other key players including UNICEF, WHO, BMGF, MOH, SPEDP, UNKEA, BIO AID, cross border networks and local authorities at the State and County level provide opportunities for additional funding, training and technical support.
3. Despite broad vulnerability and unreached communities (some that remain unreached with maternal and child health services through conventional approaches) development

needs related to AFP should be integrated with approaches that focus on disability in children.

4. Traditional structures like traditional birth attendants, local chiefs, and religious leaders share a commitment and desire to see their communities transformed. These structures are potential entry points if CGPP chooses to change strategy or leverage ongoing interventions.

#### Key recommendations

1. The CGPP should move beyond disease surveillance to integrate development-related activities with other maternal and child health services.
2. The PCE reports should be shared promptly with relevant partners to inform proper planning.
3. The WHO and the CGPP together with the MOH should harmonize field plans by sharing schedules and areas of coverage.
4. The CGPP should work with partners involved in SIA to harmonize social mobilization. This should include frequent social mobilization with clear systematic and sustained messaging on EPI.
5. To increase efficiency, County Supervisors should support PCE efforts by working as Central Supervisors in counties located far from Juba.
6. Advocacy should be integrated by all partners to address issues affecting effective vaccinations such as insufficient quantities and poor coverage to ensure all children are reached.
7. The consolidation of data collection from different partners and from different time periods should be strengthened.
8. Capacity building should be prioritized to enable strong reporting from partner Project's Officers and M&E staff.
9. Despite logistical and security challenges, PCE feedback should be provided to the field level.
10. The CGPP should share PCE data that is available with EPI TWG for planning purposes before final reports or results are compiled. Completed County data should be shared as soon as possible.
11. The CGPP and UNICEF should coordinate and collaborate on funding for social mobilization.
12. Support supervision should be intensified during SIAs to ensure vaccinators are conducting house to house vaccination.

The CGPP should ensure partners maintain up to date line list capturing all key data such as dates of onset, notification and investigation and old and new cases. This list should frequently be reconciled with the WHO validated list.

## **1 Background**

### **1.1 Polio eradication situation in South Sudan**

South Sudan has experienced one of the longest civil wars since independence of Sudan with the Khartoum government which culminated into the signing of comprehensive peace agreement in 2005 that led to the independence of South Sudan as a separate country in July 2011. Barely two years after its independence another conflict erupted in mid-December 2013.

The situation posed access challenges to most of the counties and the destruction of health facilities, including cold chain. The conflict led to a decline in surveillance, the increase in number of silent counties, and drastically reduced immunization services – all contributing to under-immunized and missed children more vulnerable to polio disease.

### **1.2 Rationale for the Core Group Polio Project (CGPP)**

The CGPP is a multi-country, multi-partner initiative providing financial support and on-the-ground technical guidance and support to strengthen host country efforts to eradicate polio. A U.S secretariat provides overall technical assistance and financial management in each country to maximize and harmonize resources and coordinate collaboration among partners.

The CGPP is organized at the country level by a small Secretariat headed by a Director who coordinates with the MOH, UNICEF and WHO at the national level and oversees the work of partner NGOs who receive sub-grants to implement project activities at the County and community levels.

### **1.3 Community based surveillance**

Beginning in October 2015 the focus of the CGPP shifted in terms of geographical areas, scope and interventions. The CGPP re-focused to support community based AFP surveillance in mostly silent counties in Upper Nile and Jonglei while maintaining its support for nationwide implementation of polio campaign independent monitoring and cross border collaboration.

With Bill and Melinda Gates Foundation support, the Core Group Polio Project moved its geographic focus and programmatic activities to concentrate largely on community-based AFP surveillance in 34 counties in conflict-affected areas of northern South Sudan.

### **1.4 About the evaluation**

The main purpose of this consultancy is to evaluate the Core Group Polio Project (CGPP) activities implemented in South Sudan. The objectives are to assess the adequacy, timeliness, reliability, and stability of the community-based surveillance system with attention to conflict-affected areas. Additionally, the purpose of the evaluation includes the assessment of the quality, adequacy, reliability, and accuracy of independent campaign monitoring data, procedures, and activities.

## 2 Methodology

Evaluation methodology was based on a desk review of key CGPP documents and reports. In addition, interviews and focused group discussions were conducted with relevant partners and stakeholders engaged in the Core Group Polio Project activities, the community-based surveillance system and independent campaign monitoring activities.

### 2.1 Qualitative Sample

Participants for the qualitative sample were selected on basis of being potential beneficiaries, partners and stakeholders who participated in CGPP and were assumed to be knowledgeable on CGPP activities. FGD and KII guides were developed to support data collection. Random sampling was used to recruit participants for FGD. The research team with the help of County Supervisors randomly selected PAs and KIs to participate in the evaluation.

Table 1 Qualitative sample

Target	Type	Total persons per meeting	Frequency	Total number of Participants
County Supervisor	KI	1	6	6
County Health Director	KI	1	6	6
PAYAM ASSISTANTS	FGD	4	6	24
KEY INFORMANTS varied	FGD	12	6	72
UNICEF	KI	1	1	1
WHO	KI	1	1	1
MOH	KI	1	1	1
BILL and MELINDA GATES FOUNDATION	KI	1	1	1
BIO AID	KI	2	1	2
SPEDP	KI	2	1	2
UNKEA	KI	2	1	2

### 2.2 Data collection approaches

Qualitative data was collected from document review and interviews while quantitative data was pulled from document review.

#### Document review

The document review focused on examining of CGPP documents and reports to generate information relevant to this evaluation. The key CGPP documents and reports reviewed included:

- Surveillance data and records from WHO
- Key CGPP planning documents including project proposals, CGPP design, annual work plans and logframes.
- Other partners documents from Bill & Melinda Gates Foundation and WHO
- The CGPP reports, including donor reports and situation reports  
field trip reports, activity schedules, participant utilization records as well as other relevant project reports, monitoring data, annual reports, project MIS, County Supervisor reports and checklists
- Relevant CGPP correspondence and meeting minutes

### Document review approach

1. Established and determined types of CGPP documents that exist and would address evaluation questions
2. Secured access to the necessary documents identified
3. Discussed with the project team and Project Manager to gain a contextual understanding of the basis for the documents
4. Further mapped out the documents relevant to the evaluation
5. Determined the accuracy of the documents by comparing the documents that contained similar information
6. Summarized the information from documents and reports; and reviewed alignment to evaluation objectives.

### **2.3 Quality assurance**

- Conducted rigorous training of the research team to ensure that they are fully conversant with the use of tools. Four qualitative researchers were trained on the qualitative tools and note taking who worked in pairs; one researcher conducted the interviews and another took the notes.
- Ensured strong data quality at all levels, including designing of tools, pre-testing, data collection, data analysis and validation with stakeholders.
- Clarified understanding on project indicators with the project team to enable consultant team gain knowledge of indicator definitions and measurement approaches as per CGPP Monitoring and Evaluation (M&E) plan.
- Used reliable sources of information, collaboration with World Vision and cross-referencing with other credible sources from CGPP partner
- Conducted routine de-briefing among the research team to share experiences and agree on improvement strategies

### **2.4 Data analysis procedures**

During data analysis, multiple perspectives were included where greater participation was done to help cross-check accuracy and improve critical reflection, learning and utilization of information. Stakeholder involvement in analysis at all levels helped ensure evaluation findings are accepted and regarded as credible but ensured ownership of findings, conclusions and recommendations.

Qualitative data was analyzed manually using content analysis through coding of themes aligned to a set of categories. All data collection tools were coded to ease data entry. All notes were typed in tables following the codes and later grouped together based on the different codes. Categories were attached to pieces of evidence and then those pieces of evidence were drawn together. There were headwords that describe the category and consisted of reading the field notes and attaching labels to different categories of evidence. The following procedures were followed:

- Typing interview notes in tables according to codes
- Cutting and pasting notes into a new structure organized by themes
- Reading through the notes and attaching labels (codes) to evidence about the related category.
- Adding text labels, comments, or highlights to electronic documents

Key findings from document review, FGDs and KIIs were summarized, whereby the consultants took note of frequent responses of the participants on various issues taking into consideration the explanations and interpretations given by the participants compared with the quantitative data summaries/reports.

## **Triangulation**

Two or more methods were used in the evaluation to check the results of one and the same evaluation questions. Information collected was triangulated with information from key informants in the CGPP implementation areas. Triangulation helped serve the following

1. Facilitated validation of data through cross verification from more than two sources.
2. Tested the consistency of findings obtained through different instruments.
3. Validated, deepened and widened understanding on performance of project indicators.
4. Strengthened the outputs of different informal and formal instruments to add value by explaining different aspects of this evaluation

## **2.5 Data presentation/dissemination methods.**

Data presentation was guided by the evaluation objectives and as such qualitative and quantitative data (where available) have been integrated. A dissemination meeting was held in Juba with CGPP staff and partners in South Sudan to share and validate key evaluation issues, feedback from CGPP staff and partners guided revision of evaluation report.

## **Ethical considerations**

Consultants sought consent from all participants in the evaluation. The consent procedure conveyed that participation was voluntary and would not affect participation of respondents in the CGPP presently or in the future. All potential respondents were informed of the sensitive nature of survey and interview questions and their right to decline to answer any question or to withdraw from the interviews at any time. Furthermore, participants were given the information about the evaluation regarding the purpose of their participation in a language they understood.

Reviewing documents that involved sensitive and confidential data about CGPP was dealt with utmost care. Such documents after review will continue to be kept where access is limited; additionally, reporting on sensitive information has been excluded from the report and individual names removed.

## **2.6 Limitations and mitigation strategies**

- Field access in South Sudan was restricted due to logistical and security constraints. The consultant team worked closely with the security department to carry out field evaluations. The agenda was interrupted in several cases:
  - In Akobo, we were not able to meet the key informants because communities were fighting for four days. Nonetheless, the team managed to interview PAs, CS and the County health director.
  - In Pibor the plan was to interview 9 KIs but only 4 turned up. This is because there was a local dance that took place in the area and lasted until midnight
  - We missed flights twice to Maban due to booking challenges and unavailable flights. Research assistants were instead deployed to the field to collect data.
- Some documents contained missing sections of required details and components or under reporting on specific issues. Some data was missing from databases and hard copy reports.

### 3 Findings

#### Demographic characteristics

Table 2 Summary of population by State

S/N	State	Total Pop	Pop under 1	Pop under 5	Pop under 15
1	Upper Nile	1,179,984	47,424	248,827	557,424
2	Jonglei	1,555,989	63,304	327,660	660,593
3	Unity	937,510	37,501	196,877	440,628
4	Kapoeta East (EE)	30,197	1,887	9,436	18,873
<b>TOTAL</b>		<b>3,703,680</b>	<b>150,116</b>	<b>782,800</b>	<b>1,677,518</b>

The Core Group Polio Project implementing partners operate in four States of Upper Nile, Jonglei, Unity and one County in Eastern Equatoria State covering a total of 34 counties. Population coverage is estimated at 3,703,680 people, of which the target population is 150,116 children under the age of 1 year, 782,800 children below the age of 5 years and 1,677,518 children under the age of 15 years.

The ability of Core Group Polio Project members to operate in South Sudan with no security restriction, speed in project startups and freedom to implemented activities in both opposition controlled areas and government areas was a cornerstone of the success of the project from its inception.

As of March 2017, CGPP expanded to 33 of the 34 counties assigned under its jurisdiction covering 97% of the most difficult to access areas in South Sudan. The project could not expand to Leer County in Unity State due to continuous active fighting between the government and the opposition.

#### 3.1 Community Based Surveillance (CBS) structure

The evaluation found that the Core Group Polio Project has instituted an effective structure composed of national level staff, partner staff, field staff and volunteers based at community level. The structure was put in place to ensure effective capacity to conduct community based surveillance but also support post campaign monitoring and vaccination campaigns within South Sudan and across borders.

The evaluation results and analysis of monitoring reports indicate well-established CBS structures with all key positions filled with exception of Leer County due to active fighting: 100% of counties have County Supervisors, 100% of Payams have Payam Assistants and 100% of Payams have at least 10 Key Informants. County Supervisors, Payam Assistants and Key Informants form the backbone of the community based surveillance system. The CGPP ensured the community based structures are recruited and filled as planned. Table 3 below shows that all Payams have at least 10 key informants.

**National level:** At the national level, positions were filled for the following: Secretariat Director (overall manager for the project), Surveillance Project Manager and Grants and Finance Officer and five support staff. At the State level, three State Surveillance Coordinators have been recruited to act as Independent Supervisors to the project who work hand in hand with the partners' Project Officers who spend 100% of their time on the project. Six Project Officers at partners level were also recruited to support the project and ensure its smooth running but also coordinate activities between the field, partner and the Secretariat. Each of the partners have

recruited an M&E Manager to handle data and reporting-related issues. Two Project Officers at partners' level are paid 100% by the CGPP for each but cost shared for the M&E Officers.

**County Supervisors:** The County Supervisors report to the partners and are trained and deployed to the counties to oversee the project implementation. They work with key stakeholders like County Health Departments, WHO field staff, Bill & Melinda Gates Foundation field consultants and other partners on the ground. At the time of evaluation, there were 33 County Supervisors except for Leer County; however, plans are in pipeline to kick start operations in this County as soon as there is relative calm. The CS ensures that the PAs are implementing their duties. They also serve as links between the CBS and WHO facility based surveillance system. The CS also manages the CBS finances at the County level.

**Payam Assistants:** These are full-time staff based at the Payam level and supervised by the County Supervisors. Payam Assistants help to establish the network of Key Informants at the Payam level. They work closely with the community/key informants. Each Payam Assistant is assigned about 10-15 key informants and supervise them, train them in collaboration with the County Supervisors, conduct community sensitization meetings to increase the knowledge of the community on acute flaccid paralysis, follow reported AFP cases and report them to the County Supervisors for further investigation.

Where the CGPP operates interstate and international vaccination posts, the PA supervises and supports the vaccinators with at least one weekly visit. They act as contact point for vaccinators as issues arise, and work with health officials and polio partners to solve problems ranging from vaccine supply to the vaccination post. PAs collect and submit data reports monthly to the County Supervisor.

Evaluation results indicate the benefits of flexibility of CGPP by working in conflict and hard to reach areas in comparison to WHO:

*“WHO has security restrictions sometimes makes them hard to access such areas that have conflicts while the CGPP does not have such restrictions and can easily access all areas easily. There is a lot of bureaucracy e.g. before getting finances, WHO has to get approvals at different levels and thus delaying delivery of activities yet with the CGPP the control and check levels are not many.” (WHO Consultant)*

**Key Informants:** These are a group of people in the community who are recruited by the CGPP as volunteers. They are local people, due to their status in the community or the nature of their work are likely to be informed about the sudden occurrence of a case of paralysis among children. They are usually people to whom mothers have been taking their suffering children with symptoms of AFP. Key informants are also people who command respect and responsibility in the community and include traditional healers, church leaders, traditional birth attendance, chiefs, headmen, women leaders, and teachers. They support active case search of acute flaccid paralysis through timely reporting of all suspected AFP cases.

Table 3 Distribution of field level team

	# of counties	County Supervisors		Key Informants		Payam Assistants	
		FEMALES	MALES	FEMALES	MALES	FEMALES	MALES
SPEDP	10	0	11	576	1208	3	76
BIO AID	16	1	14	296	585	1	81
UNKEA	7	0	7	115	335	0	48
	<b>33</b>	<b>33</b>		<b>3115</b>		<b>209</b>	

Source: M&E records

The table above shows SPEDP is operating in 10 counties and has a total of 1863 KIs and PAs while BIO AID is operating in 16 counties and has 963 KI and PA, which is almost half of what is in SPEDP. There is adequate manpower well distributed in different locations. While this seems to be an unbalanced distribution, CGPP staff explained that SPEDP is operating in areas with more Payams thus contributing to more Payam Assistants and Key informants.

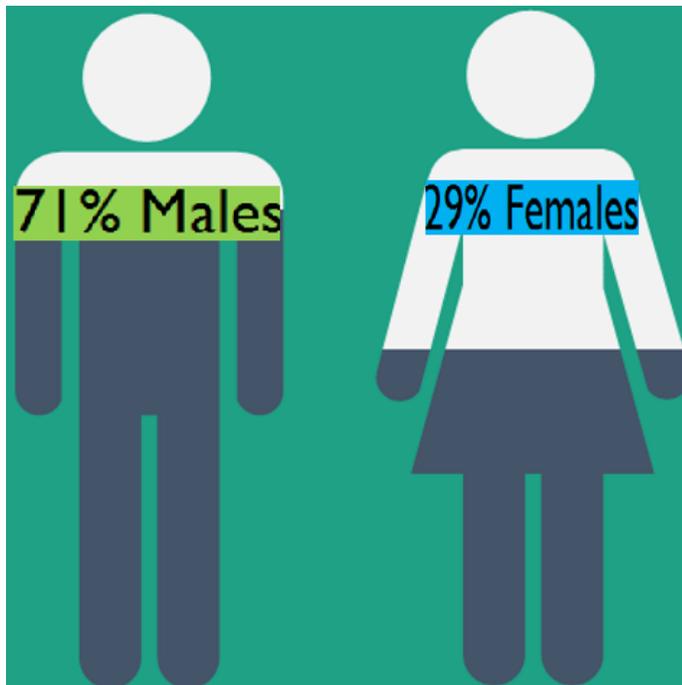


Figure 1: Sex composition of Community Based Structure (CBS)

In reviewing the gender mix of the community based structure, only 29% are females. Of 33 County Supervisors, only one is female and of 209 Payam Assistants, only 4 are women. Of 3115 KI, only 987 or 31.69% are females, the teams are male dominated. Payam Assistants are unequally represented by gender due to difficulties in finding educated females, insecurity or cultural perspective. SPEDP and BIO AID are more balanced in terms of gender inclusion compared to UNKEA across the different domains.

Table 4 Key indicators on CBS structure

Indicators	Target	2016	2017
Percentage of Payams with at least 10 Key Informants (minus the counties which are yet to be accessed E.g. Leer)	95%	100%	100%
Percentage of Payams with Payam Assistants	95%	100%	100%
Percentage of Counties with County Supervisors	100%	100%	100%
Percentage Implementation of planned visits to Key Informants	80%	76%	76%
Percentage Implementation of planned visits to Payam Assistants	80%	57%	57%

Source: The CGPP M&E records

The table above is based on counties where CBS is functional with exception of Leer County in Unity State.

**Strength of CGPP structure:**

There is greater penetration in hard to reach areas by CGPP. Due to conflicts, other partners like WHO, the government and UNICEF have failed to reach such places while the CGPP operates with community based volunteers as front-line workers in difficult areas with no access restrictions. Evaluation results show the benefits of CGPP’s flexible approach to reach conflict and hard to reach areas, especially compared to the more limiting WHO guidelines.

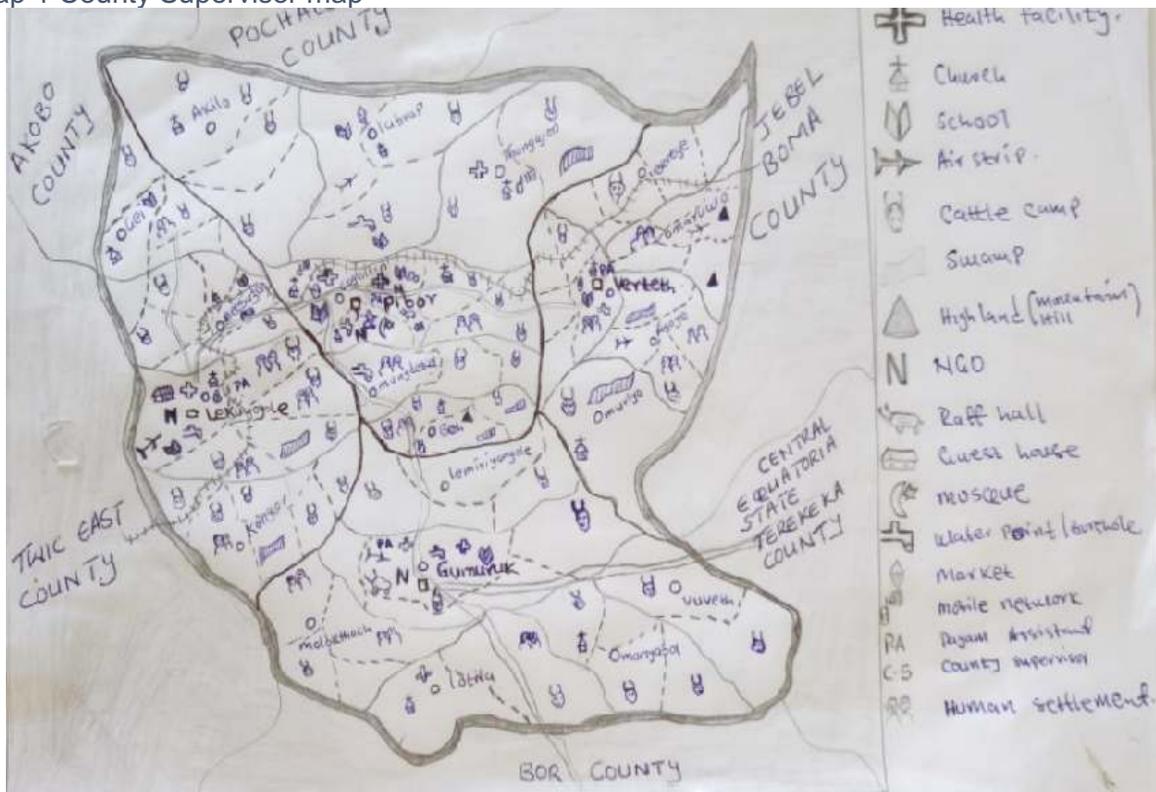
The CGPP community based surveillance structure has enabled to coordinate well at National, State, County, Payam and Boma levels in carrying out project activities. This structure is adequate and efficient and realizes its short and long-term goals. At the Boma level, however, improvements should be made in mobile communities that travel in search of pastures and water for their cattle.

The evaluation results indicate a strong collaboration between the KIs, PAs and CSs.

The evaluation results indicate that 76% of KIs were visited by PAs and 57% of PAs were visited by CS. Some of the reasons cited for not meeting the target were insecurity, bad roads and poor weather.

Performance of key duties by KI, PAs and CS are core to CBS. One of the key requirements for the CS is to prepare a detailed County social map that shows the location of PAs, schools, churches, health facilities, cold chain equipment, airstrip, reported AFP cases, etc. The photo below shows a map drawn by a CS. Details on maps for PAs are included in the annex below. Such maps are helpful tools to inform field visits and conduct training and planning for other AFP activities.

Map 1 County Supervisor map



### 3.2 Identification and reporting of AFP

The emergence of Community Based Surveillance (CBS) was a direct result of conflict that destroyed health infrastructures, displaced families, and disrupted surveillance sensitivity. Restricted movement hindered the delivery of immunization services and led to increased numbers of unimmunized children and increasing the risk of wild polio virus transmission. At the same time, the national ministries of health in South Sudan had inadequate human and financial resources to deliver high quality SIAs, provide high coverage routine immunization, or offer robust AFP surveillance. In response, community-based surveillance was instituted to improve the sensitivity of surveillance in those hard to reach areas by engaging local communities to detect and report AFP cases.

Evaluation results indicate CGPP has established mechanisms of reporting and handling cases and have closed the information gap in the reporting of AFP cases. AFP cases are reported to the Key Informants by the community, the Key Informants then report to the Payam Assistants who report to the County Supervisors. The County Supervisors and the Payam Assistants jointly return to the community to verify whether cases are old or new. The County Supervisors identify and reports the AFP suspected cases to the WHO Field Officers on ground. The Field Officers initiate investigation and collect stool samples shipped to Juba for lab examination.

*“Facility AFP surveillance is there but because the health system is not functioning in most places community based surveillance under the CGPP has been effective. Community based surveillance is based in many locations thus taking services near the people. Where the facility surveillance is working the CGPP team on ground work together with the facility and they report there daily” (EPI Director MOH)*

## **Knowledge on reporting and handling of cases**

The CGPP team has a strong understanding of how and when AFP cases are to be reported. The CGPP project has equipped its team at different levels to ensure suspected AFP cases in the community are identified and reported. Results indicate that the CGPP has contributed to increased participation from different stakeholders and are viewed as contributing to government efforts of eradicating polio.

Community value of CBS has improved as evidenced by the large number of people who attend community meetings. Since CGPP started working with the community, participation from the community has increased and there is change of ideologies and mind set regarding polio.

*“Before, cases at community level could not be reported thus leaving out cases without knowledge unless they went to the facility, but now with CBS, it is easy to detect such cases” (County health Director Pibor).*

*“I believe because people have embraced the project, children will continuously be referred to the facilities, AFP cases will be detected and referred for testing so that in future these diseases will be eradicated, people will become healthy and death rates will reduce”. (PA Kapoeta East)*

*“Honestly speaking 80% of the AFP cases have been done by the CGPP, I mean the CGPP contributed 80% to its reduction in our County Renk, the CGPP has helped our society a lot and we want them to keep on helping us and eradicate the AFP cases and also Support us in other health sectors”. (Key informant RENK)*

*“Because the Community has been sensitized on AFP cases detection, the rate of case detection has increased”. (County health Director Kapoeta East)*

*“As a result of continued community sensitization and education, apart from polio cases other disease cases like TB, measles, meningitis, cholera, Trachoma, Pneumonia have been identified and referred to health facilities” (PA Kapoeta East).*

*“There was a situation when a mother brought her child to a private clinic and the suspected case was referred to us and we went with WHO Field Officer to investigate the case”. (County Supervisor Pibor-)*

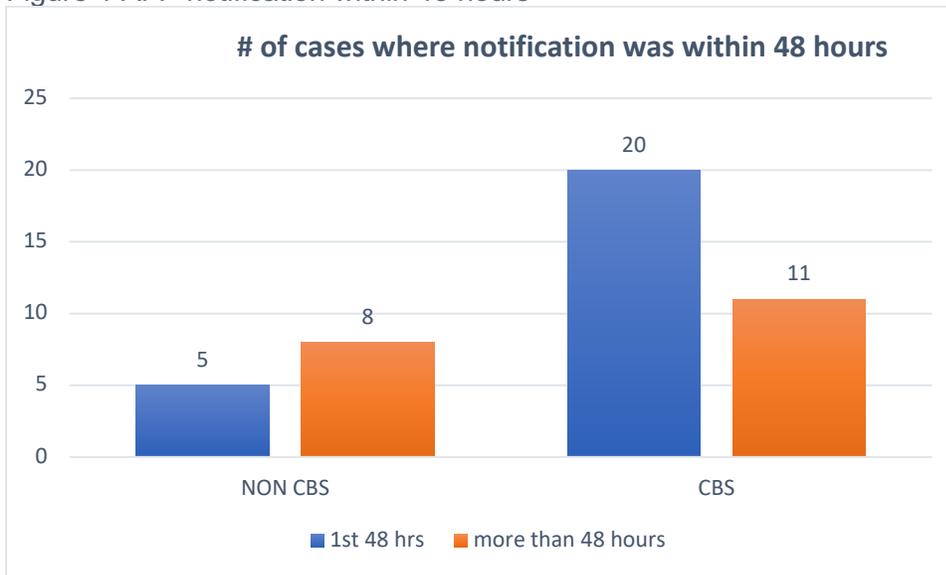
*“Because of the presence of KIs, PAs and CS, the system is so sensitive that even cases that report to the facilities are as a result of the concerted efforts by CBS team who have ensured there is enough information on suspected AFP cases at community level”. (The CGPP Director)*

## **Case reporting according to WHO standards**

Analysis of WHO line list for 2016 and 2017 indicated the following

- A total of 78 AFP cases have been reported from January 2016 to June 2017 in the counties where the CGPP is operational. Of these 44 (56.4%) were through CBS
- 38.2% of 34 AFP reported cases in 2016 were through CBS
- 70.5% of 44 AFP reported cases by June 2017 were through CBS

Figure 1 AFP notification within 48 hours



Source: WHO line list for 2016 and 2017

One of the WHO standards is to ensure that AFP cases under 15 years of age with paralytic illness where polio is suspected are reported immediately and investigated. Further analysis of the line list as shown in the graph above indicate the following: in 2017, of the 25 cases reported within 48 hours, 20 were through CBS compared to 5 through non-CBS system.

*"In June, there were 15 suspected AFP cases reported across SPEDP operational areas. Of the total reported, 14 were reported within the 48 hours. Of the cases reported to the CBS, 9 cases were excluded and 6 were referred to WHO within 72 hours. Of the total referred to WHO, 2 cases were excluded and 4 were investigated by WHO and stool samples sent to Juba" (SPEDP June 2017 report).*

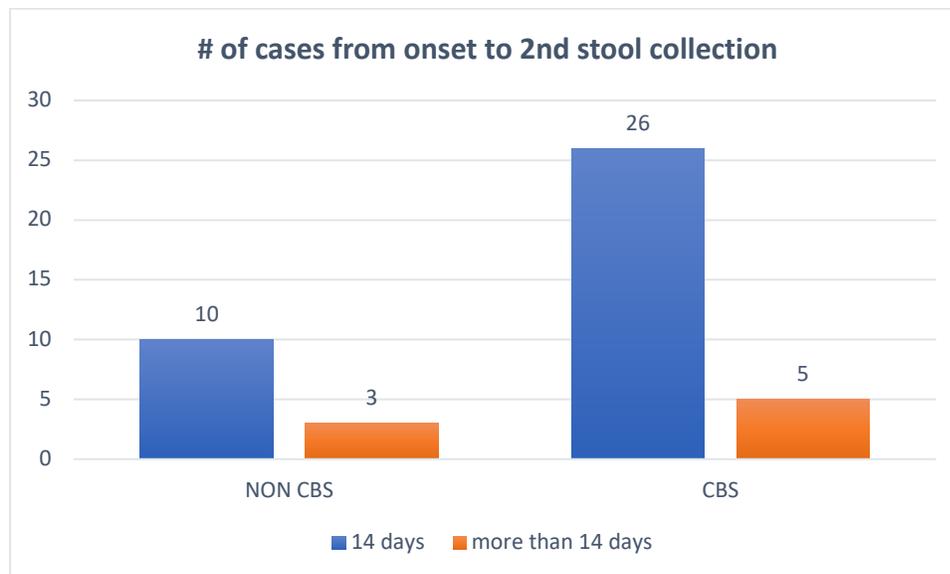
The CBS is sensitive in a way that once suspected AFP case is reported, it generates another intervention by government to perform a mop up campaign, awareness and vaccination including surrounding areas. Very effective approaches have been put in place, immunization coverage is equally done to handle cases that could have been missed out in routine activities.

*"With our situation, we are not sure if children were vaccinated on time, we conduct blanket vaccinations, but even if a child was vaccinated, we give more vaccines even up to 10 doses to ensure their immunity is boosted. Even if a child has got in routine vaccination days, and a campaign comes, still another vaccination will be given". (State Surveillance Coordinator)*

*"The community is always happy when we talk to them because we have so many Lame people and they do not want other people to get lame. When the program came, many children have been saved from paralysis, many mothers previously did not know the importance of vaccination, but now that they have known, they take their child for vaccination voluntarily". (PA Melut)*

## Sample collection and investigation of cases

Figure 2 Days from onset of paralysis to 2nd sample collection



Source: WHO line list for 2017

WHO standards cite that suspected children should be reported immediately and investigated within 48 hours and two stool specimens should be collected 24 to 48 hours apart and within 14 days of the onset of paralysis. The graph above shows that of 44 AFP cases reported and investigated in 2017 from onset of paralysis to second sample selection, those that collected the second sample within the first 14 days were 36; of these 26 were from CBS and 10 from non-CBS. While those that collected samples beyond 14 days were 5 for CBS and 3 for non-CBS.

The PAs work hand in hand with the County Supervisors and the WHO Field Officers to ensure that first and second samples are collected within the specified time period. Some of the County Supervisors have been trained to take samples from suspected AFP cases when a WHO Field Officer is unavailable. The CBS was effective in reporting and investigation of cases and samples. AFP suspected cases are taken within the expected timeline due to existing structures and capacity of the CGPP teams.

### NPAFP Rate

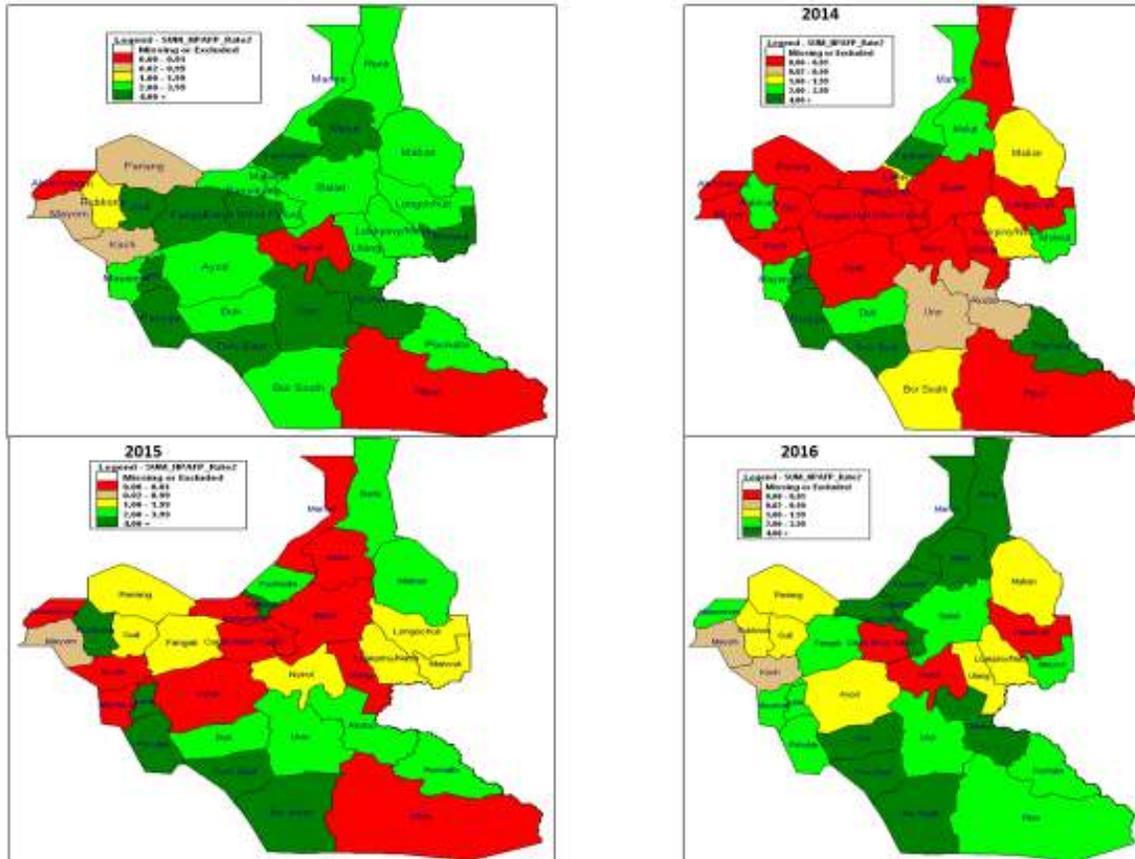
The impact of introduction of CBS can be demonstrated through the analysis of NPAFP rates in the maps shown below.

- During a period of relative peace, the NPAFP rate in 2013 was mostly green with exception of three counties; Pibor was affected by the Yau Yau conflict and Khorfulus and Abiemnhem may have been affected by poor service delivery. By December 2013, conflict broke out resulting in a huge decline in AFP performance as fewer AFP cases were reported. Many counties stopped reporting and became silent altogether.
- The poor performance continued in 2015 although improving slightly. Phase I of CBS started in late 2015 in 17 silent counties. By 2016, there was a huge improvement in the reporting of AFP cases with at least 2/100,000 reporting rate. The improvement was attributed to introduction of Community

Based Surveillance (CBS), with its structure well distributed in the 33 counties under the Core Group Polio Project.

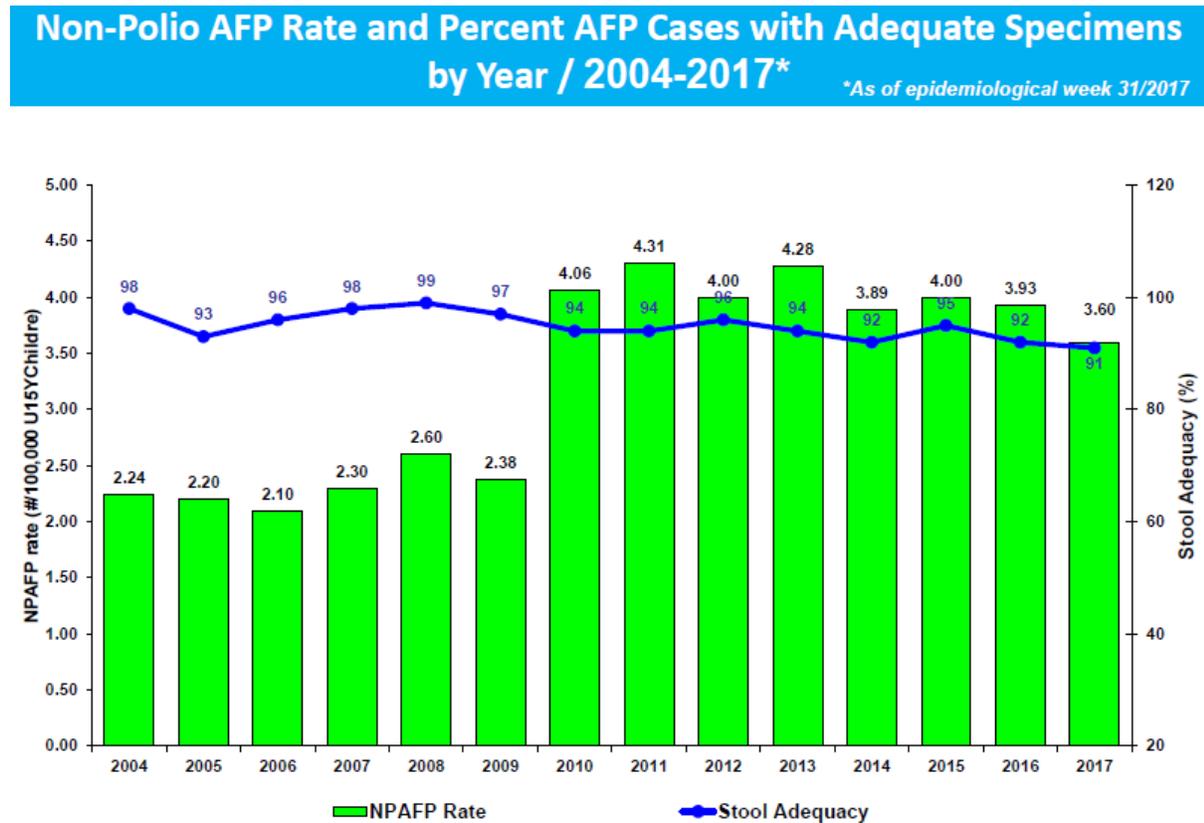
Figure 3 NPAFP RATE:

# NPAFP RATE 2013-2016



Source: WHO surveillance data 2013-2016

Figure 4 NPAFP rate:

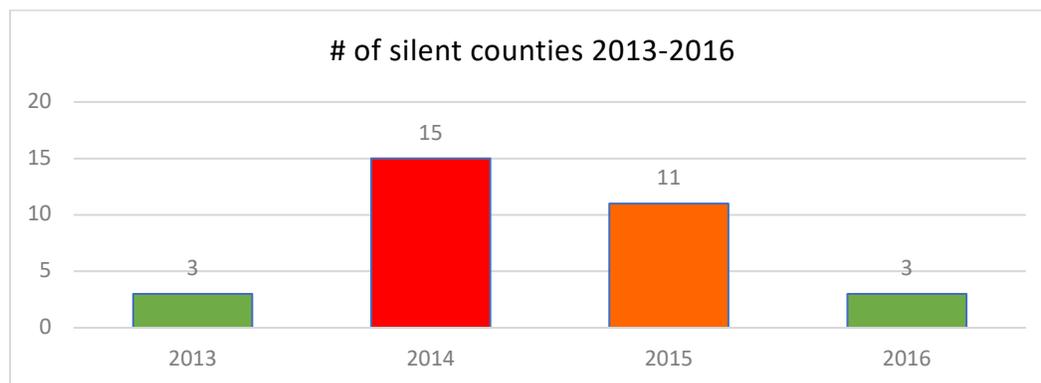


Source: WHO week 30 surveillance data August 2017

The graph above shows NPAFP rates for 2016 and 2017 is at 3.93 and 3.6 respectively and within the WHO threshold of 3%. While this is general national picture on NPAFP rates, the role played by the CBS has equally made significant contribution in the identification and reporting of AFP cases in South Sudan.

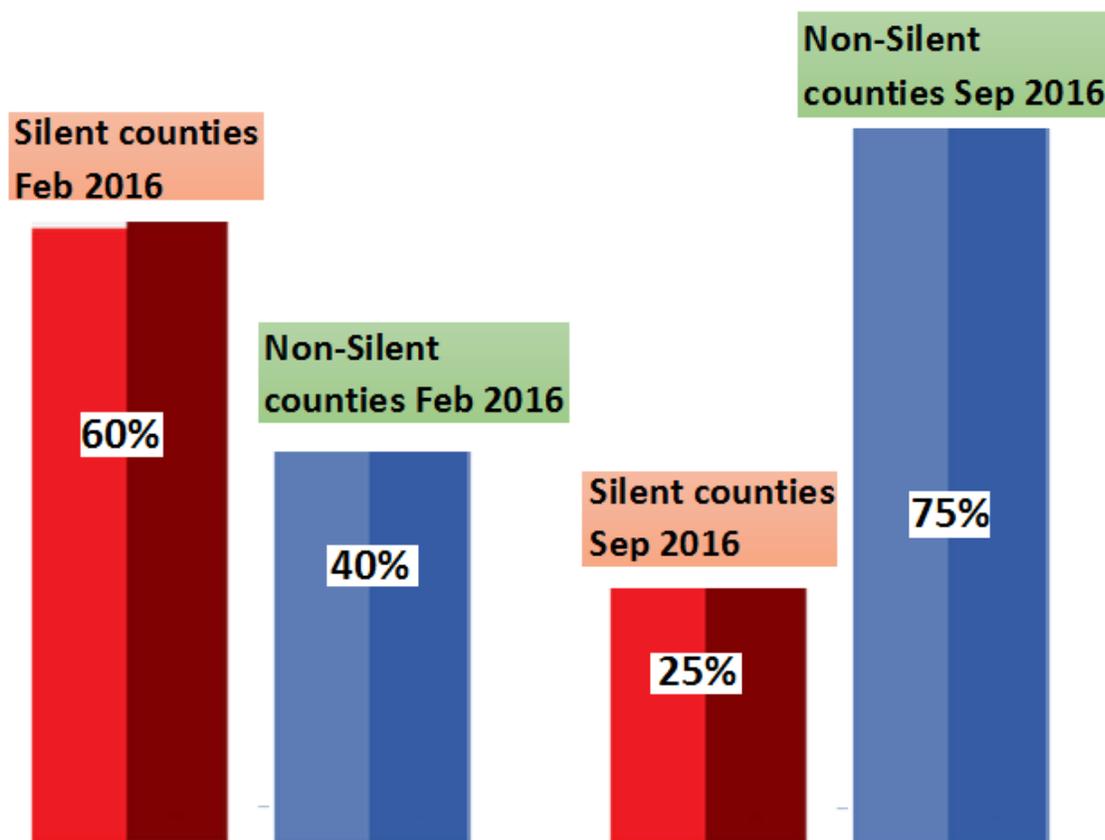
The role played by the CBS led to a reduction of silent counties from 17/33 (52%) counties to 9% (3/33) from January to December 2016.

Figure 5 Silent counties



Source: project reports

Figure 6 Silent counties:



Source: project reports

In a period of four months, silent counties dropped from 60% in February 2016 to 25% in September 2016 and non-silent counties increased from 40% in February 2016 to 75% in September 2016. Between February to September 2016 the rate of silent counties dropped by 35% while those from non-silent areas increased by almost 50%.

As shown in the NPAFP maps above and in the graph, the rate of silent counties has been reducing due to the role played by CGPP community based surveillance system. The CGPP has made significant contribution to ensure counties are not silent and all AFP cases are identified and reported within the community based surveillance system.

*“For us it is not good to report at the end of six months, we are praying hard to eradicate the polio out of South Sudan within the year 2018. If we do not report any case within six months that means we are not working and we are not honest”. (FGD with Payam Assistants RENK)*

#### **Factors contributing to improved case reporting**

Evaluation results revealed that CGPP increased community awareness on polio by providing crucial information to counter beliefs related to polio paralysis. This closed knowledge gaps that existed on reporting of AFP cases. There is a shift from seeking traditional herbal medicine to seeking polio vaccinations.

*“Before the CGPP came, people did not know what Polio was, they were not aware of vaccination, whenever children had weakness in their legs or hands, they would take them to traditional healers. The traditional healers would apply herbs on the paralyzed parts in the legs or hands, this kind of treatment would relieve the sick children a bit but still paralysis would not disappear. When the CGPP began its activities, Key Informants and respected leaders such as Traditional healers, Traditional birth attendants, women leaders, chiefs, and church leaders, in the communities were mobilized and educated on polio disease, how the disease was transmitted, and how it could be prevented. As a result, the number of children who were referred to the facility increased, many children were vaccinated, the AFP case detection rate increased. The turning point here was that the knowledge gap was closed” (PA Kapoeta East)*

### **3.3 Capacity building and facilitation**

The evaluation revealed adequate capacity building by CGPP team in polio case identification, reporting and investigation of cases. The capacity of field and partner staff and the community network of County Supervisors, Payam Assistants and Key Informants was continuously built by the Secretariat on polio, routine immunization and community based surveillance for detection of cases.

The capacity building approach used by the CGPP was both workshop related trainings and on job mentoring and coaching. CGPP worked with WHO, UNICEF and MOH to ensure Health staff and vaccinators are trained. Trainings were also conducted for CGPP national level staff and State Surveillance Supervisors. Additionally, to ensure post campaign evaluations are done smoothly, CGPP trained Central Supervisors at Juba level who in turn trained teachers at Payam level to conduct post campaign evaluation in different counties

Core Group Polio Project conducted the following key capacity building interventions:

- Oriented partners about CGPP project, the polio situation globally and South Sudan, community based AFP surveillance programming, implementation and monitoring.
- Equipped the County Supervisors to support the WHO Field Officers in the counties and conduct AFP investigations in areas where WHO does not have staff. Harmonize working relationships without over lapping, but rather ensure complementary work.
- Trained Central Supervisors to support in the post campaign evaluation
- Trained County Supervisors, Payam Assistants and Key Informants on community based surveillance tools and strategy.

*“Training of PA at County level is done during monthly review meetings and support supervision, quarterly trainings are at times done”. (County Supervisor Kapoeta East)*

A review of two training reports available at the secretariat is summarized in the table below; It shows that the Core Group Polio Project has strengthened capacity of its team with required skills to roll out community based surveillance in South Sudan.

Table 5 Extracts from training reports:

When	By Who	Participants and number	Objective	Outcome
22-24 May 2017	CGPP	53 County Supervisors, Project Officers and M&E Officers	To address existing knowledge gap, orient the newly recruited CBS.	✓ Resolved that County Supervisors (CS) should roll out refresher training for Payam Assistants (PAs) and subsequently Key Informants (KI) immediately upon their return to their respective counties
15-16 July 2017	Bio AID	County Supervisors and Payam Assistants ( <i># of participants not specified in training report</i> )	To empower the County Supervisors and the Payam Assistants with the necessary information required in the fighting against polio.	✓ The participants understood and would explain MOH guidelines for polio eradication program. ✓ Each participant knew what role he/she will be playing in the community based surveillance, AFP polio program in their respected Payams. ✓ The participants were fully aware of how to detect AFP polio case and its reporting procedures.

Source: training reports 2017

### 3.4 Coordination and collaboration between key CGPP partners

One of the best practices with the CGPP is the critical partnership with other key players in handling community based surveillance system. The CGPP has worked with a range of partners that include UNICEF, WHO, BMGF, MOH, SPEDP, UNKEA, BIO AID, cross border networks and local authorities at the State and County levels. Through these partnerships more community members have been reached in detection and reporting of AFP cases. There is active relationship between organizations with defined areas of cooperation governed by formal agreements. Resources are either combined, cost shared or given including the expertise to conduct CBS, post evaluation campaigns and cross boarder activities among others.

The CGPP is not the only funder for the projects jointly implemented; among other funders include: BMGF, WHO, UNICEF; also, the implementing partners are cost sharing on some of the staff like the M&E Officers. The CGPP has constantly kept members of the partnership fully engaged through trainings, meetings, sharing of data and information on AFP and PCE but also requesting for accountability where resources have been committed.

#### World Health Organization

The major role played by WHO is coordination of health activities together with the MOH. WHO supports sample collection, compiles and analyses AFP data coming from the CGPP. The evaluation results indicate that WHO has played its major roles in CBS. WHO analyses data from vaccination campaigns, post campaign evaluation and produces fact sheets, weekly surveillance reports and newsletters. WHO conducts supplementary immunization, special vaccination at international borders through border posts. WHO also conducts interstate vaccination and sharing of information on AFP and EPI.

WHO has established structures at State and Field Officers based at County levels. WHO activities cover the whole country. However, because of inaccessibility WHO gets limited reaching those places on some occasions. WHO Field Officers are the ones that collect samples, they however work with grassroots structures like CS, KI, PA. WHO also organizes flights to ferry in samples to Juba from the field. Data generated from the surveillance is circulated through the weekly bulletin provided by WHO. The CGPP uses this data for planning and improving its

operations, most of the discussions with CGPP team about the surveillance data is done during technical working group meetings.

## UNICEF

On the 6th April 2016 Core Group Polio Project signed a Program Cooperation Agreement with UNICEF to support strengthening community engagement and social mobilization for polio outbreak response in 24 counties in the former States of Upper Nile and Jonglei.

The objectives for the social mobilization included:

- ✓ To increase risk perception against polio and sustain high levels of awareness among 80%-95% of caregivers on importance of vaccination and repeated doses for all 0-15 years old children,
- ✓ To reduce proportion of missed children especially in hard-to reach areas, IDP sites and among migrating and mobile populations,
- ✓ To increase demand for routine immunization and supplementary immunization activities
- ✓ AFP active case finding through household visits

This PCE complemented the already existing intervention on community based surveillance in 17 counties of Upper Nile and Jonglei. The BMGF grants mainly focused on community surveillance. UNICEF grant was channeled to fund social mobilization by ensuring that social mobilizers at the Boma levels are hired and linked to the Payam and the County as a complete community based network of volunteers.

The evaluation results indicate that social mobilization activities strengthened awareness on AFP surveillance, immunization and new born identification and referral for routine vaccination. Data reviewed in monthly Progress report below for August 2016 showed the impact of social mobilization in operation areas.

Table 6 Progress on social mobilization

<b>Activities</b>	<b>Targets</b>	<b>Total</b>	<b>% coverage</b>
# of households visited by social mobilizers during SIAs	14200	12,822	90
# of community members reached with key health messages during household visit	95000	83,627	88
# of community leaders reached with key messages on AFP/Immunization	12100	1,920	16
# of people reached with health promotion talks in churches/mosques or sporting events	54000	47,023	87
# of mothers reached with key messages on immunization/AFP surveillance	42100	30,368	72
# of pregnant women identified & referred to the nearest vaccination center for routine vaccination	2500	897	36
# of new born identified & referred for routine vaccination	1100	604	55
# of nomads sensitized with the key AFP /vaccination messages	1500	955	64
# of school children reached during the month	42000	27,107	65
# of school teachers reached during the month	500	448	90

Source: social mobilization report August 2016

However, this contract the Core Group Polio Project signed a Program Cooperation Agreement with UNICEF could not mature and social mobilization was now left to the vaccinators under WHO.

Social mobilization was more aligned to vaccination schedules, this has created a gap regarding increasing knowledge in the community on importance of timely child vaccination.

#### Ministry of health (MOH)

One of the major partners the CGPP is working with is the Ministry of Health. There is coordination at both national and County levels where the CGPP team is working together regarding CBS.

MOH recognizes the fact that the health system is not functioning and thus the need to rely on partners for delivery of health services. Relying solely on facility-based surveillance and case search in conflict-affected communities with weak or non-existent health systems and a cultural proclivity is not practical

At the field level, government works together with the CGPP in joint supervision, providing updates on security situation, providing office space to County Supervisors and sharing of information collected during health coordination meetings. The government and communities have accepted the community based surveillance activities and are supportive through being involved in day-to-day activities regarding AFP cases.

*“The MOH community sensitization on how to detect AFP polio case and its reporting procedures was effective and our relationship with the community is very strong. The community knows the burden of polio especially the families of those who are affected; we have not received any rejection from any community and they need us to support them”. (County Supervisor Renk)*

*“We always visit hospital almost daily, and we make sure that we have work plans for our Key Informants to visit in Bomas according to the time schedule”. (Payam Assistant RENK)*

*“MOH repairs cold chain equipment and general maintenance and MOH together with WHO work together in cold chain management”. (EPI Director MOH)*

*“Core Group Polio Project, World Health Organization, Ministry of Health, the community, the Key Informants make a collective contribution to ensure there is change in our community; we don’t want polio to spread and I report a lot of cases”. (Key Informant Maban)*

#### Bill and Melinda Gates Foundation (BMGF)

The BMGF partners work as consultants in the field, to collect information on activities. BMGF generates and presents reports on indicators performance to CGPP, and address issues such as operational funds for CS and staff salaries and monitors the CGPP staff.

#### BIO AID, UNKEA and SPEDP

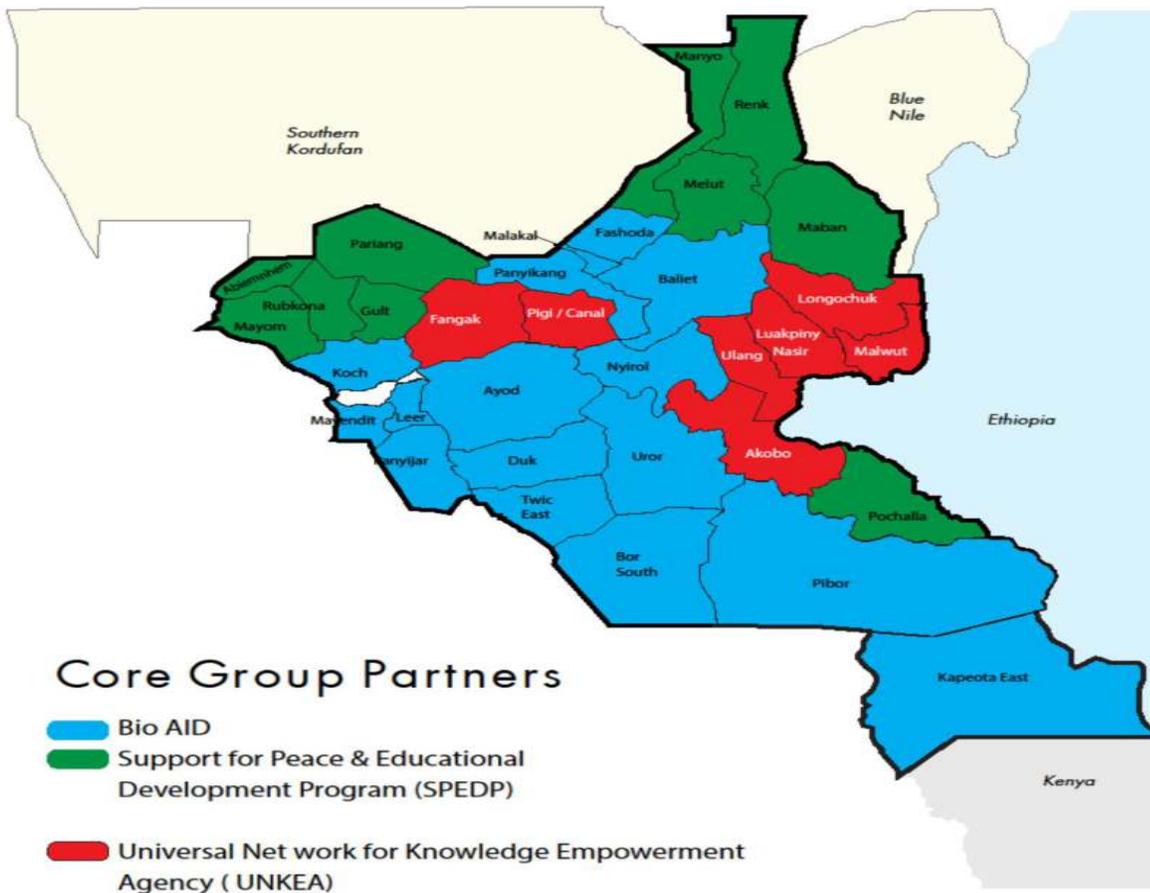
The CGPP activities are being implemented through partner NGOs working at the County or Payam level. The implementing partners are included in map below:

- BIO AID operates in Jonglei, Upper Nile, Kapoeta East and Eastern Equatoria State (16 counties)
- Support for Peace and Education Development Program (SPEDP) operates in Jonglei, Upper Nile, Unity States (10 counties)
- Universal Network for Knowledge & Empowerment Agency (UNKEA) implements in Jonglei and Upper Nile States (7 counties)

The evaluation findings indicated positive collaboration between CGPP partners as evidenced by reporting and investigation of AFP cases in counties covered by CGPP. Core Group Polio Project partners operate both in the areas controlled by the opposition and the government

The partnership and collaboration with local partners has proved an effective strategy to reach hard to reach and insecure areas with community based surveillance and AFP detection and reporting activities. This partnership with local NGOs and government has gradually improved community based surveillance activities in areas of operation.

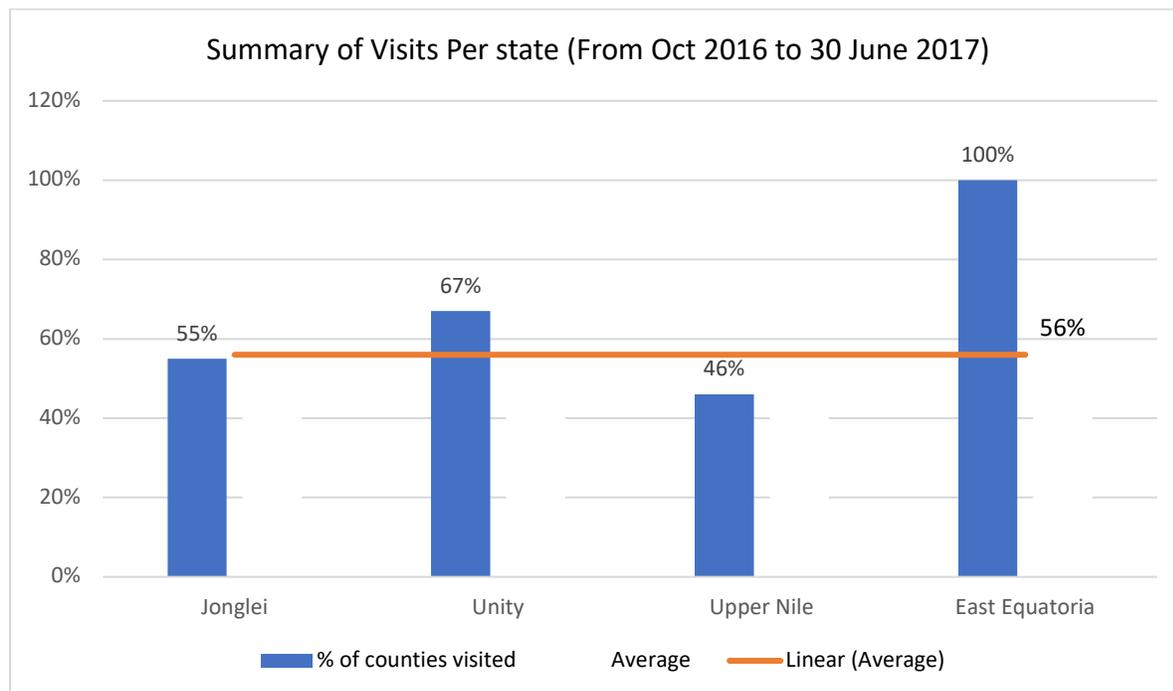
Figure 7 Core group partners areas of coverage



Role of partner organizations in supervision of CGPP activities.

To ensure effective implementation and monitoring of the CGPP, one of the requirements of the implementing partners is to ensure regular supervision of activities. Secretariat staff and Partner Project Officers are required to visit 90% of the Community Based Surveillance counties each quarter. Details on visits is indicated in the graph below:

Figure 8 Field visit status by partners



Source: CGPP tracker

The monitoring reports from the CGPP Secretariat shows that more than half of the counties were visited by partner organization in a quarter. Eastern Equatoria was visited every quarter while conflict-affected Upper Nile received least monitoring and supervision visits from partners.

Partner organizations that CGPP works with have demonstrated high level of willingness to be part of the implementation of CGPP activities and contributed to the long-term organizational vision and goals.

*“There was willingness of UNKEA to participate in the surveillance system and it’s in interest of the organization to save lives. It is not about the job but rather there is commitment on our side as an organization to deliver on our plans. Before the Core Group Polio Project(CGPP), we were doing activities and when the CGPP started implementation, its interventions were aligned to our plans” (M&E UNKEA).*

### 3.5 Development of Community Based surveillance (CBS) guidelines

The CGPP Secretariat worked in close collaboration with the Bill & Melinda Gates Foundation Health Specialists (Consultants) to develop guidelines for community based surveillance for conflict affected context with reference to South Sudan conflict affected States of Jonglei, Upper Nile and Unity States. The guideline plan is meant to show case of Core Group Polio Project experiences, challenges and lessons learned over the years in the implementation of community based surveillance. This guideline instills idea of standard operation procedure in quality implementation and streamlining of CGPP across partners and locations putting into consideration of the volatile nature of South Sudan.

Core Group Polio Project has trained implementing teams and partners on use of Community Based surveillance (CBS) guidelines, 33 of 34 counties received training on the new CBS

guidelines. The CGPP could not conduct CBS guidelines training in Leer County due to insecurity but plans are underway as soon as the security improves to roll out the tool in Leer County.

To ensure clear guidance on planning and monitoring processes, CGPP developed the following CBS documents to be used by field teams at County or Payam level or both. Validation of these documents during the field visit in the 6 counties indicated the following documents exist either in hard copies or soft copies at the County or Payam level.

Table 7 Documents used by field teams

Documents required at each level	County Supervisor	Payam Assistant
A copy of the CBS Field Guide (this document)		
Copy of the list of key informants for each Payam		
Copy of social maps showing distribution of key informants for each Payam		
Social map of the County showing location of Payam assistants		
Copy of Payam monthly work plans		
The Initial Reporting Format (IRF) for suspect AFP cases		
Updated line-list of suspect AFP cases reported from the CBS system		
File of supervisory checklists for all visits to the Payam Assistants or key informants		
A logbook/diary recording his/her activities		
Budget document: shows what funds the CS should receive for each quarter by line-item		
Budget document (for each quarter): shows CBS funds received		
Budget document (for each quarter): shows CBS funds spent		
Budget document: Fund Request Form		
Copy of all monthly reports		

The challenges encountered at the beginning were related to delays in accountability and payment of County Supervisors by the implementing partners, and occasionally resulted in delayed implementation of activities across all partners. The evaluation results indicated that the CBS guidelines harmonized and streamlined operations across different organizations implementing the CGPP.

*“At beginning we had challenges of transferring money. But after CGPP developed a CBS guideline/documents, funds are well managed. We only transfer after field teams have accounted for previous disbursement. We also monitor how it has been delivered to the field. This is updated every month”. (State Surveillance Coordinator)*

### . 3.6 Vaccinations and Cross border interventions

One of the key interventions conducted by CGPP was vaccinations and cross border collaboration and coordination. The CGPP Secretariat is a member of the country’s EPI technical working group (EPI-TWG). The EPI-TWG meets weekly on Fridays to deliberate on immunization issues in the country, share information and plan as a team. The CGPP uses these routine meetings to update other EPI-TWG members, including WHO, MOH and UNICEF on project activities, progress made and challenges.

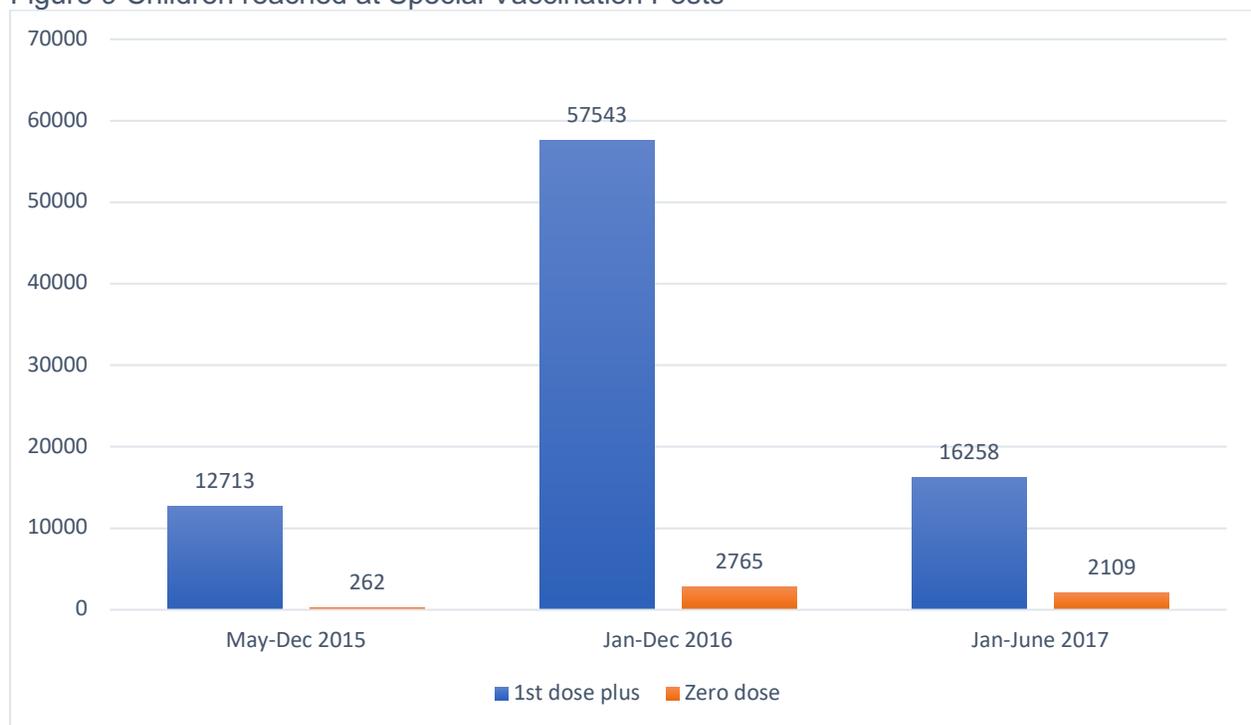
Population movements due to conflict and instability create the ideal environment to spread the polio virus. To address this, the CGPP has established Special Vaccination Posts (SVPs) to vaccinate children between the ages of 0-15 years crossing from the conflict affected States to the fairly stable States and between South Sudan border of Ethiopia, Uganda, DRC, Sudan and

Kenya to vaccinate children crossing to the camps and nomads. Some of these posts are located at the international borders while others are located within the country. The CGPP established Special Vaccination Posts (SVPs) to reach mobile populations that are typically unvaccinated or under-vaccinated. The CGPP partnered with MOH, UNICEF and WHO in providing the vaccines and manpower to conduct vaccinations.

Each of the CGPP partner NGOs provided transportation, training, social mobilization, supervision and planning support for the annual NIDS and SNIDS ensuring high quality implementation. Considering the low routine immunization coverage, maintaining high coverage through SIAs is critically important to maintain adequate protection against re-importation of the wild polio virus.

Additionally, the CGPP has managed to strengthen collaboration and coordination between countries at the subnational level and shared information on immunization, surveillance and social mobilization involving Uganda, Kenya, Ethiopia and DRC

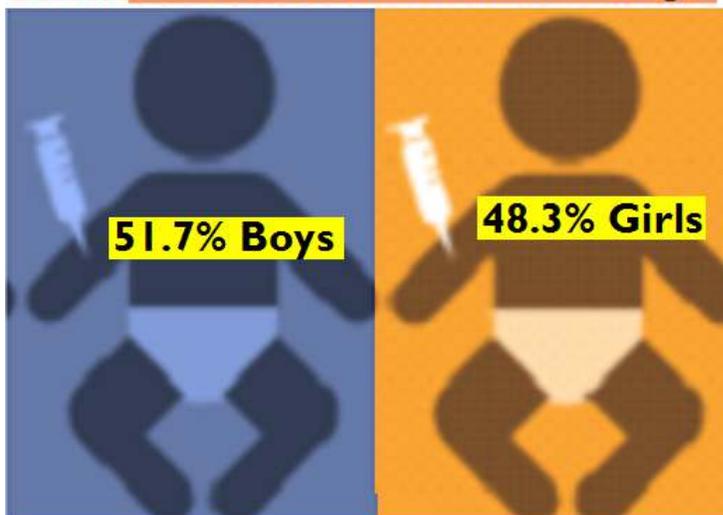
Figure 9 Children reached at Special Vaccination Posts



Source: SVP databases

The graph above shows a total of 91,650 children that have been vaccinated from May 2016 to June 2017 with at least one dose and 5.6% zero dose. There was a progressive increase in 2016 compared to 2015 and 2017. According to the project staff, most of the border posts closed during the conflict in late 2016 and were re-opened in 2017.

### Jan 2016 to June 2017 Vaccination Coverage



Disaggregated data for 2016 and 2017 shows 51.7% boys and 48.3% of girls were vaccinated. This gender difference was also observed in the monthly report for July from SPEDP

*“In the month of June 2017, a total of 570 children (M321 F249) of <15 years were vaccinated in SVP. Out of this, 560 (315M 245F) children <15 years were given 1 dose plus. Further 10 children <15 years (M6 F4) were vaccinated at zero dose”. (SPEDP June 2017 report)*

Table 8 Vaccination posts established 2015-2017

Vaccination posts	2015	2016	2017
1. ATTIT	√	√	√
2. BIEM KAT			√
3. BURIBIE(BOLE)			√
4. JODA JUNUB			√
5. KIRONYUMBO	√	√	√
6. KUDA	√	√	√
7. MINGKEMAN	√	√	√
8. MOGOS		√	√
9. NADAPAL	√	√	√
10. WUNTHOU		√	√
11. NIMULE	√	√	
12. JIKMIR		√	
13. KAYA	√	√	
14. KHOR KAYA		√	
15. LUJULO		√	
16. MALWAL		√	
17. PAGAK		√	
18. PAJAALA		√	
19. JALIMO MARKET	√		

20. ABAYA CHECK POINT	✓		
21. SERA-JALE	✓		
22. BURE	✓		

Source SVP reports 2015- 2017

The table above shows a total of 22 Border posts that have been established since 2015 to date. Due to prevailing favorable security, the following five have never been closed: ATTIT, KIRONYUMBO, KUDA, MINGKEMAN and NADAPAL. As of 2017, only 10 border posts were operational. The following four JALIMO MARKET, ABAYA CHECK, SERA-JALE and BURE only operated in 2015 and closed due to insecurity along Border posts. While the following four were newly opened in 2017: BIEM KAT, BURIBIE(BOLE), JODA JUNUB and KAT (ABIEMNOM). The border posts are along borders with Ethiopia, DR Congo, Uganda, Sudan and Kenya. Those that were closed was due to worsening insecurity and evacuation of the areas occupied by the civilian populations.

*“South Sudan is still not safe because most south Sudanese are in exile in neighboring countries, wild polio virus might be existing and can be brought to South Sudan again”. (County Supervisor RENK)*

*“The CGPP has introduced more vaccination posts including State borders and cross country where children are brought for vaccination instead of moving longer distances including places where WHO cannot reach” (WHO consultant).*

### Cross border meetings

The CGPP facilitated cross border meetings with the aim of eradicating polio. Cross border points are potential entry points for transmission of Wild Polio Virus (WPV). The WPV among other communicable diseases spread from country to country thriving on the cross-border communities and population and within mobile populations.

One of the actions from previous cross border meeting indicated, *“most of the action point was implemented by all the three countries, what is not implemented is carried forward for the next quarter plan”*. (April 2015 cross border meeting report page 3)

Cross border meetings led to informed discussions with actionable recommendations developed to address issues identified. Below are some of the issues and resolutions developed in cross border meetings.

Table 9 Resolutions in cross border meetings

Purpose	Issue	Resolution
South Sudan, Uganda and the Democratic Republic of Congo Cross Border Collaboration Meeting for Polio Eradication. Arua Uganda Dec 2016	<ul style="list-style-type: none"> <li>✓ Massive presence of Sudanese refugee children without or insufficiently vaccinated</li> <li>✓ Koboko District data for cross border activities not segregated</li> <li>✓ Breakdown/destruction/looting of the Cold Chain</li> </ul>	<ul style="list-style-type: none"> <li>✓ South Sudan, Uganda and the DRC agreed to support continuous coordination among them through sharing of updates on cross-border surveillance and EPI activities</li> <li>✓ Involve every district/sector bordering the 3 countries.</li> <li>✓ Involvement of Custom officials and security officials to be part of such meetings.</li> </ul>

	<ul style="list-style-type: none"> <li>✓ Insufficient documentation of foreign children taken by immunization services</li> <li>✓ Prosecution of participants by border services</li> </ul>	<ul style="list-style-type: none"> <li>✓ DRC and Uganda partners agreed to step up their routine immunization activities along border cross points to ensure that South Sudanese Refugees are immunized.</li> <li>✓ The three countries agreed that each cross- border Health Committee should step up resource mobilization efforts so that joint cross border coordination meetings can be conducted at least twice in a year</li> </ul>
Cross Border Quarterly Review Meeting in Aru DRC April 2015	<ul style="list-style-type: none"> <li>✓ There are still children along the border corridor, not been yet reached with services.)</li> <li>✓ All the antigens and their coverage is low, there was vaccine stock out</li> </ul>	<ul style="list-style-type: none"> <li>✓ Focal persons to take the list of technical teams to immigration/border posts and timely sharing of list of members to allow free movement for quarterly meetings</li> <li>✓ The technical team members to harmonize the IEC translation into local language and UNICEF, MOH, WHO be involved in ensuring social mobilization IEC materials are the same for the three countries</li> <li>✓ Disaggregate data to include cross border details in SIAs and mass campaigns and share in the google mail</li> </ul>

It is therefore clear that the cross-border meetings have managed to discuss critical issues around child vaccination with the aim of eradicating polio across the border. The cross-border meetings facilitated by the CGPP have enabled more children along the border to be reached with vaccinations and made significant contribution in building relationship with neighboring State health systems, and thus directly contributing to reduction of risks associated with polio transmission among children across borders.

### 3.7 CGPP Meetings

#### Partners Monthly meetings

The Core Group Polio Project (CGPP) continues to engage its implementing partners through monthly meetings. The meetings are organized by the Secretariat and are held on the third or fourth week of the month. The Secretariat uses these meetings to jointly share information, best practices and lessons learned, discuss progress, inactivity implementation and achievement made, agree on standard operating procedures for quality improvement and review challenges facing project implementation and jointly recommend mitigation measures to address them. Outcomes of the monthly meetings are documented through meeting minutes and shared with the partners for future reference. Minutes of the meeting reflect clear resolutions to effectively contribute to the effective implementation of the project. Some of the outcomes of these meetings have included the following presented in table below:

Table 10 Outcomes from monthly meetings

Minute	Issue	Resolution
2/6/2017	There is still incomplete filling of the line list for suspected AFP cases, BMGF Consultants are developing template for reporting which will be reviewed and shared with CGPP and subsequently partners	All the line list to be update in the new format even if some information is still missing
3/5/2017	There was concern over misuse of project assets, notably motor bikes by un authorized persons including soldiers, notably by Soldiers in Malakal.	Partners to take responsibility for keeping, maintaining, securing and ensuring proper use of project assets in their custody
3/3/2017	Field operation money not sent in Guit and Rubkona and most of all the locations across all the partners and yet it is critical for implementation of the activities in the field	Partners should ensure operational money is sent in time for implementation of activities.  All the partners should submit a list of operation money last sent to the field with its purpose and should be updated on monthly basis.
	There were issues that County Supervisors are not keeping copies of the monthly compilation report submitted by the Payam Assistants due to lack of stationary.	The CGPP should introduce cupboard copy of monthly reporting tool where the original will be submitted to the County Supervisor
7/32017 follow up meeting	Disparities in salary payment; where it was noted during last month's monthly meeting that County Supervisors (CS) receive 600 United States dollars (USD) and Payam assistants (PA) received 150 USD as salary from BIO AID instead of the budgeted 700 USD and 200 USD respectively	BIO AID to pay County Supervisors 700 USD and Payam Assistants 200USD as budgeted
March 2016 No minute number	The County implementing partners said they have limited vaccine, which cannot be enough for implementing the SVPs other than for routine and outreach services	Meet the Health Coordinator from the national office – GOAL in Juba to discuss ways to streamline vaccine requests to the County.

There is an improvement in documentation of CGPP records especially documentation of meeting reports from 2016 to 2017. For 2016, some of the minutes were not numbered while others were not dated and without clear action points. The 2017 meeting minutes are well structured with clear resolutions. Areas of discussions and resolutions taken during meetings shows CGPP meetings have helped discuss critical issues regarding CGPP effectiveness.

### Technical working group meetings

The CGPP Secretariat is a member of the country's EPI technical working group (EPI-TWG). The EPI-TWG meets weekly on Fridays to deliberate on immunization issues in the country, share information and plan as a team. The CGPP uses these routine meetings to update other EPI-TWG members, including WHO, MOH and UNICEF, on project activities, progress made and challenges. Some of the outcomes of TWG have included the following:

Table 11 Resolutions from TWG meetings

Minute	Issue	Resolution
02/6/ 2017	TWG Meeting: noted that the three conflict affected States Upper Nile and Unity have not implemented the campaign, however Jonglei has partially started the campaign and completed this week	Paulo Okech to crosscheck the preparatory in the counties of conflict affected States that have not conducted the campaign, on their level of preparation for the MFUP Campaign
	Following the serious reports from Kapoeta and press release by Hon. Minister of Health	There is a need for Radio Talk shows to be conducted very urgently to correct the

		misunderstanding of public from what happened in Kapoeta (Daniel/Aping)
	Discussion on the email claimed to be sent by MOH to partners in the conflict affected States to only select Certified Health Workers to participate in the simulation exercise for MFUP campaign	Dr. Silvester to share the email send by MOH regarding the certified health workers to participate in the simulation exercise in the next meeting  MOH to write a letter to Health Cluster on the possibility of Measles vaccination exercise to the Conflict affected States but also considering using the existing vaccinators/Health workers and extend the date of the campaign as a second Option

As a good practice, a reporting template developed by the secretariat in May 2017 to track actions made by TWG to ensure clear follow up, implementation and reporting. At the time of evaluation, the template was not yet fully operationalized.

*“The CGPP uses surveillance data for planning and improving its operations, most of our discussions with CGPP about the surveillance data is done during technical working group meetings”. (BMGF Consultant)*

### 3.8 Post campaigns evaluation (PCE)

The CGPP has been supporting post evaluation campaigns targeting the whole country and especially in the more stable counties. The PCE is done four times in a year since these campaigns do not follow the normal quarters. They are normally conducted during the dry seasons i.e. February/March and November/December to reach many areas. The role of Core Group Polio Project during these polio campaigns was monitoring of the quality of the polio campaign. The post campaign evaluation involves training of Central Supervisors from Juba level which is followed by field deployment.

The house to house vaccination involves several vaccinators who are volunteers and selected by their County Health Departments to participate in this exercise. They undergo a day of training conducted by the County EPI Supervisors and WHO Field Assistants, each of them are provided with vaccines in vaccine carries, tally sheets, marker pens and chalk and deployed to their various Bomas. Deployment follows a series of social mobilization activities conducted through several channels such as community volunteers, church leaders, radio FMs, banners, mounted megaphones etc. to inform the community of the vaccination campaign, its importance and when and for how long it will take place.

Evaluation findings shows the post campaign evaluation (PCE) collects very good data through semi structured questionnaires developed by the Ministry of Health through the technical assistance of WHO. In each of the Payams, 4 areas/clusters are chosen to be included in the evaluation biased towards the worst performing areas. In each of the Boma, a total of 10 households are selected randomly, and first household chosen through spinning pen in the middle of the Boma. In each household, every child below the age of five is considered eligible, and every child with no finger mark is considered unvaccinated during that round.

A comprehensive data collection tool collects data from house to house on polio campaign immunization status of children under five (0-5) years within the selected areas/Bomas of the Payams to establish the coverage based on finger marks. It also collects data to monitor the work of social mobilizers before polio immunization campaign and the work of vaccinators who move

from house to house immunizing children under five years of age. During the PCE, data is also collected from households on whether the vaccinators had asked all care takers (parents) about any case of sudden paralysis (acute flaccid paralysis) within their area of residence while administering the two drops. For example, in February 2016, 4969 households were asked about AFP cases. This is another good strategy of integrating search for AFP cases using PCE.

Evaluation findings indicate that this PCE data was analyzed and PCE reports prepared. The PCE reports were used by the MOH and WHO to take corrective actions. Some of the issues identified in PCE reports included: vaccinators not covering the whole area, limited time given for vaccination and poor social mobilization.

Specific extracts from PCE reports highlighted the following issues:

*“During the exercise, the independent monitors found out that the following Boma Kun, Ngenyngok and Wathyoaka in Guit counties were not covered by the recent December round by the vaccinator due to long distances and inaccessibility due to the river where the vaccinator needs to cross by the canoe. Feedback information was shared by the responsible stakeholders, such as County Health Director and WHO Field Officer for actions; a resolution was made to send the team of vaccinators to those locations having poor vaccination coverage”. (December 2016 PCE report).*

*“Some vaccinators complained of their areas being too vast to be covered effectively within the 4 days allocated for the campaign hence missing some areas. Some household members refused their children to be vaccinated, because they were not aware of the exercise or campaign. And in some areas the community members reported that vaccination team collect children in one central place and administered the vaccines instead of vaccinating the children door to door. While on the other hand another person goes around marking the houses making it difficult for them to know whether all the eligible children have been vaccinated or not, because their interaction with the care takers were so minimal if not limited”. (November 2015 PCE report)*

*“Most of the care takers in both Nimule and Mugali reported they did not hear any message prior to the onset of campaign”. (April 2017 PCE report)*

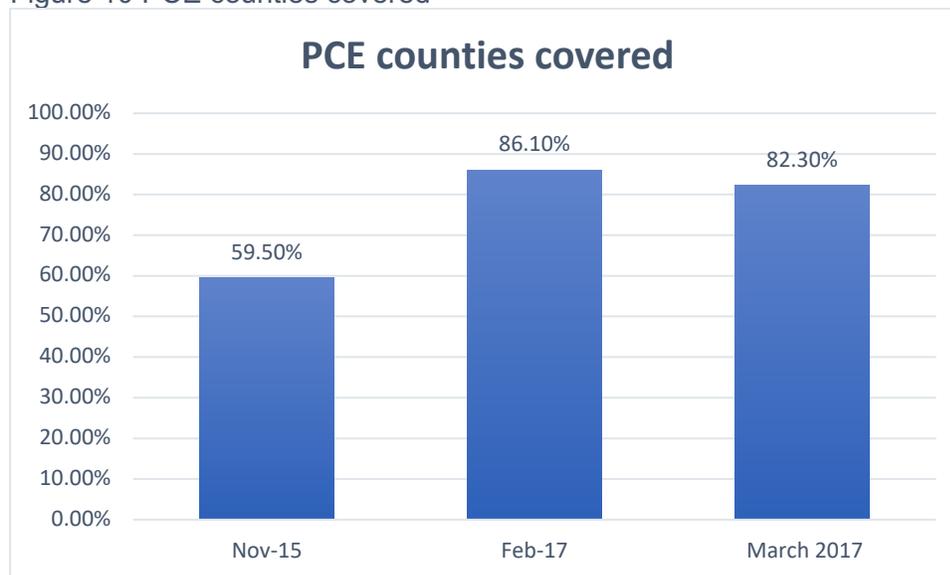
Independent Central Supervisors were deployed in States to support identification of data collectors (who are mostly teachers) and act as independent monitors, they were trained for a day, provided with data collection tools and facilitated their transportation to the Payams and Bomas for data collection for a period of 3 days. Data collection has ensured all counties covered by vaccination campaigns are reached, data is collected and shared with the Juba office. Independent monitors have managed to converse all areas under their jurisdiction, collected all required data, and documented and shared key issues.

Table 12 Some of the results from PCE

Indicator	Mar-17	Apr-16	Dec-15
Social mobilization coverage	86.00%	88.30%	90.10%
% of HH Visited	95.49%	95%	97.40%
# of HH asked about AFP	1928	4969	4103
coverage by finger print	86.00%	94%	95.10%
coverage by history	88.80%		
% zero dose	5.50%	11.60%	16.50%
% of HH marked	23%		93.3%

Source: PCE database

Figure 10 PCE counties covered



Source: The PCE administrative data

Evaluation findings indicated in the table and graph above provided the following evidence: Regarding whether vaccinators had visited households, at least 95% of the households were visited. Social mobilization is lowest at 86% in 2017 and highest at 90.1% for Dec 2015. In terms of coverage by counties, there is an increase in terms of PCE coverage from 2015 to 2017 from 59.5% to 82.30% respectively. Lack of coverage of a majority of counties was due to the variation of the vaccination campaign rounds as some are national campaigns targeting the whole country while others are sub national campaigns just targeting few counties. The other reason for not reaching maximum number of counties was insecurity where not all counties were covered in all rounds.

*“Majority of project counties met the 90 percent benchmark or pass rating for the quality of the campaign. During the first two NIDS in FY 2016, 32 of 40 project counties in November and 34 of 40 project counties in December met the threshold. During the February 2016 SNID, 19 of 22 counties met the pass rate of 90 percent coverage. During the April 2016 campaign, 33 of 41 counties received a pass rating while eight counties failed. The primary reasons for missed children during the campaigns included vaccination teams not visiting the household or the child not being home during the visit”. (2016 annual report)*

The PCE provided reliable data on vaccination coverage and missed children. This supported MOH and WHO in better planning for either mop up vaccinations or capacity building of its team to ensure all future vaccinations should cover all targeted children. Useful data was also provided on quality of NIDs/SNIDs, including coverage, awareness on SIAs, reasons for missing children, reasons for zero dose. The PCE has helped assess social mobilization by learning whether the messages that were passed out by the social mobilizers were received by the community. The MOH and WHO use this to review their targeting approaches in the next campaign. The PCE results have also helped assess household coverage through establishing number of marked households and households not marked are targeted first in the next vaccination campaign.

*“The PCE is done to inform the next vaccination campaign, such that the children who have not been reached will be given the first priority during the next campaign”. (County Supervisor Kapoeta East)*

*“Using PCE data, the MOH follows up to hold those areas accountable that are not performing well. Sometimes the vaccinators are told to go back and address the households with children not vaccinated”. (Count Supervisor Pibor)*

*“We got the marked houses in the community which shows vaccination took place in the specific house; children who are able to speak are asked whether they were vaccinated. We also visit the chief of the area and ask him to know from him if his area was covered properly or not”. (Teacher and Independent monitor Maban)*

### **3.9 Monitoring and evaluation**

The evaluation results indicate that CGPP monitoring, reporting and evaluation processes are stream lined to ensure information is disseminated to all stake holders, CGPP project partners and key stakeholders.

Results indicate that the functionality of M&E system varies from partner to partner and is dependent on the effectiveness of the partner project M&E system. Core Group Polio Project partners data contributed significantly to meet its reporting and documentation needs, accountability, learning and decision making. At CGPP partners level, quantitative systematic and rigorous data collection procedures were employed to collect evidence to support decision-making.

Implementation of activities at the partners level was done in accordance to agreed-upon plans in collaboration with local government at the County level. Data collection tools to guide the monitoring processes have been developed, including PCE tools.

*“Before, M&E data was inadequate, specially using the forms which did not pick details. WHO designed a detailed form to pick details especially those sent with samples”. (State Surveillance Coordinator)*

Information from the secretariat M&E Officer shows 100% of partners submitted 100% of monthly progress reports. The progress reports were used during the monthly partners’ meetings to discuss status, under performance, lessons learned and other areas that would contribute to better handling of CBS and independent monitoring.

The CGPP emphasizes the importance of knowledge growth through meetings and field support visits.

Information is collected from the community daily, from KIs and PAs. County Supervisors use monthly reports to identify gaps and challenges highlighted and develop action plans to guide their field supervision for the following month. More complex issues are referred to the implementing agencies for attention.

*“We go to the field and gather information on ground regarding the work of the CGPP, we generate a report and present to the CGPP on the findings as soon as possible. Some of the things we look at are operational funds for County Supervisors and Salaries for the staff among others”. (Consultant BMGF)*

*“I receive information from PA, on monthly basis, I check for document completeness, I compile the report and send it to M/E Officer of BIO AID in Juba. I usually send it by E-mail, if not possible this way, then hard copy can be sent to Kapoeta south where it is transported to Juba by plane”.  
(County Supervisor Kapoeta East)*

Monitoring and evaluation is also done by the following: State Surveillance Coordinators, Project Officers, partner M&E Officers and the secretariat staff. Project visits were accompanied with visit reports. This therefore shows combined efforts from the secretariat team, Bill and Melinda Gates Foundation and partner Project Officers in conducting field monitoring visits to ensure the project is being implemented as planned.

Table 13 Extracts from project support visits and actions taken.

Trip date	Who	Purpose of trip report	Findings	Outcome
<b>28<sup>th</sup>– March- 2017-4<sup>th</sup> April-2017</b>	Maliamungu Anold from the secretariat	<ul style="list-style-type: none"> <li>✓ To conduct monitoring and evaluation of the recent SIA-NIDs in the two counties.</li> <li>✓ To offer support supervision to the CBS activities</li> </ul>	<ul style="list-style-type: none"> <li>✓ No line list filled for the 2 cases of suspected AFP reported</li> <li>✓ Staff salaries not paid for three months. Jan-March/2017.</li> <li>✓ No operation funds sent to the County since the project started.</li> </ul>	<ul style="list-style-type: none"> <li>✓ The CS agreed to have a list of the Key Informants (KIs) by Payam as per the CBS guideline</li> <li>✓ He was mentored on the procedures regarding reporting, collections of stool samples and filling of WHO form A-B</li> <li>✓ To have an updated line list of all reported AFP cases.</li> <li>✓ Salary payment issue and ID cards to be communicated to Juba office. The team promised to make a follow up in the earliest possible time including operation funds.</li> </ul>
23-27 March 2017	Rumbe Samuel from the secretariat	<ul style="list-style-type: none"> <li>✓ To do Support supervision of CBS in Akobo County</li> <li>✓ To Strengthen coordination between CBS team and other stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>✓ Logistical challenges to deliver vaccines and other supplies to the Payams</li> <li>✓ Late delivery of social mobilization funds.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Copy of Community Based Surveillance Standard Operating Protocol printed and provided to CS</li> <li>✓ Multiple copies of checklist used during supervision printed and provided to CS</li> <li>✓ Refresher training on tools used during PCE conducted to County Supervisor.</li> </ul>
<b>May 5, 2017</b>	Animut Ayenew From BMGF	<ul style="list-style-type: none"> <li>✓ Participate in planning, implementation and monitoring of SIAs</li> <li>✓ Assist planning, implementation and monitoring of AFP surveillance activities</li> </ul>	<ul style="list-style-type: none"> <li>✓ The field assistants in Pochalla County did not get salary since July 2016 and as a result they are very much discouraged to conduct surveillance.</li> <li>✓ No WHO contracted Field Supervisor in Nyirol County.</li> <li>✓ Neither the Field Supervisor nor the</li> </ul>	<ul style="list-style-type: none"> <li>✓ WHO Hub coordinator in Bor communicated about the salary of Field Assistants and agreed to facilitate the Field Officer to travel to Juba and take their Salaries immediately after the measles campaign.</li> <li>✓ Field Supervisor and Field Assistants were oriented on the different forms of planning and reporting</li> </ul>

			Field Assistants have monthly work plan in both counties	✓ On site orientation and discussion held about documenting the line list of AFP cases by Payam Assistants.
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**Data management and information flow**

Efforts were put in place by different players to ensure that data quality issues are observed. At the partners’ level, for example, any questionable data is double checked by field teams to ensure validity. The same applies to WHO regarding samples and corresponding data shared. Data collected through PCE is checked for errors before entry in the central database at the secretariat. This is also thoroughly cleaned before sharing.

Cases were given unique codes based on their Bomas, counties and Payams to ensure there is no mix up in data and results. This helped improve data management. When the County Supervisor received AFP suspected case, she/he together with the Payam Assistant visit the case to verify, if it’s new or old case. If it’s a new case, the County Supervisor together with the WHO Field Officer assess the case before it’s sent to WHO Juba. The County Supervisors also cross-checked information from KI and see whether it was in line with that of the PA. During support supervision in the community, KI were met and asked whether the PAs reached them or worked together with them to validate cases.

At partners’ level, data was checked by Project Officers and M&E Officers for all details e.g. name, area, code, containers with labels and any missing information. In case data quality issues were identified, Project Officers had to call the field people to verify and update before sending. The consistence of information was also checked, if data met the standard expected. At different levels, e.g. at secretariat level, partners’ level, WHO, etc. took time to check the quality of data before using it. There are also different tools to be filled, and various checks are made to ensure effectiveness of the system. Validation was done by looking at the forms signed by the KI and the PA. Cross checking of information from KI and seeing whether it is in line with that of the PA was also done.

The CGPP team and partners’ Project Officers including their M&E Officers made field visits and reviewed information on reports submitted to national office and compared with those filed by the County Supervisors and PA to ensure they are the same and consistent

County Supervisors have ensured close supervision and validation is done by looking at the forms signed by the KI and given to the PA. They also cross check information from KI to establish whether it is in line with that of the PA. During support supervision in the community, the County Supervisor asks the KIs whether all the PAs reached them or worked together with them to validate cases.

Various data and information management systems and mechanisms were employed by the CGPP to store and retrieve data to ensure security and accessibility of data. Information and data was kept in hard copies and soft copies. The soft copies included databases and or internet like email. The CGPP Information Technology department conducts monthly back up of data.

From counties, data was shared with WHO in form of hard copies and cleaning was done centrally. If there was missing information from the field, WHO contacted field teams either through phones or emails to provide the information.

*“When the data comes in hard copies on AFP cases we check all details and in case we find there are issues in the form, samples cannot be sent to Kampala but first called the field people or Project Officers to verify and update before sending. Some of the things checked include missing information e.g. age, containers with labels to ensure the container information tally with hard copy forms”. (Data Manager WHO)*

*“I check data always got from the field, to make sure it is accurate and timely, I request for attendance list and photos that are taken during the meeting of KI, and PA. sometimes I have to go to the grassroots and see if it is valid or/not and make sure only cases reported are seen”. (County Supervisor RENK)*

*“Where the case is reported, we make sure that we see whether the case is new or old case through the signs and symptoms then after that it is reported to County Supervisor”. (FGD Payam Assistants RENK)*

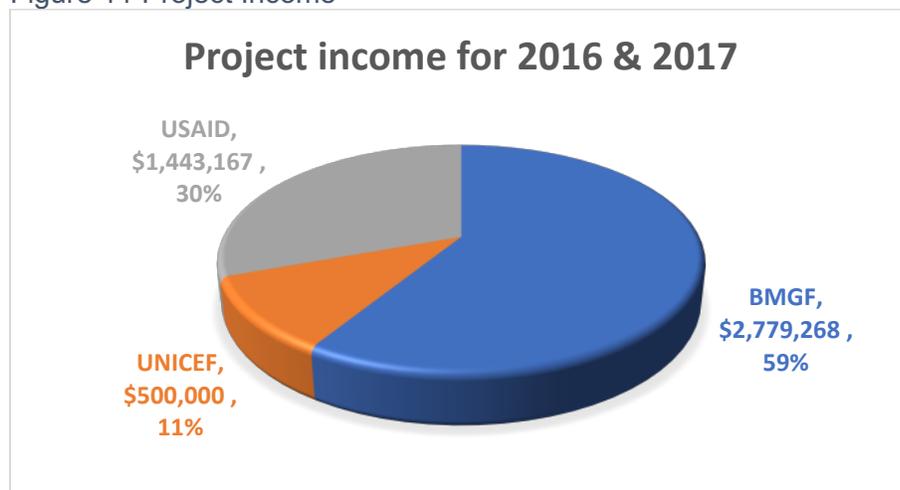
*“In 2015 when the project began there were documentation gaps, but after proper training of the PAs in June 2017, we have registered completeness and accuracy of data. The data collecting tools were revised and now enough information is collected”. (County Supervisor Kapoeta East)*

*“Feedback is also received on monthly reports from the CGPP e.g. on quality and completeness. Sometimes we are asked to adjust the report and then resubmit for example, June report had issues with data and was rejected, which we had to revalidate before resubmitting the report”. (M&E UNKEA)*

### **3.10 Project finance management**

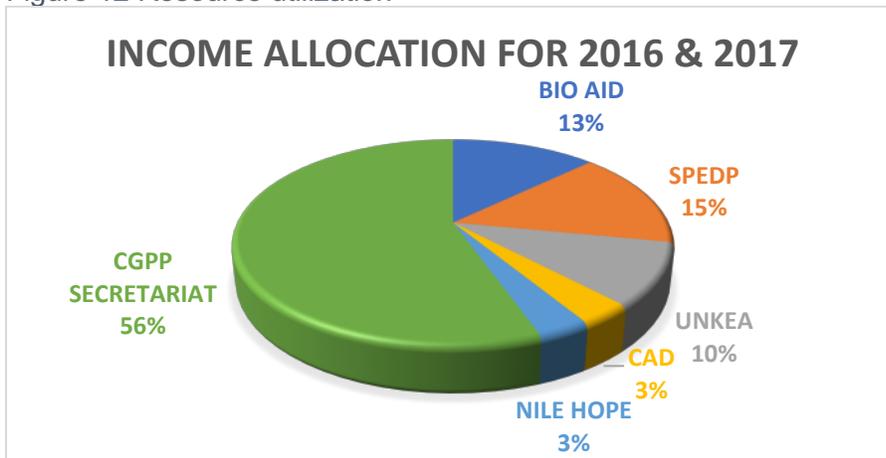
The CGPP receives funding for activities in South Sudan from the BMGF, USAID and UNICEF. USAID funds were primarily used to support independent campaign monitoring for the whole country in 2016 and a portion of the Secretariat costs. UNICEF funded social mobilization through community mobilizers and BMGF funded community based AFP surveillance in 33 targeted counties out of a total of 70 counties in the country.

Figure 11 Project Income



The chart above shows total funding for two years 2016 and 2017 is \$4,724,435; of this, BMGF funds 59% of the budget, followed by USAID 30% and UNICEF 11%. UNICEF only funded for six months and closed due to contract terms that could not be sustained as explained in the gaps sections of this report

Figure 12 Resource utilization



The chart above shows 56% of the budget was allocated to the secretariat, 15% to SPEDP, 13% to BIO AID, 10% to UNKEA, 3% to Nile Hope and 3% to CAD. According to the secretariat, the contract for Nile Hope was not renewed at the end of September 2016 due to poor performance.

Table 14 year to date expenses

	Total budget	YTD Actual	Budget variance	Explanation of any variance more than+ _10%
BIO AID	\$607,600	\$623,100	-2.6%	
SPEDP	\$717,905	\$625,324	12.9%	Logistical challenges, insecurity caused delay in liquidation hence low burnt rate
UNKEA	\$465,435	\$460,435	1%	
CAD	\$158,052	\$100,000	27.9%	Terminated in May 2016 due to funds mismanagement
NILE HOPE	\$154,950	\$154,950	0%	
The CGPP SECRETARIAT	\$2,620,493	\$1,769,196	32.5%	Insecurity in Upper Nile, Jonglei and Unity including other counties in the seven relatively stable States hence funds planned for these areas not utilized
<b>TOTAL</b>	<b>\$4,724,435</b>	<b>\$3,735,005</b>	<b>21%</b>	

Budget monitoring and performance is constantly done. The CGPP introduced finance management tool to be used by County Supervisors to counter issues noted in poor management of funds by partners.

End of July 2017 finance report showed the year to date budget utilization is at 79%. Some of the issues for under expenditure included: logistical challenges and insecurity which caused delay in liquidation hence low burnt rate.

### 3.11 Challenges

The evaluation ensured that challenges that emerged during CGPP implementation were clearly documented. The challenges identified are meant to support the CGPP plan better in future for maximum realization of the desired benefits.

#### **Community Based Surveillance system**

##### Delays in providing feedback

The Evaluation team noted important delays in providing feedback to field and families on samples sent to Juba. It is expected that after AFP samples are shared with WHO in Juba, it is ethically correct for the families to know the results. Multiple respondents at County levels indicate WHO takes too long to share results and sometimes fails to share them. Families are anxious to know the test results but do not have the ability to access this critical information. WHO indicated they share results with State Field Officers. It apparently appears to be simple enough to coordinate at Juba level than State level and not very clear why this information cannot be shared at County level or at least at the partners' level.

There is also information and capacity gap regarding interpretation of databases, line list shared by WHO. Sometimes partners do not keep up to date line list, making it hard to verify AFP cases. Secondly.

*“Sharing of information with WHO is mainly one way, since we started operations in April 2016, we only received results in March 2017; when it comes to information flowing back to us, it is not effective. If data is continuously collected on AFP cases, why is it not shared with field staff on time”. (County Supervisor Pibor)*

*“The biggest challenge we have in the community is the need for the stool results, the mothers whose children stool samples were removed keep on asking for their results”. (Key Informant Melut)*

##### Inadequate facilitation

WHO does not have Field Officers in all operational counties, and even when they are present, it appears they are not very effective. There is inadequate logistical supplies and facilitation of WHO field staff to support reporting of cases. WHO field staff are not adequately supported to perform their roles. Staff report lacking transport, computers and other relevant equipment like cameras.

*“We are actually not well facilitated to do the work for instance they promised to give me a camera and they never gave me; for the last 19 months, I had not received my salary, they just gave me this week”. (WHO Field Officer Pibor).*

*“There are cases reported but the WHO Field Officers are not there, even where they are recruited, they are not on ground and we have to follow the collection of samples ourselves”. (State Surveillance Coordinator)*

##### Accessibility

Some Bomas cannot be accessed even by bicycles. In Kapoeta East it was noted that some places are far (the longest is 300km away from the County). The terrain in some places is difficult and cannot be reached by motor bikes making some Payams and Bomas inaccessible.

*“Some of us our Payams are far from the County where we report cases, it is hard for us to pass the information due to transport and network problems, transport sometime is expensive and scarce”. (PA RENK)*

Some areas do not have a communication network making communication very difficult.

*“In my Payam, we are using network for Sudan which is expensive, one minute is 100 SSP so it’s a big challenge and we can’t afford to buy the airtime all the time”. (RENK Payam Assistant)*

### **Conceptualization and operationalization of CBS Guidelines**

The secretariat and its partners are equipped with very clear tools and guidelines to guide how the project should be implemented and tracked. There are concerns, however, that these guidelines are frequently updated. A new version of the guideline is presented before the previous version is internalized. While innovations and changes could be positive, it makes it difficult to consistently track progress based on different standards emerging at short intervals.

*“At the level of County Supervisor, we have been attending the training and they give us tools but the challenge they keep on changing the tools every month”. (County Supervisor RENK)*

### **Incomplete line list being maintained at partners level**

The CGPP has innovated its own line list that captures additional information on both old and new cases. The list has some sections which are not complete e.g. decision by CS (recent/old), referred to WHO (yes/no), date of referral to WHO, validated by, outcome of validation, samples reached Juba (yes/no). The same issue was raised in June 2017 monthly partners meeting (Min 2/6/2017).

### **Post campaign evaluation**

To avoid moving from house to house, vaccinators have also opted for an easier way of collecting children in social centers to immunize children. This makes it hard to mark houses and thus during independent monitoring such houses cannot be verified based on marks. It also makes it difficult to establish the children that have been vaccinated from those that have not been vaccinated based on households that have been marked.

*“Vaccinators sometimes collect children in one central place and administers the vaccines instead of vaccinating the children door to door meanwhile one person goes around marking the houses making it difficult for them to know whether all the eligible children have been vaccinated or not, because their interaction with the care takers were so minimal if not limited”. (The PCE November 2015 report)*

*“Vaccines supplied were for host communities but not for the Internally displaced persons, so many children were missed”. (County Supervisor Melut)*

### **Challenges related to PCE**

While the issue of Central Supervisors may appear to be a good idea, it is expensive and time wasting to keep moving these people from County to County to facilitate training and data collection. Meanwhile, County Supervisors could be used to support PCE at that level, if available.

Late reports cannot inform proper planning, especially for the TWG plan for the next SIA. Sharing results more than two weeks late are not useful. Some reports are received a month or two after the post campaign evaluation.

Interviews with CGPP State Surveillance Coordinator and discussions with SPEDP show that WHO has never covered all States in terms of campaigns.

*“We normally give them a schedule of the campaigns and expect them to also plan accordingly but instead take their own time and share the reports late (WHO Consultant)”*

*“We try to cover all in post campaign evaluation, but WHO can share a program showing they have reached those counties but when we go on ground we discover they have not done anything in that area”. (State Surveillance Coordinator)*

### **Social mobilization**

While CGPP is doing well around partnership, the issue of social mobilization is still a problem and information is not delivered to all families regarding SIAs.

*“We used to have social mobilisers who would move from home to home sensitizing parents on NIDs. In Pibor, we used to have 26 social mobilisers conduct social mobilization; They could raise awareness in the community on EPI which led to increase of children being vaccinated frequently but since UNICEF cut the funding this was affected. The current social mobilization is limited to NIDs” (County Supervisor Pibor)*

### **Monitoring and evaluation**

There are general concerns regarding monitoring and reporting processes. There is no systematic way of collating data.

1. The databases are not readily available. The M&E must dig through different files to locate relevant information. This makes it difficult for the CGPP to consolidate information from different entities it supports. At the partners' level, there are issues regarding data management. The consultant team planned to review data on immunization and AFP lists but it was not possible to obtain a consolidated list. A staff member could share data for 5 months in separate monthly databases. Data in scattered forms is difficult to aggregate and interpret. Each partner project has several decentralized databases and have not been totally integrated thus falling short of organizing data collected by the project to generate the required reports. Data collation from partner organizations to the secretariat at times has been tedious, inconsistent and late.
2. Data shared is presented in spread sheets, making it difficult to interpret it both at CGPP level and at different partners' level. There are no analytical reports in terms of general findings, lessons learned and actions to be taken from the data being shared.

*“They share data although not regularly, the data we get from WHO is very general and does not specify what is from the CGPP”. (EPI Director MOH)*

*They share data in a spread sheet and sometimes the quality of data is questionable; besides they do not provide analytical reports except data and we fail to make meaning out of such data given. At times, the data is very raw and rough and it is left to us to analyse and make meaning. (C4D Officer UNICEF)*

Monthly reports from partners are thin on logical interpretation and thorough analysis - most are raw data with no explanation. Reading partners reports show significant concerns about their capacity in reporting.

#### 4 Lessons Learned

1. Whereas it may be hard to meet and satisfy the interest of every stakeholder in the partnership, considering their priorities and power dynamics will help in working towards common agenda that will further make partnership meaningful and effective
2. CBS focus on AFP is good approach to reporting and handling cases however integrating another approach that focuses on strengthening routine immunization, other child survival programs or networks on disability will have far reaching benefits compared to doing CBS alone
3. Community based surveillance for AFP cases is effective where cases are promptly reported, investigation done including sending results back to the families in a timely manner
4. Community based surveillance is a very effective approach in fragile context in the event that communities may not be accessed by formal systems. Likewise, where it is hard to access such places a network composed of community based people working together with development partners with local residents in their communities will continue reporting AFP cases
5. Whereas the secretariat and its partners has come with very clear tools and guidelines to guide how the project should be implemented and tracked, there are concerns that these guidelines are frequently updated and every other time a version of the guideline comes up before the old one is internalized. While innovations and changes are good, it makes it hard therefore to consistently track progress based on different standards emerging at short intervals.
6. The conventional methods sometimes may fail to reach some areas based on terrain or by the occupation of the affected groups. Care has to be taken to ensure services reach those in the greatest need through active participation. For AFP, immunization and post campaign evaluation to be successful, participation by those in greatest need is critical
7. Understanding of ethnic back grounds before deploying staff to work is a big strength, i.e. people working in their States of origin
8. Use of NGOs and other partners to run activities in places where they have structures on the ground can be replicated elsewhere
9. Challenges are multifaceted and will require different approaches to handle them. E.g. need to address duo challenges: wet season, roads are impassable and during dry season communities migrate in search of pastures and water moving with children and their cattle far away where they cannot be easily accessed.
10. Partnerships built with organizations with shared values, common standards and principles are more sustainable as opposed to different priorities. A good number of organizations the CGPP is partnering with have strong focus on child health.
11. Without frequent social mobilization, communities are likely to forget about routine vaccination and not even come when not alerted. Systematic and sustained messaging on EPI for a good period of time will keep communities/families alert on the need to have their children vaccinated
12. Well balanced projects that integrate both development and support activities with good preparedness plans to respond to emerging diverse beneficiary need have far reaching impact compared to those focused on single or few priorities

## 5 Opportunities

1. The CGPP has a structure from the national level up to the Boma level that has managed to bring services closer to the community. The CGPP has a comparative advantage, other partners and government don't have. This is a good opportunity to use these well-placed structures to help CGPP carry out other interventions e.g. social mobilization, PCE and WASH.
2. Partnership with other key players UNICEF, WHO, BMGF, MOH, SPEDP, UNKEA, BIO AID, cross border networks and local authorities at the State and County level. This is another opportunity for additional funding, training and technical support
3. Existing levels of vulnerability in the country and unreached communities; some of them have never been reached with immunization services through conventional approaches. Other development needs connected to polio eradication e.g. integration of other approaches that focuses on disability in children
4. Opportunities for funding from multilateral donors for example WB, USAID and EU,
5. Integration with World Vision South Sudan projects being implemented in same contexts for resource mobilization, learning from them and support to beneficiaries.
6. The whole area of social mobilization is still having gaps and needs highly committed agency to tap into. Systematic and sustained messaging on EPI for a good period of time will keep communities/families be alert on the need to have their children vaccinated
7. Traditional structures like traditional birth attendants, local chiefs, religious leaders all have a commitment and desire to see their communities transformed. These are potential entry points if CGPP choses to change strategy or leverage on the ongoing interventions.
8. The fact that the government and partners in Juba entrusted CGPP to manage PCE poses yet another opportunity to do it smart

## 6 Conclusions and Recommendations

### 6.1 Conclusions

#### **Community Based Surveillance system**

It is clear that through the CGPP community based surveillance structures and the way it has located its manpower, has improved sensitivity of surveillance through community involvement and participation. Such structures especially those based at community level will go a long way in eradicating common diseases in the communities. The way it is structured has enabled it to coordinate well at National, State, County, Payam and Boma in carrying out project activities. This structure is adequate in delivering project in the most efficient and appropriate manner to realize its short and long-term goals. However, at Boma level, there are still some few areas to be fixed especially communities that are mobile in search of pastures and water for their cattle.

The impact of the introduction of CBS can be shown through the analysis of NPAFP rates. By 2016, there was a huge improvement in the reporting of AFP cases. The improvement is attributed to the introduction of the community based surveillance under the Core Group Polio Project (CGPP) which contributed to the reporting of AFP cases with its structure well distributed in the 33 out of 34 counties of its areas of operations.

The CGPP has established strong partnership with other key players in handling of community based surveillance system. The CGPP has worked with a range of partners that include and not limited to: UNICEF, WHO, BMGF, MOH, SPEDP, UNKEA, BIO AID, cross boarder networks and local authorities at the State and County levels. Through this partnership more community members have been reached. There is active relationship between organizations with defined areas of co-operation governed by formal agreements. Resources are either combined, cost shared or given including the expertise to conduct CBS, post evaluation campaigns and cross boarder activities among others. The CGPP is not the only funder for the projects jointly implemented; among other funders include: BMGF, WHO, UNICEF; also, the implementing partners are cost sharing on some of the staff like the M&E Officers. The CGPP has constantly kept members of the partnership fully engaged through trainings, meetings, sharing of data and information on AFP and PCE but also asking for accountability where resources have been committed.

#### **Post campaign evaluation**

Post evaluation campaigns targeting the whole country has been done four times in a year since these campaigns do not follow the normal quarters. They are normally conducted during the dry seasons i.e. February/March and November/December to reach many areas. PCE has thus proved to be a good strategy and has managed to provide reliable data on vaccination coverage and missed children. This has further helped MOH and WHO in better planning for either mop up vaccinations or capacity building of its team to ensure all future vaccinations should cover all children. Useful data has also been provided on quality of NIDs/SNIDs (including coverage, awareness on SIAs, reasons for missing children, reasons for zero dose. The PCE has helped assess social mobilization by finding out whether the messages that was passed out by the social mobilizers was received by the community and where results show poor mobilization, the MOH and WHO used this to review their targeting approaches in the next campaign. The PCE results have also helped assess household coverage through establishing number of marked households so that those that have not been marked will be targeted first in the next vaccination campaign.

#### **Cross border activities**

Cross-border meetings have managed to discuss critical issues around child vaccination with the aim of coordinating, collaborating and sharing information on routine immunization. The SIAs and

surveillance along the border counties/district to respond to any polio outbreak and act in counties or districts that are performing poorly to reduce risk of polio transmission across borders has been done. The cross-border meetings facilitated by the CGPP have enabled more children to be reached with vaccinations and made significant contribution in building relationship with neighboring State health systems thus directly contributing to reduction of risks associated with polio cases among children across borders.

### **Monitoring and evaluation**

Functionality of the CGPP M&E system is dependent on the effectiveness of the partner project M&E system. While the partner project M&E is focused on both CGPP data requirements, it is also addressing specific project needs not necessary of community surveillance in nature. The partner project data is contributing significant data to meet the CGPP reporting and documentation needs, accountability, learning and decision making. At partners level, quantitative systematic and rigorous data collection procedures are employed for gathering evidence to support decision-making.

Data is checked by Project Officers and M&E for all details e.g. name, area, code, containers with labels and any missing information. In case data quality issues are identified, Project Officers call the field people to verify and update before sending. The consistence of information is also checked, if data meets the standard expected. At different levels, e.g. at secretariat level, partners' level, WHO, etc. take time to check the quality of data before using it. There are also different tools to be filled, and various checks are made to ensure effectiveness of the system. Validation is done by looking at the forms signed by the KI and given to the PA. Cross checking of information from KI whether it is in line with that of the PA.

## **6.2 Recommendations**

### **Community Based Surveillance system**

There is a need to design strategies to ensure children are reached to address duo challenges: during the wet season roads are impassable and during the dry season communities migrate in search of pastures and water, moving with children and their cattle far away where they cannot be easily accessed.

1. In places with close access to the Nile, some community members suggested motor boats.
2. In communities where children cannot be accessed during the dry season, there is need to provide motorbikes to PA to be shared among 3-4 PAs. This will enable them easily to reach deeply in the Bomas and contact some far to reach cases.
3. In areas where communication is a problem, the CGPP could consider providing Thuraya phones for PAs to facilitate communication. However, this needs to be done on case by case basis and after assessing the implications and their safety in the hands of PAs.
4. Given the fact that cattle camps could be far withdrawn from the selected PAs and KIs, it would be important to consider these structures at camp levels so that when the community is mobile in search of pastures and water, they will always have such resource persons to handle any issues that emerge.
5. The CGPP should collaborate with WHO to conduct community Children stool sampling in silent counties highlighted in the findings
6. The CGPP should establish contact with WHO every 2 months to resolve issues of follow-up and giving feedback for AFP samples collected from the field.
7. The CGPP should ensure the partners have up to date line list capturing all key data e.g. dates of onset, notification and investigation; old and new cases. This same list should frequently be reconciled with that of WHO validated list.

8. There is need to do further assessment of camps that may not be having KIs and ensure more are recruited to close gaps related to mobile and far to reach communities  
*“We recommend that there should be separate PA and KI for Cattle camps to report cases because the cattle camps accommodate people from Kapoeta East, North and South” (KI Kapoeta East)*
9. The CGPP needs to look beyond AFP surveillance and bring other health components like maternal child health, other vaccine preventable disease like Neonatal Tetanus Surveillance (NNTS), education etc.
10. There is need to go beyond surveillance and integrate with development related activities that addresses prevailing needs holistically.

*“We are asked for tricycles, and they asked me that the child’s legs are the only ones paralysed and the hands are okay, why can’t you help him to go to school”. (KI Pibor)*

*“Sometimes we encounter cases that need help and plead with us to advocate for them that any help may be extended to especially lame children who may need wheel chairs and other walking equipment and we cannot provide that. There is need to link such cases to agencies that may provide other support to disabled persons; equally there is need to integrate disability related interventions”. (PA Pibor)*

### **Post campaign evaluation**

1. The CGPP should ensure PCE reports are timely shared with relevant partners to inform proper planning
2. WHO and the CGPP together with MOH need to sit together to harmonize field plans and be honest with each other on schedules and areas of coverage.
3. The CGPP needs to work with partners involved in SIA to harmonize social mobilization. This should include conducting frequent social mobilization, with clear systematic and sustained messaging on EPI for a good period of time to keep communities/families alert on the need to have their children vaccinated
4. Where there are structures like County Supervisors, they would be a good asset to support PCE at that level as Central Supervisors. This will help reduce on time wasted by Central Supervisors moving from Juba to cover all counties they are supposed to cover. Where there are no County Supervisors, that would be the only scenario where Central Supervisors could be recruited.
5. The CGPP should make more meaning out of the data shared. Analytical reports should be developed capturing the methodology used, challenges, what worked well, lessons learned and future plans based data collected.
6. Independent Monitors should be deployed in the communities as soon as the immunization campaign begins, this will improve verification of evidence of household with immunized children.
7. Plan adequate time for PCE, given that the three days’ timeframe is very short based on the vast areas for evaluation and vaccination. So PCE should be allocated more time and resources to be more effective.
8. Vaccinators should try as much as possible to vaccinate children from homes. Approval should first be sought from MOH/WHO regarding the change in strategy of vaccinating children in social centers. However, vaccinators and social mobilizers need to be well trained to trace and mark households where children have been vaccinated from social centers.
9. WHO with MOH should do proper planning and logistical support to ensure vaccines and all the other required logistics reach the places in time.
10. Support supervision should be strengthened during implementation of the NIDs.

11. Cattle camps should be given special attention during social mobilization, vaccination, and during post evaluation campaigns.
12. Advocacy needs to be integrated to ensure all parties concerned in the MOH, UNICEF or WHO address issues affecting effective vaccinations e.g. insufficient quantities of vaccines and poor coverage to ensure all children are reached as a means of eradicating polio
13. The PCE feedback need to be two-way feedback to WHO but also CGPP delays for various operational reasons, including logistical and insecurity among others and feedback to Field level not provided after PCE
14. The CGPP to share PCE data that is available with EPI TWG for planning purpose before final reports or results are compiled. Whatever data is available for completed counties should be shared.
15. The CGPP and UNICEF should come together to harmonize and collaborate on the issues of funding for social mobilization.
16. Need to intensify support supervision during SIA to counter vaccinators that opted for easier way of collecting children in social centers to immunize children instead of house to house vaccination.

#### **Cross border activities**

1. There is need for various partners to coordinate and work together during immunization campaigns to improve coverage and funding.
2. UNICEF M&E Officers should update their list on the number of people both in the host community and IDPs to ensure sufficient vaccine supply.
3. Conduct frequent social mobilization, with clear systematic and sustained messaging on EPI for a good period of time to keep communities/families alert on the need to have their children vaccinated

#### **Monitoring and evaluation**

1. Make data more usable so that it can communicate; perform further analysis on the data shared beyond the spread sheets and develop analytical reports in terms of general findings, lessons learned and actions to be taken from the data being shared.
2. Build capacity of partner staff in quality reporting
3. Strengthen consolidation of data collected from different partners and different periods. Proposed data base to aggregate data is shown below, this can further be broken into monthly, quarterly, annually, year 1, year 2 etc.
4. There is need to undertake regular data quality assessment audits to verify accuracy, completeness and sources of data.

Table 15 Sample data aggregation database

Indicator	Baseline	Target	January 2017			Average
			BIO AID	UNKEA	SPEDP	
Number of children receiving one dose						
Number of children receiving dose zero						
Number of HH reached with social mobilization						

A simple spread sheet should be developed to capture indicators for the 12 months with formulas to automatically aggregate totals for each. Project partner teams should consistently update this database wherever an activity is completed. At the secretariat level, the M&E Officer should aggregate this in one by copying and pasting in the excel tool. The spread sheet should have two

worksheets, the first one to capture monthly progress and more columns to be created to automatically total for the quarters, the second sheet to capture annual progress. Both the monthly and annual worksheets should be formatted in such a way to capture target, actual and variance. Monthly, quarterly and annual reporting should be based on data emerging from these databases.

### **Collaboration and partnership**

1. The CGPP has been working with WHO, UNICEF, BMGF and each of them have standards they expect the CGPP to implement. This makes it hard for CGPP to meet the diverse interests. The different players at consortium level should harmonise expectations and standards that are suitable to all parties. Such expectations should be included in contracts. In the future, the CGPP should not hurry into accepting funding where it knows it won't be able to fulfill the standards
2. Build the capacity of partners' Project Officers and M&E in good reporting approaches

There is need to engage State leadership for purposes of ownership and accountability at that level. Besides there is need to engage technical government teams beyond opening and closing of workshops.

## 8 Annexes

### 8.1 Impact stories

#### **The CGPP increased community awareness on polio, identification and reporting of polio cases-** By Nakali Nakorot- A Payam Assistant: Katodori Payam- KAPOETA EAST

Before the project started in our community, people did not know what polio was, they were not aware of vaccination. Whenever children had weakness in their legs or hands, they would take them to traditional healers, the traditional healers would boil herbs in pots, these herbs would be directly pressed and squeezed on the paralyzed parts in the legs or hands, this kind of treatment would relieve the sick children a bit but still paralysis would not disappear. When the project began its activities, people were not fully responding, however, as time went on the key and respected leaders such as traditional healers, traditional birth attendants, women leaders, chiefs, and church leaders, in the communities were mobilized and educated on polio disease, how the disease was transmitted, and how it could be prevented. These respected persons were then encouraged to pass messages about community based identification and reporting of polio cases to the people who came to them for assistance.

As the project activities intensified, community meetings were held in different Bomas and Payams to sensitize the people about polio cases, the Payam Assistants organized the communities to have Key Informants (KI) elected, the KI were trained and they continued sensitizing the communities on how to detect and report the cases, and the importance of having the children vaccinated during the National Immunization Days (NIDs) and also in health facilities. The NIDs began last year in March, more so in 6 Bomas, the women leaders were most influential in mining areas and so the project targeted them. For me the shift from traditional herbal medicine to vaccination and other medication in the health facility was a very tremendous change, the number of children who were referred to the facility increased, many children were vaccinated, the AFP case detection rate increased.

The major factors that led to this tremendous change were as a result of proper mobilization, continuous community sensitization meetings, women leader meetings, training of PAs, KIs and communities in AFP case identification and reporting, training of vaccinators, TBAs, traditional healers. I personally believe that I contributed to this change, because I was able to train the KI, organize community meetings, also got first-hand information from women groups.

I believe this change will go a long way in eradicating common diseases in the communities, because many people now go to the health facilities, I also believe that polio will be eradicated, and since the society has been empowered, I believe there will be sustainability, I only recommend that the facilities should remain functional, community awareness and sensitization continues, as well as immunization programs.

#### **The CGPP increased identification and reporting of polio cases-** By Manna Eliah, Payam Assistant of Kauto,

Before the project came in, we only had the Carter Center in our community, this one was dealing with guinea worm and the rest of the diseases were being handled in the health facility. At that time, it was not clear what was causing paralysis, people thought it was guinea worm, so when BIO AID came in, people's thinking was changed, because the two programs became clear, Carter Center was handling guinea worm cases and BIO AID was handling AFP cases. As a result of community sensitization, the community was able to understand that polio was different from

guinea worm, so then patients who had fever and paralysis were referred to BIO AID staff and to the health facility, while those with swollen legs or hands were referred to Carter Center.

The turning point here was that the knowledge gap was closed, so that people realized that different kinds of diseases were treated differently. The community responded by referring cases to Key Informants, health facilities and to Carter Centre basing on the signs and symptoms that the patients had. The key factors that contributed to the shift were community meetings, KI trainings, meetings with chiefs, Payam Administrators, awareness campaigns conducted by PA, and County administration.

As a Payam Assistant, I have sensitized my communities on polio detection, and how guinea worm is different from Polio in terms of the causative agent and mode of transmission, when CGPP project strengthened awareness campaigns on polio in Payams and Bomas, the community believe that polio was a result of witchcraft was cleared off people's mind.

I believe that in future because people have embraced the project, children will continuously be referred to the facilities, AFP cases will be detected and referred for testing by Key Informants and Payam Assistants, those suspected of guinea worm will be referred to Carter Centre for treatment, so that in future these diseases will be eradicated, people will become healthy and death rates will reduce.

**The CGPP increased identification and reporting of polio cases-** By Peter Kufu KEY Informant Chief Pibor

Before this project came to Pibor, there was no commitment by any partner or government to handle AFP surveillance in the community. The only thing done previously was National Immunization Day (NID) campaign which was done once a while. There was also mild intervention regarding AFP in the health facilities.

One of the big changes that has occurred is that; there are now trained people at the moment that are looking for AFP cases and report them accordingly at community level. BIO AID has trained its staff which also trained the PAs and KIs in every Payam. We conduct community sensitization together with the BIO AID staff to increase the knowledge about reporting of AFP cases.

Additionally, the Key Informants and Payam Assistants have conducted intense awareness which has led to improved knowledge about AFP in the communities where we work.

As a result of the community based surveillance done by the Key Informants, vaccination has improved because now people know the dangers of not vaccinating their children on time. I normally visit and tell families to report any suspected AFP case to me. I also tell mothers with children below one year to take them to the facility for vaccination. As result, there is improved case detection, every suspected child is investigated and reported accordingly from the KI to the PAs and then County Supervisors

Mothers have also realized the importance of vaccinating their children and there is improvement in prevention of children getting infected with polio because more mothers are taking their children for vaccination. The mothers have also willingly participated in the reporting of cases; sometimes when the mothers note any form of paralysis in the children, they report immediately to Key Informants.

The flow of information from the Key Informants to the Payam Assistants and then to the County level has improved thus enabling surveillance in the community to be effective. There is also a good working relationship within the network that further contributed to the surveillance system for example we work well with the communities, mothers, PAs and County Supervisor.

Even if the CGPP stops, the project benefits will be sustained through the trained community based local people deployed in the County and Payam; however, this depends on the stability of the government to play its part.

**The CGPP increased community awareness on polio-** By Abraham Korok Katur; KI CHIEF PIBOR

Before CGPP started in our community, people were not aware of this process of case detection. It was very difficult to differentiate whether it was a polio case or not. Besides, people didn't know the dangers of polio disease. People used to believe more in traditional healers and their herbs than in taking their children for vaccination but were not of help as more paralyzed children were being seen in the communities.

There is now a very big change, very few people now believe in traditional healers and their herbs. For example, recently a three-year-old child was referred to me from a witch doctor's place from Manyiramy BOMA which I referred to the Payam Assistant for further investigation.

Through detecting of all suspected AFP cases and non-polio cases there is a better and safer environment for children to live. Key Informants have created awareness about community based surveillance and encouraged parents to take their children to health facilities for vaccination. Key Informants identify and report any suspected child with AFP to the Payam assistants.

When the CGPP came there was a conducive welcome and acceptance in the area. There was also willingness of the stakeholders, Key Informants and Payam Assistants to work with the project who were members of the community which increased acceptance of community based polio surveillance activities.

The CGPP ensured there is man power at community based level who can easily conduct community surveillance system. The CGPP also provided bicycles and motor cycles to key staff to ensure they are mobile to reach all corners of the County with information on community based surveillance. The CGPP has also conducted community meetings and workshops to ensure information on community surveillance and AFP is passed at all levels. The information flow and communication between us and the higher staff has been good ensuring effective flow of information at all levels. There was involvement of other people like mothers, chiefs, traditional healers among others in the community in reporting of AFP cases but also passing on key messages on AFP at community level. The government side also participated for example during intercommunal meetings with chiefs and traditional elders

The project has created a sense of alert and understanding of how one can detect an AFP case but also how to prevent it. When an AFP case is noted, at least people know where to go and report to the KI or PA and sometimes to the County Supervisor or health facility as opposed to how it was done previously. With the presence of trained manpower on ground, even if the project closes, it will still leave behind a greater and sustainable package that it has imparted to the people.

## **CGPP increased immunisation of children in the communities- By PA Melut**

Before CGPP came in, most people in the community did not see any value of taking their children to the health facility for vaccination, most women with paralyzed children used to take them to witch doctors. It was only a few educated people who could take their children for vaccination, but when CGPP started implementation and recruited KI, they conducted community meetings with the leaders of Payams, and organized house to house visits, visited churches, mosques, schools, traditional healers, traditional birth attendants and social functions where people gathered, and passed the message on polio and the importance of vaccination

I made sure that as I moved in different places and met some people, I told them about polio and more so AFP. After this was done, I started getting calls from many people asking me to go and see their children. I remember the first time they called me I found a child with all the signs and symptoms that we were told during the training and called the County Supervisor. We went together with him and when he saw the case he called the WHO Field Officer and the stool sample was taken, that was the first time ever in life that I received \$ 50. There is no any other organization I have seen doing surveillance in Melut like this one

After community awareness on importance of immunisation, there is now positive response to immunisation compared to before CGPP implementation, in 2014, I was working as a Vaccinator, this was a time that whenever mothers knew or saw a Vaccinator coming they would hide their children, or even chase Vaccinators because they were scared that the vaccine was a poison that can kill. After community awareness on immunisation was done, most mothers started voluntarily taking their children to Vaccinators for immunization.

After community sensitization in Bomas, many women would come looking for Key Informants and asking them to go and check their children. Many cases of AFP have been detected, children have been vaccinated and children have had opportunity to get vaccines for other diseases and they have as well received treatment for other diseases. I believe if this continues, one time we will have no more polio in Melut, that means we shall have children who walk normally and are healthy, such that if this program closed the community will remain sensitized and people will continue to value their health.

Positive response to immunisation in the community was achieved because PAs and KIs fully engaged key community leaders including chiefs, Payam Administrators, church leaders, mosque leaders, market administrators, and other influential players, like the traditional healers, and traditional birth attendants. As a person seeing all these changes in my community, I am now self-motivated to work to see that the children in our community are free of paralysis and optimistic that one-day polio will be no more in my community. Since I am knowledgeable about polio even if SPEDP closed I will continue to educate my community such that children remain healthy and free of paralysis

## 8.2 Photographs

Photo 1 County Supervisor sensitization meeting



Photo 2 PA sensitizing community elders on AFP



Photo 3 County Supervisor filing system



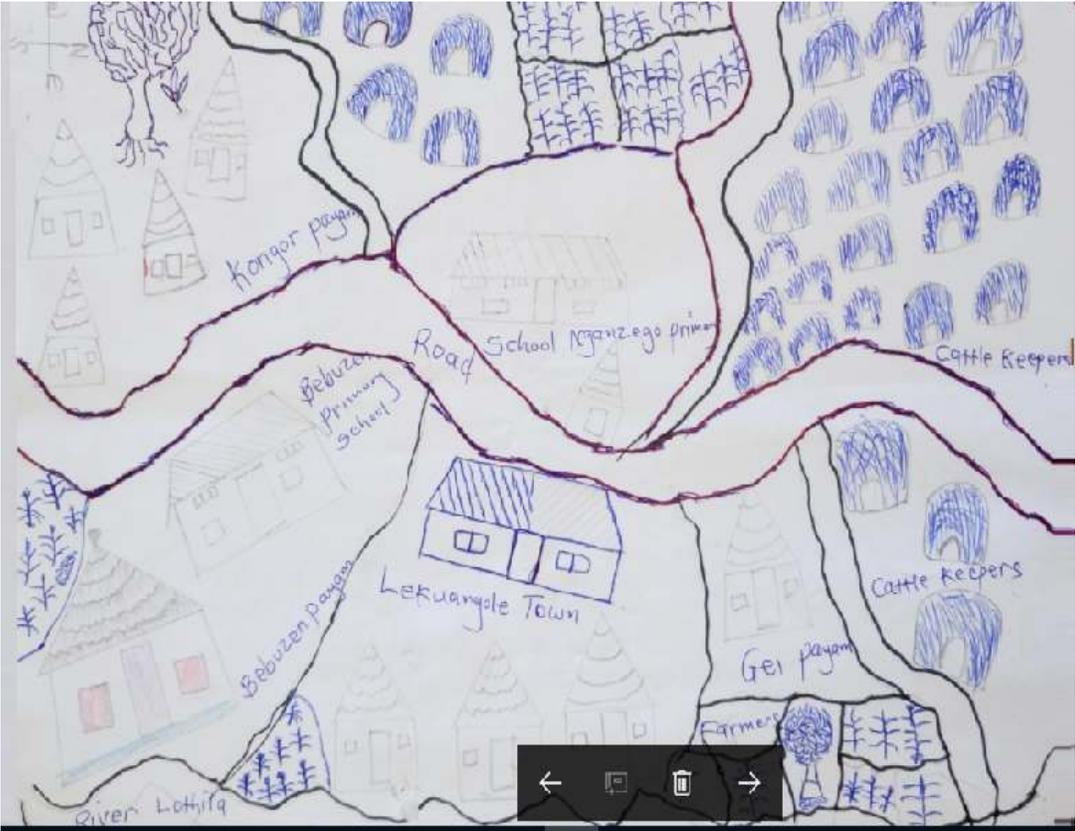
Photo 4 PA sensitizing women groups on AFP



Photo 5 Research team on the road to the airfield



Map 6- PA map of Payams, routing and important social centers



Map 2- PA map of Bomas, Payams, routing and various social centers



Map 3- PA map of Payams, Bomas, cattle camps, routing and important social centers



### 8.3: List of partners met at national level

S/N	NAME	ORGANIZATION	TITLE
1.	SHAH JAMAL	UNICEF	COMMUNICATION SPECIALIST
2.	KUJANG LAKI	UNICEF	C4D OFFICER
3.	MELISACHW ADANE	WHO	CONSULTANT
4.	IRANYA PATRICK	WHO	DATA MANAGER
5.	DR ABDALLA ELKASABANY	BMGF	POLIO CONSULTANT SOUTH SUDAN
6.	LINA JUAN	BIO-AID	M&E OFFICER
7.	ABURE ISAAC	SPEDP	M&E OFFICER
8.	BEBE DOMINIC	UNKEA	M&E OFFICER
9.	DR ANTHONY LAKU	MOH	EPI DIRECTOR
10.	ANTHONY KISANGA	CGPP	PROJECT DIRECTOR
11.	DR RUMBE SAMUEL	CGPP	PROJECT MANAGER
12.	MALIAMUNGU ANOLD	CGPP	STATE SUPERVISOR
13.	BAUSUMO ABIUDA	CGPP	PROJECT M&E OFFICER
14.	AZORU LUCIO	CGPP	STATE SUPERVISOR