



Comprehensive Assessment *of the*
CORE Group Polio Project (CGPP)
A Process Evaluation Perspective

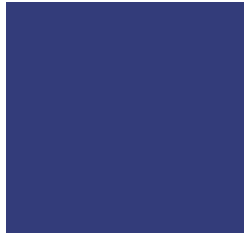
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Abbreviations

BCC	Behavior Change Communication
BMGF	Bill and Melinda Gates Foundation
C4D	Communication for Development
CBD	Community-based Development
CBO	Community-based Organization
CDC	Centers for Disease Control
CE	Community Engagement
CGPP	CORE Group Polio Project
CHV/W	Community Health Volunteer/Worker
CSIS	Center for Strategic and International Studies
EOC	Emergency Operations Center
GHSA	Global Health Security Agenda
GIS	Geographic Information Systems
GPEI	Global Polio Eradication Initiative
HOA	Horn of Africa
ICC	Inter-Agency Coordinating Committee
IKM	Information Knowledge Management
NGO	Non-governmental Organization
PVO	Private Voluntary Organization
SMNet	Social Mobilization Network
TAG	Technical Advisory Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

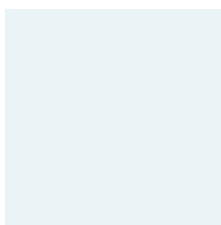
Cover Photo:

*A CGPP-trained Community Volunteer administers OPV to a child in Gambella, Ethiopia.
Photo by CGPP Ethiopia*

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A young woman in India smiles during a group meeting for young women.
Photo by Avani Duggaraju.



Introduction

The CORE Group Polio Eradication Initiative (CG PEI) was created in 1999 with a USAID grant awarded to World Vision, as the prime contractor, under the auspices of an NGO-led Partners Project of the CORE Group, a membership association of US-based non-governmental organizations working in community-based maternal and child health. (Ref.: *Final Project report 1999-2008/Legacy files and MTE 2012 program report*). As CORE Group PEI has evolved over the years, its name has changed to the CORE Group Polio Project (CGPP) in most countries; but Nigeria is an exception where it is referred to as the CORE Group Partners Project (same acronym).¹ At the field level, the CGPP is often simply referred to as the CORE Group. The CGPP has supported GPEI objectives since its inception by: (i) implementing community-based AFP surveillance, (ii) supporting OPV provision through the routine immunization system by promotion of community capacity-building and system strengthening for healthcare providers, and (iii) participating in supplementary immunization campaigns. The CGPP works only in high-risk areas as determined jointly with each country's Inter-agency Coordinating Committee (ICC), using objective criteria, such as routine immunization rates, campaign quality indicators, and polio transmission history.

Using polio funds received from both USAID (primarily) and until more recently, the Bill and Melinda Gates Foundation (BMGF), the CGPP conducts community-based activities designed to strengthen supplemental polio immunization, routine polio immunization, and surveillance of Acute Flaccid Paralysis. Over the past 20 years, CGPP has worked in 11 countries: Angola, Afghanistan, Bangladesh, Ethiopia, India, Kenya, Nepal, Nigeria, Somalia, South Sudan, and Uganda. Currently, the CGPP is operational in eight countries: Ethiopia, India, Kenya, Nigeria, Somalia, South Sudan, Afghanistan

¹ This slight variation in name was taken to address the stigma that was associated with the term 'polio.'

and Uganda. The Horn of Africa (HOA) CGPP is the ‘youngest’ program among the CGPP family and has benefitted from inputs from more seasoned colleagues in its formation and development. For example, technical support and guidance has been provided by CGPP India and Ethiopia. Under the auspices of a CGPP National Secretariat, the CGPP’s interventions and activities are implemented by US-based NGOs and their local partners (NGOs and CBOs).

Previous program evaluations of the CGPP have identified specific results achieved in their contribution to the program eradication effort. In addition, to country-specific assessments, several global evaluations and reports have also been completed; namely Final Report 1999-2008, and the CGPP Final Evaluation Report FY12-FY17. In these exercises, the evaluation questions were designed to answer: “what results?”, “how much/well?” and “when?” as their primary focus, with a smaller emphasis on processes. However, the most recent report did highlight that each CGPP country has come up with new methods or strategies some of which were also being replicated in the other CGPP countries:

Kenya and Somalia led the Cross-Border Health Initiative through establishing cross-border health committees to convene inter-country border stakeholders to synchronize campaigns and other efforts to reach every child. CGPP has been proactive in engaging and working with pastoralist and other remote and/or high-risk communities for polio eradication. As such, the implementing NGOs have supported outreach to nomadic populations by providing social mobilization and transportation for health facility staff to support integrated routine immunization activities.

Ethiopia established a mobile device and web-based disease surveillance system, developed a system for newborn tracking of polio birth dose and strengthened cross border collaboration with CGPP HOA. Additionally, both CGPP HOA and Ethiopia have established robust surveillance systems for measles and neonatal tetanus (NNT), in addition to polio.

India has reached under-served communities mainly through interpersonal communication sessions, group meetings and the creative use of mixed media. Apart from this, many innovative and creative solutions were adopted to include fathers and both parents, etc.

Nigeria established a successful network of community volunteers and expanded their capacity to deliver quality health care interventions beyond polio eradication, such as WASH, nutrition and malaria prevention, and leveraged community structures to boost surveillance at all levels. CGPP was the first PEI partner to introduce RI Card holders, increasing RI Card retention. In addition, the community volunteers now maintain pregnancy and birth registers and conduct defaulter tracing for routine EPI.

South Sudan instituted Independent Campaign Monitoring across the entire country to measure the reliability and accuracy of campaigns, recruited and trained nearly 2,000 “community key informants,” such as traditional healers and birth attendants, religious leaders, and community leaders to improve CBS, and facilitated cross border meetings to synchronize campaigns and build relationships with neighboring country health systems.

Angola introduced Community Based Surveillance (CBS) based on a network of 2,710 community health workers and independent campaign monitoring. The program also increased routine immunization using community registers, and leveraged skills of CHWs to tackle other health initiatives such as the use of treated bed nets and malaria drugs.

A child receiving
OPV in Nigeria.
Photo by Kathy
Stamidis



Evaluation Objectives

This evaluation exercise was designed with the aim of providing a comprehensive assessment of the CGPP by: a) documenting its accomplishments and key contributions to the global polio eradication initiative results, b) identifying pertinent programmatic innovations and strategies, c) highlighting challenges or difficulties and d) preparing a report of the findings that include key lessons learned and recommendations for transition, future programming and potential adaptation of the CGPP Secretariat Model. As such, it complements the previous global and in-country evaluations which focused primarily on program implementation results in terms of social and behavior change, e.g. reaching unreached children, surveillance, identifying missed children at community level and improving polio vaccination rates. At the same time, this assessment builds on the earlier evaluation findings by concentrating on the perceptions of those currently involved in the actual work of polio eradication.

Evaluation Team Composition

A team of three external polio experts served as an evaluation panel to assess the program's impact on the global polio eradication initiative. They included: Dr. Erma Manoncourt as team leader and two additional polio panel experts (Drs. Rafah Aziz and Benjamin Nkowane). Collectively team members represented a range of public health skills in epidemiology, social and behavior change, management and monitoring and evaluation. Additionally, they have distinguished public health qualifications and extensive field experience in polio, other public health domains and wider development programming.

Of the current eight CGPP program countries, evaluation team members visited five of them as listed below:

Evaluation Team Member	Field Visit Countries
Dr. Erma Manoncourt	Kenya (HOA)
Dr. Benjamin Nkowane	Nigeria; South Sudan
Dr. Rafah Aziz	Ethiopia; India

During field visits, they conducted in-depth, key informant interviews with CORE Group members, their GPEI partners and government counterparts and participated in field visits and/or meetings with community mobilizers.

A vaccinator carrying OPV through a river in a remote area of HOA. Photo by CGPP HOA Team.



Evaluation Methodology

The focus of this evaluation was to address the following questions: “how,” “what characteristics” and “where?” by exploring the processes and mechanisms that have been implemented to achieve the results previously documented in earlier investigations. The evaluation research methodology was composed of two initial phases: a) secondary data analysis – i.e. reviewing key program documents of eight country programs; and b) visits to five active CGPP programs as reflected in the table below. The purpose of the visits was to conduct interviews with CGPP staff (e.g. Secretariat, community mobilisers and NGO partners), GPEI partners and government representatives.

TOTAL	Ethiopia	HOA	India	Nigeria	South Sudan
Govt	2	2	1	17 (3 National, 4 State, 10 Local Govt.)	3 (National)
USAID	1	1	1	3	2
Rotary	1	-	1	4 (1 National, 3 State)	-
WHO	3	2	2	4 (2 National, 2 State)	3 (2 National, 1 State)
UNICEF	3	2	1	2 (State)	2
BMGF/McKing				-	2
Secretariat	7	2	4	3	4
NGOs	yes	yes	yes	-	3
Mobilizers/Volunteers				5	-

In the third phase, as a complement to field perspectives, additional key informant interviews were held with both senior-level representatives of GPEI partners at the global level and the US-based CGPP Senior Management:

CGPP Global (3 current staff)	5	USAID (1 former CGPP)	3	WHO	2
CDC	2	BMGF	2	UNICEF	2
TOTAL INTERVIEWS					15

The in-depth interviews of key informants were guided by a semi-structured questionnaire of 12 key questions (see Annex section). However, researchers were free to probe and explore other relevant dimensions of a question as they surfaced. This approach contributed to both a domain and content analysis of the qualitative data findings.

The purpose of these interviews was to explore further previous written report findings to better understand what works/doesn't work and to identify good practices and lessons learnt that contributed to the results. The evaluation exercise has resulted in this comprehensive evaluation report that details the contributions of CGPP to global polio eradication efforts, pinpoints successful strategies and key challenges, and offers recommendations for forthcoming work and transition. In addition, country evaluation reports for each of five current CGPP programs that were visited during this exercise have also been prepared. Their findings will be submitted separately to the following CGPP Secretariats: Ethiopia, India, Nigeria, Horn of Africa (Kenya/Somalia) and South Sudan.

Enumerators during a polio campaign in South Sudan. Photo by CGPP South Sudan Team



Background: Setting the Context

The CORE Group Polio Project (CGPP), commonly referred to as CORE Group and the CGPP for short, was formed approximately twenty years ago and since its inception has been active in the polio eradication initiative in eleven different countries. This unique model of NGO collaboration in the polio eradication context was conceived by Ellyn Ogden, USAID, based on her experience in three areas. First, she observed that the original polio eradication efforts were built around the smallpox eradication program, with a community-based focus receiving relatively less attention than other interventions. Secondly, recognizing the role that NGOs could take in filling this gap, she wanted to explore other ways of working based on her experience with the U.S. small grants child survival program under which different NGOs traditionally competed against each other for funding, using different business models and intervention approaches. Lastly, she became aware of a network of independent US-based NGOs or PVOs working in international development, whose technical experts voluntarily met on a regular basis (think tank) for knowledge exchange, information-sharing of lessons learned, good practices, tools, as well as joint problem-solving and evidence-generation in child survival.² Building on the spirit of collaborative action, she developed a ‘bundled’ proposal request (no competition) which required NGOs to jointly submit a proposal bid for funding and was able to secure special Congressional earmarked funds for the polio eradication effort (similar to smallpox eradication). Using an “opt-in” approach, 10 to 12-member organizations of the original CORE Group Inc. agreed to participate in the CGPP, and for financial and legal reasons, World Vision serves as the prime contractor of USAID funds. While partner NGOs are officially recognized, the

² Later this platform was incorporated as CORE Group, Inc. (now composed of 100 members from both international and US-based NGOs, foundations etc.) and as independent organizations, each maintain their own identity and programming approaches but still operate as a consortium (CORE Group Inc.) and has an advisory function to CGPP.

CORE Group Polio Project is not a ‘stand-alone’ organization which is formally registered but rather a long-running project, which is operationalized through the formation of Secretariats, which are neutral technical units working across partner NGOs who have agreed informally to the CGPP identity.

The Secretariat Model – A Mode of NGO Collaboration at the Global and Country Level

Global Secretariat: The global CGPP Secretariat is virtual in that its staff, although working as a team, are hosted in different NGOs. In guiding and operationalizing its work, the Secretariat sets the foundation for program coordination and management, at both global and national levels. The Global Secretariat is composed of the following positions: Director,³ Deputy Director/Technical Lead; Technical Advisor, Monitoring & Evaluation; Technical Advisor, Communications; and, most recently, a Senior Technical Advisor in Global Health Security has joined the team. Staffing is further complemented by administrative and financial management support provided by World Vision. In terms of program implementation, the Global Secretariat staff is responsible for overseeing the overall management of CGPP national Secretariats, providing technical support and assistance to country teams, report-writing as well as representing CGPP in global meetings and discussions related to polio eradication. To accomplish their responsibilities, Secretariat staff are engaged in periodic technical and oversight visits to CGPP countries, online consultations, participation in polio Technical Advisory Group (TAG) meetings and wider global discussions, negotiations with donors, report-writing and documentation of program results, good practices, and lessons learned.

National Secretariat: At the country level, the Secretariat Model is replicated, but adapted to each CGPP country context – whereby the CGPP leadership is composed of a small technical team who coordinates and oversees local/partner NGOs who have agreed to join the polio program. Like the global model, the national Secretariat is independent, such as CGPP India or Ethiopia, but hosted by a partner NGO for administrative and logistical support which may differ according to each organization.

The Secretariat Model format is based on fundamental principles such as transparency, broad participation, and shared human resources so potential variations in structure are possible, giving an organizational philosophy that “one size doesn’t fit all!”

Current CGPP Country Secretariat Staffing

India	Nigeria	S Sudan	Ethiopia	HOA
4	6	4	8 incl. finance	4
Host NGO				
Project Concern International	Catholic Relief Services	World Vision	The Consortium of Christian Relief and Development Associations (CCRDA)	American Refugee Committee

³ To date, there have only been three Executive Directors: Frank Conlon (current), Ellen Coates and David Newberry

The National Secretariat staff facilitates communication, coordination, and transparent decision making among all its NGO partners. Through this model, the Secretariats 1) provide supportive supervision to and build the skills and capacity of NGO polio partners and community workers, 2) coordinate and promote civil society engagement in polio eradication, while simultaneously injecting a crucial community-level component through the focused activities of thousands of community health workers. The Secretariat staff in each country also participates in national polio decision-making bodies such as ICC and EOC and coordinates its work with the host government and other polio eradication initiative partners, such as UNICEF, WHO, BMGF, Rotary International, and CDC. In practice, the Secretariat model facilitates a close linkage between the community-level expertise of international and local NGOs with the knowledge and strategies of national governments and the Global Polio Eradication Initiative partners.

Whereas the Country Secretariat director and staff report directly to the Global Secretariat, partner NGO staff are paid by their respective organizations using sub-grantee funds received from World Vision, as prime contractor, under USAID polio financing. As such, funds are channeled through the host organization (e.g. Ethiopia, HOA, Nigeria, South Sudan) for CGPP operations. These channeled funds are monitored and verified by Secretariat staff, excluding CGPP India which only monitors program activities. The Secretariat Director at the country level has a pivotal role; but there is no CGPP official policy as to whether this position needs to be a national or international recruitment. However, the key criterion is that the individual should know and have extensive experience in the country. It is noted that if one considers the pros and cons of national/international, the following advantages should be weighed in recruitment selections:

- National: alignment with government, connections and alliances and local access/cultural insights
- International: lobbying, potential for wider/global connections and international access

According to previous evaluation reports of its programming results, the CORE Group Polio Project has had a positive effect in increasing community awareness and responsiveness to polio vaccination.⁴

As initially conceived, *the CGPP was designed for surge capacity; and there was no intent for it to be sustained by USAID beyond the original 2000 Polio End Goal, hence Congressional earmark funding. However, if national governments found the model useful, the possibility of other support was an option* (Ellyn Ogden⁵). More recently, now that the ‘proof of concept’ has been accepted, new funding opportunities under the Global Health Security Agenda (GHSa), have enabled CGPP engagement on zoonotic diseases in Ethiopia and Kenya, plus employment of a technical advisor in the Global Secretariat to oversee and manage these activities.

In terms of programming, the 2017 Final Evaluation Report summarized the comparative CGPP activities according to eleven key interventions:

4 CGPP Final Evaluation Report, FY 2012-2017; CGPP Final Evaluation Report, 1999-2008

5 Interviewees, across the board, acknowledged Ms. Ogden’s critical role in CGPP’s formation as well as her tireless efforts and advocacy to ensure that the NGO platform was given a “voice” and their contributions given visibility within the polio eradication initiative.

CGPP INTERVENTIONS BY COUNTRY 2012-2017 ⁶

Intervention	Ethiopia	India	Kenya	Nigeria	Somalia	South Sudan
Participation in national polio coordination	X	x	X	X		x
Strengthening routine immunization	X	X	X	X	X	
Planning and participation in SIAs	X	X	X	X	X	X
Independent or post-campaign monitoring				X	X	X
Social mobilization	X	X	X	X	X	X
Special vaccination posts at borders and Transit Strategies			X	X	X	X
Work with nomadic populations	X	X	X	X	X	X
Newborn tracking and vaccine registers	X	X		X		
Work with IDPs or refugees	X		X	X	X	X
Promoting cross-border collaboration	X		X		X	X
Community-based AFP surveillance	X		X	X	X	X

The above-mentioned interventions set the framework around which interviewee perspectives and perceptions, especially among external partners, have been formed about CGPP's polio eradication work.

⁶ CORE Group Polio Project (CGPP) – Final Evaluation Report, 2017

Women learning during a Mother's Group in India.
Photo by Lydia Bologna



Discussion of the Findings:

The Secretariat Model

GPEI Partner Reflections

Whereas the CGPP leadership at the global level was acknowledged, much emphasis was placed on leadership and staff of the Secretariat at country level for whom interviewees were most familiar. Ministry officials positively perceived coordination with the CGPP, viewing it as complementary. They also appreciated the NGO coordination provided by the Secretariat and noted that its presence allowed for NGO representation on government bodies (i.e. EOC, ICC) and serving on different polio task forces, as needed, and provided technical support to the Ministry. One interviewee characterized the Secretariat as “*creating the link*” by facilitating coordination with neighboring countries.

All country-level GPEI partners had the same positive impression of the Secretariat’s coordination role and mentioned its function of monitoring and providing supportive supervision to local NGOs (one even referred to it as “*the mother NGO*”). In terms of coordination, they highlighted the Secretariat’s effectiveness in empowering NGOs and cited an advantage that the work was complementary and no competition or duplication among NGOs because clearly identified who works where. The partners also saw another advantage in NGOs training together, using the same monitoring tools, gaining trust on the ground as well as the Secretariat’s bridging function, responsiveness and power to act. When reflecting on what would have not been achieved, if the CGPP was not present, one interviewee stated: “*NGOs as cowboys-doing their own thing;*” and another noted that the regular supportive supervision that the CGPP provides would be missing (South Sudan, Nigeria). One partner stressed that the Secretariat model

was constraint friendly (i.e. few staff & members with limited resources) but has had a huge imprint (e.g. Ethiopia and India) and made great strides for accessing other global health funding (e.g. Ethiopia).

Great value was seen in having “one voice” to express the NGO perspective in polio and one interviewee expressed: *“less of a burden on donors to work with one program.”* Besides the coordination function, the Secretariat has also gained respect as a complementary, technical resource to the GPEI’s work in-country. In fact, positive comments were consistently made about the high caliber of the CGPP Secretariat Directors.

Among global interviewees, all but one of the GPEI partners had formed an impression about the Secretariat Model. Overall, they were positive about its functioning at the country level, either from their direct experience with the Directors and/or observations and interactions at TAG and other key partner meetings. Most weren’t aware of the organizational dynamics and perceived the Secretariat to be a “non-traditional model” of a development program, but effective in coordinating local and diverse NGOs, streamlining agreements on methods/training as well as monitoring work in the field. As a critical coordination unit, the Secretariat (both at global and country level) was also characterized as key in mobilizing funds and resources for the wider NGO network/partners, bringing NGOs together and garnering HR and ensuring used appropriately, putting together succinct reports of NGO activities, and then representing NGO views at senior levels and national fora. In fact, one partner cited CGPP India as an excellent example with tight management and rigorous practices. In contrast, several other partners noted a problem in South Sudan with the functioning of one of the NGO partners and CGPP South Sudan – issues of Secretariat/programmatic coherence were at play – perhaps because it was a newer network under difficult circumstances. In terms of CGPP Global, the work of the Deputy/Technical Director in attending country-level TAG meetings and supporting in-country teams was noted. However, the larger issue of CGPP representation in global fora was also raised because there is a perception of it being overshadowed by its primary donor.

CGPP Reflections

At the global level, there is a perception that the CGPP approach is critical to the NGO contribution to the polio eradication initiative because of its consolidated focus of partner NGO efforts, which includes experience and information-sharing as well as collective trouble-shooting and problem-solving that responds to on-the-ground realities. Other positive attributes included: multi-directional communication, linking local community work with national and international strategies (i.e. Secretariat participation in EOC). When comparing CGPP Secretariat to other consortium models, one former CGPP interviewee characterized the difference as follows: 1) The Secretariat is nationally-led by technical professionals/peer leaders who are independent and recognized by MOH, partner NGOs, staff/key in-country networking; 2) the focus is polio eradication which is a single identifiable goal that is uncontroversial and clear cut on what is needed; and 3) The opt-in participation of partner NGOs has contributed to minimal competition and more transparency in funding and has been needs-driven (e.g. proportional population = allocation). Additionally, there is the perception among several of the interviewees that the CGPP/Secretariat Model is replicable in other programming areas – a concrete example was given of its use in pandemic preparedness.

The CGPP at Country Level Highlights: Both Secretariat staff and NGO partners expressed appreciation of the coordination function and team spirit of the CGPP.

Partners working at the local level noted that it made a positive difference having the Secretariat represent NGOs at the higher level, providing access to and troubleshooting on their behalf with the government and GPEI partnership.

They also highlighted a sense of no competition and the complementary nature of their work without duplication because locations of operation are clearly defined at onset. While recognizing the current status of speaking with one voice, one interviewee raised the question: “What happens to the CGPP and what it represents once polio eradication ends? Does it hold?”

Evaluator Comments/Observations

The national Secretariat Directors were charismatic, had a collective vision towards engaging local communities in the polio eradication effort and were able to clearly articulate the contributions that their implementing NGOs make to the polio eradication initiative. The strength of the CGPP has been tailoring global polio standards and requirements to address specific cultural realities and social norms in each country.

Both the management and technical competence of Secretariat Directors ensured the CGPP’s positioning and increasing visibility within the GPEI.

This, however, requires continuous contact and supervision of the NGOs’ work and identification of constraints and challenges which they bring to the GPEI at national level. For example, the transition of the work of the CGPP operations in South Sudan (i.e. shifting from one geographical area to the Southern part of the country reflects the adaptability of the Secretariat Model in identifying other geographical areas of operation, while simultaneously having set a foundation for new supervision and a new coordination mechanism under another internationally funded NGO (McKing Consulting Corporation). Despite CGPP’s relocation, the intervention will basically remain the same, which reflects the quality of the operation that the CGPP had been coordinating and supporting.

Whereas GPEI partners acknowledged and tended to highlight the NGO coordination function of the CGPP, the uniqueness of the Secretariat Model, itself, was not always perceived; and hence potential misunderstandings existed. These could be attributed to a lack of understanding of the Core Group mandate and the way in which the “Secretariat Model” works. For example, some of the partners felt that:

- *“The CGPP work should expand the coverage areas and not restrict themselves to only some parts of the country or local areas;”* This was noted in both Nigeria and South Sudan,

but it is important to remember that that current funding parameters dictate the CGPP mandate and its intervention focus;

- *“The Secretariat Directors undertake a lot of travel to meetings;”*⁷ This observation doesn’t reflect an understanding of the Secretariat’s critical role in providing supportive supervision and monitoring the quality of NGO work; and
- *“CGPP should be providing technical assistance, including financial management assistance, to implementing local NGOs.”* This comment shows a lack of awareness that the CGPP does provide technical support (both from national and global Secretariat) and unclear notions about the relative roles of financial accountability between the CGPP Secretariat and implementing NGO agencies, themselves. In fact, implementing NGO staff in all of the CGPP countries express appreciation for the technical support received.

Major Contributions: Success Strategies

GPEI Partner Reflections

Government counterparts across the five visited countries highlighted that the CGPP had made major contributions to the PEI in the following areas: a) community-based surveillance (some even mentioned AFP surveillance; b) SIAs; c) community mobilization/sensitization, emphasizing the work of social mobilisers (AFP & EPI mobilisers, SMNet in India); and providing technical support to the Ministry of Health. Specific emphasis was placed on the important role of the CGPP in defaulter tracing and zero dose follow-up; plus, its Secretariat in coordinating local NGOs; as one interviewee stated: *“without which we would not know what is going on.”* Several others also mentioned the CGPP’s efforts in birth registration and helping to ensure stool samples reached the laboratory in a timely manner (Kenya government official) as well as quick response, problem-solving and ability to reach communities.

Country-level GPEI partners reinforced the CGPP’s SIA involvement, expanding beyond polio to measles, periodic intensified routine immunization (PIRI) etc. and community engagement (i.e. village community mobilisers in Nigeria, frontline workers in HOA).

One partner in India referred to CGPP as *“the eyes and ears”* who are quick to act and reach communities and know how to address obstacles.

Partners further elaborated upon these points by stressing the CGPP’s work in ‘no go’ and/or hard-to-reach and cross-border areas (e.g. Somali region, Turkana border etc.), its ‘bottoms up’ perspective, and

⁷ It should be noted that this was not an issue in Ethiopia and India.

reinforced the Secretariat’s coordination function and support to other NGOs. As one interviewee stated: *“it is a good example of how partnerships work.”* In Ethiopia, it was even noted that the CVs were more effective than the government extension health workers. It was remarked by HOA interviewees that if no CGPP presence in polio eradication, the “doing business as usual” routine would not have been broken to enable closer relationships with communities and cross-fertilization to reach the underserved. Additionally, one interviewee noted that “the government can’t be everywhere,” so CGPP’s ability to work in cross-border areas is important (Ethiopia-Somalia-Kenya borders). This was amplified more recently in South Sudan with an Ebola outbreak was detected in the Democratic Republic of Congo. Another respondent indicated that demand creation would not have been as successful without the presence of CGPP (India).

At a global level, GPEI partners reiterated many of the points made by their field colleagues and commented on the added value of the CGPP in the following areas: 1) effectively engaging communities and extending the need to build trust and capacity in underserved communities; 2) determining how best to select high-risk areas for locally tailored interventions; 3) playing a pivotal role in community-based surveillance and helping to improve the sensitivity of AFP surveillance; and 4) providing surge capacity in poor performing areas plus serving as an “early warning system” for peak refusals; and 5) providing leadership in cross-border areas. It is also perceived that the Secretariat Model has contributed to more collaboration and ownership at the national level. As one partner summarized, “the CGPP extended GPEI beyond the government, UN and international partners to the local communities, themselves.” Another stated that if USAID had not invested in CGPP,

“GPEI would have lost ability to reach the unreached, cross-border communities making them aware of the risks and what to do to help. The key of USAID’s GPEI investment was CGPP’s “local human resources” who are still there and with a little support are sustainable.”

This observation was reinforced by another interviewee who remarked that if CGPP no longer received USAID funding, it is unclear how networks would be maintained, and transition achieved, e.g. Sudan and Afghanistan, given lack of global interest.

CGPP Reflections

Like GPEI partners, CGPP members also positively highlighted the CGPP ability to reach underserved communities in remote areas (Ethiopia) or in conflict/high risk areas (South Sudan, cross-border Kenya & Somalia) with vaccines and induce trust and overcome resistance (India). One interviewee highlighted that engaging NGOs from the ground up for social mobilization and using community health volunteers has become accepted as a standard practice in polio eradication. Another (former) CGPP interviewee noted one of CGPP’s defining contributions, especially at the beginning of the polio eradication initiative, was showing that community science is involved in reaching the last 20% of children and is just as relevant as top-down technical interventions (e.g. India, Nepal, Bangladesh etc.).

When questioned about funding, global interviewees perceived several lost opportunities if the USAID investment had not occurred. First, polio interruption, in such places as Angola, India, Nepal, and Bangladesh would have been delayed. For example, it was highlighted that Angola relied on NGOs who provided 400-500 CHVs, cars and money to support the effort. Even though the BMGF introduced more funds into Nigeria, it was also noted that the quality was not the same (example: upscaling to 1000 social mobilizers with 1-day training vs. more in-depth training for a smaller number of mobilisers.) Secondly, the CGPP would have needed GPEI partners support to engage into new countries (example: South Sudan where staff resistance was faced).

It was also perceived that the CGPP work has contributed to blending systematic, data driven and very detailed micro-planning at the grassroots level; while maintaining different partnerships at all levels, including national and global; e.g. CGPP India, Angola and Ethiopia. Among some interviewees, there is a perceived co-leadership with UNICEF on community engagement and social mobilization (the application of communication science principles to polio eradication).

The CGPP at Country Level Highlights: The CGPP staff highlighted their major contribution in the area of community engagement and participation, and community-based surveillance. Regardless of the country, they all linked their social mobilization efforts to individual behavior and community change and emphasized their role in demand creation. Secondly, they noted their ability to identify and notify about suspected polio cases especially in ‘no go’ areas for the government and GPEI partners. Thirdly, they also noted community acceptance and use of community volunteers and community-based organizations which enable them to work in high-risk/security-risk areas and remote villages. As one interviewee stated: “we are the eyes and ears on the ground.”

Evaluator Comments/Observations

The challenges faced by the CGPP when working in underserved and hard-to-reach/high-risk areas have resulted in a very strong program on the part of its NGO implementing partners, which is based on a deliberate strategy of working with communities and engaging volunteers who are accepted by the community. This approach has been useful in crafting messages and has led to families vaccinating their children because they have been engaged in a culturally accepted manner and by a familiar and trusted source (i.e. local influencer, respected opinion leader etc.). Although initially focused on polio eradication, the CGPP recognized, along with GPEI partners, the importance of improving routine EPI to maintain the gains of the GPEI. The principle of community-level operations that are guided by clear national/state strategies with collaboration of the local authorities is a principle that is well recognized to have the potential for expansion to other health and non-health community initiatives.

Main deliverables and GPEI Program Objectives

GPEI Partner Reflections

In terms of key results or deliverables, government interviewees provided concrete examples mentioning the CGPP's systematic outreach and role in improving SIA coverage to reach every district or county/sub-country (e.g. Nigeria, South Sudan, HOA) and birth registration (Nigeria), AFP surveillance (HOA and Nigeria) as well as providing assistance, at government's request, in timely stool shipments in HOA despite it not being a CGPP responsibility. A concrete example was also provided of how the CGPP played an instrumental role in the turnaround/interruption of polio in Uttar Pradesh, India. In terms of meeting program objectives, a Nigerian official noted that its CHIPs plan entails integrating the CGPP Community Health Volunteers into the Government System. They also noted that if the CGPP had not been present, EPI and community-based surveillance in security-compromised areas and cross-border outreach (South Sudan, HOA, Ethiopia) would have been more difficult, if not impossible. In terms of behavior change, officials acknowledged the CGPP's community mobilization and engagement activities which create awareness (Nigeria) and empower communities (HOA); but several also felt that there was no systematic analysis and reporting of the change over time although post-campaign monitoring/surveys are conducted. This perception reflects perhaps a lack of knowledge of or familiarity with the periodic CGPP program evaluations that are undertaken and a lack of awareness of reports on Knowledge, Attitudes and Practices (KAP) survey findings and specific behavior change results according to baseline/midterm/final measures in each grant cycle. Besides dissemination of written reports, the analyses are also available on the CGPP website. A more recent example is also South Sudan. PCE/ICM is conducted after every round and the CGPP shares the data and reports of ICM for the entire country with GPEI partners. Implementing local NGOs had concerns that it is currently accepted core indicators based on global standards make it difficult to link/attribute behavioral improvements directly to their work unless separate indicators are established, which contradict the global initiative.

Among country-level GPEI partners, it is perceived that the CGPP is contributing to and helping meet the PEI program objectives. Key results of its efforts have been improved SIA coverage including a decrease in zero-dose children (all countries), and routine EPI strengthening in India, vaccinology training & micro-planning in Ethiopia; and reduced dropouts and defaulter tracing in Nigeria. The above-mentioned examples, as well as demand creation, are most often cited as key CGPP results. Additionally, other results included: improved AFP surveillance (community reporting in HOA, Ethiopia), CBS (HOA, South Sudan) and measles case detection as well as cross-border activities/coordination being strengthened in South Sudan and Ethiopia. One partner also felt that if the CGPP was not present, systematic cold chain implementation would not have been achieved and community identification and notification would be lost.

In terms of the behavior change dimension of the program objective, GPEI partner perceptions of the CGPP were mixed. On a positive note, some felt that there was progress in family awareness of and norms on EPI, community engagement (house-to-house) during campaign rounds, the use of new technology and KAP survey-knowledge of the community and others felt that social mobilization for demand creation not possible without the CGPP. Another noted that interpersonal communication was effective with religious leaders (India). In comparison, another GPEI partner alerted that the CGPP doesn't provide solid evidence

of its work and behavioral results because of its tendency to only share process indicators (e.g. nomad mapping, water holes etc.) rather than data on behavioral (or proxy) indicators such as # and types of attitudes or practices or actions taken and by whom. According to documentation provided, the CGPP does use globally agreed upon indicators on immunization, surveillance, and immunization related behaviors to complement their other program assessment indicators. Perhaps more emphasis is needed on reporting such findings in public forums and technical meetings.

Global GPEI partners who were interviewed almost unanimously identified **community engagement** and **community-based surveillance** as the main CGPP deliverables.

With respect to the latter, they placed emphasis on the CGPP's ability of reaching the 'hard to reach children,' in addressing community level resistance/reluctance by reassuring and helping communities understand why polio exists; and playing an instrumental role in involving local government in polio eradication efforts with the caveat as stated by one partner: "When the government owns the program, it doesn't automatically translate in communities demanding vaccination." Several other partners noted that the CGPP put in place an important platform for social mobilization which can expand beyond polio to child survival & development and wider social outreach and as a complementary partner reinforce other UN efforts by strengthening the community engagement contribution to GPEI. Secondly, GPEI global partners' positive acknowledgement of CBS highlighted the contribution of community volunteers trained by the CGPP to identify and report suspected cases that can be later investigated, thereby increasing AFP surveillance sensitivity. One partner noted that their efforts contributed to an increase number of cases being identified, and in some instances, the community volunteers were the first to pick up measles, cholera, and hepatitis cases.

With respect to social and behavior change, only three Global GPEI partners made specific observations. One partner considered changing knowledge, attitudes and practices as the focus of CGPP's work but questioned if the model was applied rigorously and with strategic visioning and guidance (i.e. quality, methodology etc.) on behavior change that was provided by the CGPP Global Secretariat. In terms of behavior and social change, another emphasized CGPP's contribution in overcoming resistance, building trust and community knowledge, helping engage community leaders, understanding social aspects, reaching children repeatedly, and explaining/keeping trust with communities. This perspective was complemented by another partner who highlighted CGPP's development and use of tools to make a systematic approach to communities and making them aware/providing feedback on final assessment of what communities did (i.e. level of awareness – what is next step – problem or not).

CGPP Reflections

In the eradication effort, it was felt that CGPP has provided "proof of concept," i.e. how to establish real trust, reach reliably underserved communities and strengthen community structures.

In terms of project objectives, an observation was made that they should be informed by the Secretariat

Directors and GPEI partners who are best positioned to identify priorities on the horizon. Additionally, it was mentioned that partner NGOs have innovated and made significant deliverables to the polio eradication initiative in the following areas:

- **India:** Supportive supervision in between polio campaign rounds in western UP that contributed to community confidence and a reduction vaccination refusals
- **Angola:** Community-based surveillance, Independent campaign monitoring (Army)
- **Nepal:** GIS household mapping
- **India:** Tracking newborns
- **Afghanistan:** CBD mainstreaming/piloting
- **HOA:** Community-based surveillance and strategies to stop outbreaks
- **Ethiopia:** Working with pastoralist/nomads/border communities; immunization
- **Nepal/Bangladesh/Angola:** Working with poor performing districts.

In terms of social and behavior change, CGPP global staff observations are consistent with numerous perceptions among the GPEI partners.

They also emphasized the CGPP’s effectiveness at the community level—engaging community leaders, creating relationships with influencers, working with household caregivers and changing attitudes that yield normative and community change not just individual behavior change.

Specific emphasis was placed on CORE Group NGO partners’ ability to penetrate communities to focus on what matters to them, what they want & do and then link to polio eradication, while building trust (which is not often expressed) and local capacity.

CGPP at Country Level Highlights: The CGPP team (CGPP staff and NGO partners) highlighted their work in cross-border and ‘no go’ areas as main deliverables. One interviewee also noted the continuous coordination. In the case of both Ethiopia and India, mention was also made of the network of community mobilizers that had been established. At the same time, it was noted that in terms of sustainability, obstacles have been encountered. For example, in India, the government could absorb them in its ASHA system, but different recruitment criteria exist; and in Ethiopia, the government has established its own system of community health volunteers.

Evaluator Comments/Observations

Since technical oversight for the GPEI activities is provided by national government authorities in conjunction with WHO and UNICEF, the CGPP program implementation has been consistent with global standards and national requirements. The latter was highlighted repeatedly by government counterparts

that were interviewed. In fact, CGPP field supervisors demonstrated the capacity to adapt the nationally or state level agreed upon strategies to local, community contexts and thereby contribute to increasing vaccination coverage during SIAs and improving routine EPI activities during the inter-campaign periods (e.g. Northern Nigeria, and South Sudan where in most parts of the country EPI is delivered through campaigns – PIRIs; nomadic populations in Ethiopia, Kenya and Somalia).

Strengths/Successes/Accomplishments vs. Weaknesses/Challenges

GPEI Partner Reflections

When considering the CGPP strengths, government counterparts first mentioned coordination and collaboration, which in their perspective, contributed to NGOs following recommended plans and guidelines. Greater visibility and links between NGOs and the GPEI were also noted positively. Again, the CGPP's cross-border work and collaboration with neighboring countries was especially appreciated by government counterparts. In fact, it is perceived that the biggest impact of the USAID investment in the CGPP has been access to security-compromised areas in the country. No specific weaknesses were signaled by government interviewees other than one observation around stool samples.

Among in-country GPEI partners, the presence of the Secretariat at national and sub-national level and its participation in EOCs (also providing regular NGO updates), as well as its NGO coordination role and related NGO capacity-building, were most often mentioned as a strength. A second focused on the CGPP's capacity to work with local governments in insecure and/or border areas. For some, supporting the introduction of new vaccines (India) and digital real-time reporting (Ethiopia) were identified as good practices. In terms of process, there was also a positive reflection on the CGPP's use of standardized messages, frequent meetings and joint decision-making with NGO partners on programming locations. For India, specific mention was also made of the freedom to develop and test new materials and tools. Whereas in HOA, the provision of a stipend before, during and after campaigns in security compromised areas was positively noted, because of its impact on volunteer motivation and sustainability. Lastly, the CGPP's work in awareness-raising and demand creation, especially in difficult or border areas, was reiterated, repeatedly.

In terms of areas needing improvement, only three observations were made. First, there is a perceived need to improve data collection and documentation. Second, more technical cooperation/ a need for more bilateral discussions with relevant GPEI partners (Ethiopia, HOA) and a perception of isolated planning⁸ by CGPP India were also flagged. Thirdly, the CGPP was perceived as having 'good depth,' but limited focus so partners suggested a need to hire more technical staff and obtain more financial resources. Sustainability challenges of CORE Group mobilizers are experienced in both Nigeria (Government has no capacity) and India (difficulty in government system absorbing the well-trained mobilizers).

⁸ One negative comment from a partner was that the program was so focused on Polio that "it did not have the time to look into other areas to replicate."

With respect to the CGPP strengths, Global GPEI partners discussed its value-added contribution across five dimensions. First, it is perceived that its community base enables CGPP members to provide critical voices from the field and therefore have credibility in national and global planning and decision-making fora by helping see critical gaps as strategies are being developed.

A program strategy of engaging members of community, themselves, in polio eradication and soliciting their ideas/suggestions about polio activities and problem-solving have been key contributions to reaching hesitant community members.

Second, the good coverage of community volunteers (because NGO is already present or willing to go to a location) fills an unmet need of reaching the unreached. The CGPP's use of community workers and access to local community influencers enables them to be more effective in communicating polio messages in culturally sensitive and relevant modes. Third, the CGPP's tenet of linking local NGOs with their international counterparts ensures alignment and unification of effort and polio work can build on the broader development and basic needs of diverse NGO platforms. As a result, partners also observed that in practice, the CGPP "brand" replaces individual NGO identities when they undertake polio work. In recognizing the importance of being part of a system, the CGPP brings together different NGOs with specific functions but working in clearly defined areas, which leads to good collaboration. The CGPP's capacity to speak in 'one voice' for a wider partnership of NGOs facilitates the communication process and efficiency when presenting civil society perspectives and experiences in polio eradication activities. Fourth, partners note that the CGPP has demonstrated its availability and reach in places where other partners and the government are not present or can't go (e.g. cross-border) and its ability to mobilize NGOs and communities in such environments. Finally, some Global GPEI partners also acknowledged the technical competence of the Secretariat staff, especially directors, as evidenced by their planning, management, tools and M&E strategies. The supportive supervision provided by the CGPP at local levels was repeatedly highlighted by interviewees and consistent between both GPEI and CGPP staff, themselves.

Despite the favorable perceptions of the CGPP, global partners also identified some challenges and/or areas needing improvement. First, with respect to data and information, several partners flagged that the CGPP is weak in documentation/reporting. It was noted that information is often anecdotal, impressionistic and self-promotion (example: TAG meetings) and thereby missing an opportunity for evidence-based reporting (e.g. socio-demographic, combining 'human' reasons with facts etc.). A concrete example was provided in HOA. Whereas there has been good coordination at regional level, the CGPP has been to: *"able to connect the dots and met regularly but maybe less coherence on products, training, tools, min. standards, and key messages."*

Secondly, creating and maintaining resources was flagged as a management challenge for the CGPP. Given the demand and a need of financing to support community-based work and the 'hard to reach,' CGPP resource base is not always sufficient to support its role in GPEI. As one partner stated: *"if plan then they should have the resources to act; the number of NGOs affects the ability to completely oversee – therefore*

there is a need to strengthen, more qualified supervisors for monitoring.” A concrete example cited was Ethiopia and South Sudan – both having bigger sub-office Secretariats. Thirdly, in terms of social mobilization, one partner flagged the need for closer integration and conceptual alignment between the CGPP and other GPEI partners (like what occurred in India and Nepal when there was closer connection). Finally, another partner noted that for some, the CGPP is perceived as too much of a US initiative (a political dimension) with insufficient visibility in its own light. Although a separate entity from its donor, there is a perceived rigidity in CGPP functioning vis-à-vis USAID rules and regulations and a lack of clarity among partners of how easy to access.

CGPP Reflections

Global CGPP staff perceptions were like their GPEI partners. Observations were made that, with a few exceptions, the CGPP is staffed locally which increases their ability to understand the issues and places an emphasis on capacity-building of local NGOs and CBOs in a range of areas: technical, management and financial. The “opt-in” approach enables NGO partners to join or leave the consortium, depending on their status and capacity. Besides the Secretariat Model itself, some other strengths that were identified include:

- cross-border collaboration
- documentation: grassroots defaulter tracing system
- use of community registers (India) data so community members such as influencers could review, receive feedback start to see patterns
- community-based surveillance.

Additionally, a former CGPP staff member also reminded that clarity of focus (conceptually) is important, as well as the engagement of civil society, itself, in polio eradication efforts.

With respect to weaknesses, at a global level, it is perceived that it took a long time for the CGPP Secretariat to garner respect among GPEI partners (as one stated: “gate-crashed the party”), despite USAID (i.e. Ellyn Ogden) being a champion. However, it was noted that via USAID presence and advocacy, the CGPP was then later involved in meetings and deliberations of the ICC, TAG, MOH and currently, based on its hard work, is considered a relevant GPEI resource. While acknowledging that things may have changed in the external climate, one interviewee noted that there have been mixed messages internally about polio engagement by CORE Group Inc. (the global consortium) For example, initially, there was excitement among partner NGOs to join the polio effort then a period of difficulty was encountered during which little attention given to polio at global Board meetings.

Two interviewees also raised concerns about gender equity in the CGPP family. It was noted that whereas significant amounts of polio-related community work centers around women, i.e. mobilizers, CGPP supervisors and senior staff tend to be predominantly male (e.g. only one Secretariat Director is a woman).⁹ Finally, consistent with GPEI partner perceptions, it was noted that initially CGPP’s work was not data driven enough and it took a while to strengthen to the M&E component by hiring qualified staff and incorporating epidemiological and analytical findings in the reporting (around 2008). An exception noted was India who begin this work much earlier. Currently there is recognition of the need to invest in qualitative research <not just baselines> and undertake midline surveys on a more regular basis.

⁹ A review of the CGPP website staffing profile reveals a low presence of women in senior management.

CGPP at Country Level Highlights: The CGPP Secretariat and NGO partners highlight that recognition as the “CGPP” and not by their individual NGO organizations has been a plus in polio eradication work. As such, it has contributed to visibility and access to the Government and served as a unified advocacy framework for local community action – “it is one voice, one team.” However, in a contrasting opinion, one interviewee questioned the significance of the CGPP voice at international level/fora and noted that whereas the CGPP Secretariat attend TAG meetings, NGO partners could also benefit. In terms of strengths, some other interviewees noted that they have been able “to do a lot with little resources;” but also indicated that they have insufficient funding to respond to all the demands. It was also acknowledged that the CGPP has benefitted from strong, positive leadership by the Secretariat Directors and both the wisdom and institutional memory of those who have been with the CGPP since its inception, but one interviewee raised the question: “what happens if they leave?”

In terms of weaknesses, beyond those discussed in the country-specific synopses, two other considerations were flagged by individual country-level CORE Group members: 1) the lack of the CGPP being a government registered entity could pose a problem in India and blocked CGPP participation in transition planning <a Secretariat respondent> and 2) a perceived Washington bureaucracy or bottleneck leading to slow fund transfer and staff attrition which has required NGO partner to use other funds to temporarily cover costs <a NGO partner>.

Evaluator Comments/Observations

The sense of CGPP identity is strong throughout the countries visited and as such, contributes to its cohesive approach to its community mobilization and surveillance activities.

The collective emphasis on community engagement as a wider remit and forerunner of social and behavior change is reflected by evaluation findings that show positive results in expanding vaccine coverage, reducing missed children and improved community knowledge and attitudes about polio vaccination and routine EPI immunization (**CGPP FINAL EVALUATION REPORTS, FY 2016 & 2017**).

To this end, constant supervision has remained a key for the success of community level activities in support of identifying and notifying about suspected cases of acute flaccid paralysis (i.e. community-based surveillance) and other diseases such as measles and cholera.

GPEI partner perceptions about data collection and reporting raise questions since the CGPP has systematically been conducting periodic evaluations using global polio standards and preparing reports that available to all partners. This may be an instance where partners are unaware of the reports or challenge the data itself. The CGPP Secretariat is also active in national EOCs, except in South Sudan where it is not very functional, and this national forum is an excellent platform for sharing data and information among all partners, as inputs into strategic planning exercises.

In terms of gender issues in staff recruitment and retention, the polio eradication initiative has been and is male dominated, especially in leadership positions. While the “global CGPP Secretariat staffing” appears

balanced, most senior leadership positions, including Secretariat Deputy Directors and main Secretariat staff tend to be male apart from the India Director and two communications senior staff in the India and Ethiopia programs, respectively. In comparison, in the CGPP country programs women are more numerous at the community level. Considering cultural and social norms, the feasibility of gender parity requires further discussion within the CGPP.

Opportunities (4-5 years transition)/Specific Lessons

GPEI Partner Reflections

Factoring in the polio eradication end and using the next 4 to 5 years to transition, government officials identified other, non-polio interventions where the CGPP could be effective. These include routine immunization/SIAs, water and sanitation (WASH), and expansion to other maternal and child health issues, including family planning. For example, in Nigeria polio plus activities are planned to link polio work with routine EPI, sanitation, measles. In comparison, in Ethiopia a comprehensive training package including a variety of topics is being prepared, as well as linking each volunteer to health clinics.

Furthermore, in-country GPEI partners identified similar non-polio opportunities for CGPP involvement. Concrete actions were identified in several countries such as working with the private sector (India), strengthening national resilience so government takes over short-term activities, and replicating model and behavior change activities in other programs/training and strengthening follow-up. Specific program areas identified were sanitation/WASH, routine EPI (incl. measles), child survival initiatives, universal health coverage and even other communicable diseases, rabies and dengue fever as well as health emergencies. In addition to health, suggestions also expanded to other sectors such as education, agriculture and social affairs.

Numerous lessons learned in polio eradication were highlighted to guide future CGPP action and opportunities. Learning from the Ethiopia experience, partners noted: the importance on internal coordination meetings and using the same plan and 2) the power of digital CBS. In South Sudan, strengthening local NGOs and providing more supportive supervision were identified as key lessons. The re-introduction of the Reach Every District (RED) strategy in Nigeria showed how an effort could be accelerated and maximized. A follow-up lesson from Nigeria is moving beyond financial incentives to motivate mobilizers through recognition/award ceremonies. In HOA, it was learned that given that security is complex, there is a need for increased local partnerships focused on task. India provides a final lesson. The CGPP has been recognized as a key partner and instrumental component in polio eradication effort so there is added value in its continuity for demand creation given that BCC is a foundation of primary health care but the sustainability of its community mobilisers is contingent on linkage with the state government.

The next 4-5 years is a transition period; and GPEI partners noted potential action or activities already underway that could guide the CGPP during this period. In HOA, work on the independent monitoring/LQAS process and explore wider surveillance in current network, plus develop exit strategy that focuses on task. Transition planning is underway in South Sudan with active participation at all high-level forums to develop

transition plan and in Nigeria with an emphasis on assets mapping. Among the two oldest CGPP programs, Ethiopia has completed its transition plan and funding has been secured. In comparison, India is exploring sustainability options for its volunteers with local state government since their absorption into the ASHA (India government approach) is problematic.

Like country-level GPEI, global partners envisage other opportunities and a wider remit possibility for the CGPP.

Recognizing that polio is just one milestone and preparing for a polio-free environment, it was noted that the CGPP's community engagement for well-being in general is important in immunization.

As such, the importance of continuing to engage religious leaders and addressing peaks of refusals-initially signaled by 'anti-vaxxers.' It was noted that the CGPP platform could continue to serve as an early warning system and to maintain community surveillance that focuses on vaccination event clusters, anti-vaccination and vaccine preventable diseases, etc. One partner indicated that CORE Group can be in the forefront of other simple interventions – i.e. polio plus/ Vitamin A (house-to-house), health education and referral to facility, nutrition education and clean water, etc. Others perceived that the CGPP, through its community networks for community engagement and social outreach, can engage communities and civil society around all disease outbreaks; MCH services; a bigger children's agenda – e.g. Asian flu, child health/monitoring; and child protection/FGM. Finally, it was also an ambitious proposition was made that the CGPP, with an eye for replication and sustainable upscaling of its work, could lead the way to fully systematized other simple interventions by clarifying and documenting : 1) what they have been doing; 2) the extent to which it is being done properly; and 3) what advice is given for new interventions; and then incorporating strategic thinking and advice from partners & consensus among partners.

Operating from a position that there is value-added in the CGPP's continued work beyond polio and noting that if USAID reduces financial support, several observations were made by the global GPEI partners. In the next 4-5 years of the transition period, global partners noted the need for the CGPP to articulate its vision for going forward and make an investment case that could appeal to a broader audience. Simultaneously, there was a desire for ongoing dialogue between the partners and the CGPP to determine how collectively to face transition challenges. *Other concrete suggested actions include more focus on 'hard to reach' communities to avoid reoccurrence and maintaining a focus of high-quality community engagement (CE) and CBS since there still is an unfinished polio agenda. Additionally, a need was identified to document more of what has been done and how; focusing on other communicable diseases (e.g. measles, Hep C, E, TB and other vaccine preventable diseases) and addressing how the CGPP could engage in emergency and other outbreak responses.*

It is also important that the CGPP continues to advocate for community ownership and document lessons learned from countries that have already transitioned, such as Angola, Nepal, Bangladesh etc. of which some are identified below:

- Community work benefits from a coalition of NGOs working on one umbrella to ensure one direction and should be based on building local capacity for sustainability

- Field presence for hard to reach/underserved communities is possible by partnering with local NGOs and CBOs in small, remote villages
- Community-based surveillance and social mobilization should be routine components of community engagement
- Although not resource intensive for local community engagement, seed money is important. One partner reminded: “It provides stability, consistency and sustainable progress and given networks already in place, it is easier to sustain in small quantities since starting up costs more.”

CGPP Reflections

Global staff acknowledged the need for secession planning and ensuring that “one voice” as a single communication reflecting “team think” is continued along with good practices such as national leadership, community-based surveillance, social mobilization, strategies for working in remote/underserved communities, mutual accountability and independent monitoring. At a global strategic level, it was also anticipated that once polio virus transmission is interrupted that there must paradigm shift to a one health platform but considering that other diseases may not be so straight forward as polio. As such, several potential new areas of intervention were posited. First, if immunization, then could get involved in the roll out new vaccines and measles elimination. Secondly, possibilities to be explored in dealing with other treatment protocols; scaling up family & community hygiene and maternal health as ways of contributing to neo-natal health. Finally, a suggestion was mad that the CGPP might explore how it could play a role in addressing more chronic diseases at community level.

The CGPP global staff also recognized that during the next 4-5 years, more documentation is needed of what has worked / not worked and exploration of other ways of applying/adapting the model in new, more difficult settings e.g. Afghanistan. Three key lessons that should be taken into consideration are:

- CGPP necessary for North India/Angola – without its presence/work, it would have taken much, much, longer to eradicate. Based on this experience, two other lessons:
- Never underestimate the power of community to do things (door-to-door, community mobilization) and the power of collaboration. The CGPP experience demonstrates that people want to work together to solve problems and save lives
- Civil society participation facilitates mutual accountability between communities and the government

The changing programming environment shows other pressing, competing development problems than polio such as global health security and increasing emergencies where the CGPP approach is applicable. However, experience shows that changing social norms is difficult (e.g. Ethiopia and India), so may be difficult to implement transition planning while AFP surveillance is still needed. One question that was raised centered around the extent to which national governments could absorb the funding of a CGPP network if it was transitioned.

CGPP at Country Level Highlights: When queried about specific lessons learned, the CGPP respondents highlighted innovations that they believed had future application and/or activities that they felt made a significant difference in their functioning. For example, Ethiopia interviewees highlighted the importance

of real-time reporting that facilitates addressing discrepancies and providing feedback for action. This was possible using different digital Information Knowledge Management (IKM) platforms that included: mobile devices and a web-based disease surveillance system that will now be aligned to the WHO and Government systems. Specific experience has shown its effectiveness for routine immunization and strengthening community-based surveillance. In the HOA, CGPP members use the WhatsApp platform for information-sharing, reporting and convening virtual meetings. Interviewees also flagged the importance of quarterly meetings and google sheets for report preparation. In a parallel manner, South Sudan respondents noted the importance of monthly CGPP briefings and a circular feedback loop among NGO partners where issues are raised and feedback provided. It was also noted that their data is incorporated into the WHO system for which analysis is provided.

In discussing potential programming areas of CGPP involvement beyond polio, some interviewees cited other vaccine preventable diseases (e.g. measles) and polio plus activities such as routine EPI (e.g. PIRI), nutrition, sanitation (Nigeria, Ethiopia. HOA) and zoonotic diseases (specifically mentioned in Ethiopia and HOA where some early pilots occurred under financing through One Health/Health Security Agenda). In addition to development programming, others perceived a role for the CGPP in the humanitarian/emergency sphere (South Sudan) as well.

During the next 4 to 5-year transition period, some interviewees highlighted the need for more community involvement, especially community-based surveillance which is perceived to provide recognition and visibility to CGPP efforts. With respect to the funding situation over this period, it was noted that globally GPEI has been extended to 2023 and: 1) transition planning is underway in India but the CGPP is blocked from the process, and 2) in Ethiopia, funding has been secured until 2022. An interviewee in Nigeria reported that “it is business as usual.” In contrast, in South Sudan it was flagged that the situation was fragile, with human resources costs only covered for 4 years and in HOA, the need to seek additional funding for CGPP work in remote areas was identified.

Evaluator Comments/Observations

The CORE Group Polio Project has evolved beyond a vertical program and benefitted from the experience of two long-serving staff (Secretariat Directors in India and Ethiopia, respectively). Interestingly, in terms of human and technical resources, the CGPP has sufficient capacity to use its own “in-house” expertise rather than external consultants to build and reinforce competencies of implementing NGOs and their polio workers – e.g. training workshops in social and behavior change, and M&E, providing technical assistance /mentoring (e.g. sending staff from Ethiopia to South Sudan). An interesting observation was noted in Kenya in which the CGPP opens its training programs to GPEI partners, but it hasn’t been reciprocal. At the same time, the CGPP have developed numerous materials and tools that have implications for use in other community-based activities programs financed by other GPEI partners, such as UNICEF etc.

The position of the CGPP is strengthened when, at both national and state levels (e.g., Nigeria, a government controlled/mandated mechanism, such as an Emergency Operating Centre (EOC) is functional, regularly meets and to which all GPEI partners are fully engaged.

The participation of the CGPP Secretariat in the EOC and other relevant meetings, where polio eradication strategies, proposed activities and progress are monitored, is critical to ensure that the field and community perspective are factored in the planning and strategy development processes.

This perspective was consistently reported by GPEI partners and resonated with CGPP staff and NGO partners themselves.

Since NGO partners were already operating in designated areas prior to joining polio eradication work, the lessons learned, tools and techniques developed under the CGPP should be incorporated in other aspects of their ongoing programs in other development sectors. In this regard, it would be useful in the work CGPP is showcased regularly at the Global CGPP discussions that engage a wider number of NGOs and private voluntary organizations that don't necessarily work in the polio eradication initiative; for example, the CORE Group Conference, Center for Strategic & International Studies (CSIS), Social and Behavior Change (SBCC) Conferences and the American Public Health Association (APHA) national meetings, etc.. At the same time, current GPEI partners should explore how the CGPP good practices could also be applied to other programs that they support and incorporated their own organizational culture. For example, while USAID has been an ongoing champion, it would be also useful if UNICEF and WHO-sponsored international and regional meetings include participation by CGPP representatives as a means of highlighting good practices that could inform community engagement interventions in a wider public health and development agenda.

Children playing during a Mothers' Meeting in Ethiopia. Photo by Lydia Bologna



Conclusions and Recommendations

- 1 Both outcome evaluation results and the findings of this process evaluation confirm that the CGPP has made and continues to make major contributions to the polio eradication initiative, especially at its most critical stage of termination/extinction of the virus which involves dealing with the most difficult and final resisters (e.g. remaining 5-10%). In fact, CGPP has tended to work in areas where the virus is silent and routine immunization is minimal or non-existent. By building community capacity to be self-sufficient and using community mobilizers and/or community health volunteers, the CGPP has been able to reach underserved and remote populations and strengthen house-to-house contact and information exchange. Through their intensive community contact and involvement of community members in polio planning processes, they have been able to develop trusting relationships, and demonstrate respect for cultural/social norms while offering change options in a non-threatening manner. While the CGPP focus has prioritized polio eradication, it has been requested to intervene and respond to other child health needs, e.g. PIRI in Nigeria. At the same time, it has evolved into a social communication and community surveillance platform that has the potential to expand in other programming areas beyond health.

Future Implications/Recommendations (Programming):

- CGPP specialization in working in remote and high risk underserved locations has potential use in other development and emergency programs. As such, as polio tasks wind down, NGO partners should explore other areas of potential engagement. The current experiences in routine EPI and

zoonotic diseases should be followed closely to understand better what is necessary to transition the approach to other areas.

- Specific attention should be placed on how the CGPP concept can be implemented in emergency and humanitarian situations. In this regard, Afghanistan can provide concrete polio examples and therefore, documentation of the processes involved, and results will be important.

2 In terms of operational characteristics, the concept of a unified NGO network seems to positively resonate across all interviewees. As such, the Secretariat model is a key foundation for the CGPP; and the entire network is structured to take advantage of NGO partner strengths and their respective, strong sub-national and local, district focus. Secretariat is the link between on-the-ground operations and strategic, decision-making processes. Although the basic format (a small independent staff and host NGO) is the basic model, it may be operationalized differently in different countries, depending on need and NGOs involved. The future of the CGPP Secretariat – formal recognition as registered organization vs. independent project - is posing a challenge for India. Since CGPP India is not a registered entity and cannot receive funds directly, it is a challenge to partner with the government formally, such as in transition planning, etc. This is a dilemma and has led to consideration as to whether the CGPP Secretariat could be registered as subsidiary of CORE Group Inc. At the time of this report, the situation had not been resolved.

Future Implications/Recommendations (Secretariat):

- The employment of local human resources (or internationals with extensive in-country experience) to achieve objectives through a simple, independent coordination mechanism, with supportive supervision, is a replicable model. In its application, specific emphasis should be placed on:
 - Secretariat Director recruitment
 - Exit strategy and secession planning for CGPP Secretariat staff
 - Gender considerations in CGPP staffing and NGO partner—explore different mechanisms that facilitate more women’s involvement in supervisory and management positions, where possible.
- In terms of organizational structure, it is possible that a different type of Secretariat model may be needed for routine EPI or other diseases, therefore one should consider potential adaptations – along with their pros and cons - of the Secretariat model whereby:
 - The Secretariat is staffed and hosted by a partner NGO
 - The CGPP has the potential to register nationally as a subsidiary of CORE Group Inc.

- 3 Several GPEI partners view the CGPP as a fast and efficient implementing partner of the GPEI and not a GPEI member, per se. While accepting that the CGPP provides grounded information about community realities, they are also perceived by some of having a micro-perspective of what is occurring and not necessarily a big picture of what is needed. This may explain the perception of several CGPP interviewees that the CGPP’s work is overshadowed by UNICEF and other UN agencies and that GPEI partners are not always open to their work, i.e. challenging ideas/motivations. As such, it is perceived that GPEI partners need to be more willing to give NGOs/CGPP a “voice at the table” and to quote one interviewee: “Be more open and less defensive, less control - “If succeed, plenty to share!” Consistent with this remark, there is consensus among CGPP members that they should be included in future planning and discussions with the government and receive partner support for their efforts. At the same they realize that as an NGO project, the CGPP has a behind scenes role in supporting the government in polio eradication so there is a fine balance to be maintained – i.e. being recognized for work accomplished but not upstaging.

Future Implications/Recommendations (Partnerships):

- In TAG and international meetings, provide an opportunity for the CGPP to formally present their findings as part of the Government/UN presentations and/or formal processes.
- Provide an opportunity for CGPP partners to attend and participate in GPEI partner-sponsored training workshops, e.g. UNICEF C4D training and to have access to WHO/UN tools and materials, and vice-versa.
- Where possible, provide opportunities for NGO partners to join CGPP Secretariat staff at EOC and national fora. This would provide exposure and further capacity-building experiences.

- 4 Although the CGPP has maintained consistent evaluations over the years, the need for better documentation for which the researchers are also in agreement. Building on the current evaluations, the potential exists to collect data on behavioral determinants that could explain community responses. This information would complement the process evaluation results and provide a fuller picture of what is happening and why specifically.

Given that the different CGPP operations have developed numerous tools and materials, they have untapped resources that could be shared more widely to improve community-based practice more widely, i.e. social and behavior change communication materials developed by CGPP-India or community-based surveillance protocols developed by CGPP-HOA. The Angola experience in independent monitoring has already set a global standard which is being applied in current polio eradication programming efforts. However, there is the potential for more application in other development/public health contexts. As such, given the CGPP Secretariat’s current workload in-country, expanded documentation (i.e. rapid assessments on threats/obstacles to behavior change and results of behavior monitoring) would require additional resources that perhaps could be supported by the global CGPP Secretariat.

Future Implications/Recommendations (Documentation):

- Ensure that CGPP reporting tracks and links behavioral data findings to the community surveillance results and the effect of community mobilization and communication activities. Given that CGPP

already tracks standard indicators for immunization and behavior change on a quarterly and annual basis; future evaluations could explore more closely the interdependence of results (i.e. cross-tabulations of results) as a means of documenting cause-effect interactions.

- Expand documentation of CGPP experiences and processes (i.e. training, mobilizer motivation, materials development etc.) as well as related lessons learned and good practices to facilitate information/knowledge transfer and influence the profession. This should involve:
 - Presentations at national conferences sponsored by the American Public Health Association and Society of Public Health Education, plus international conferences such as Social and Behavior Change Communication (SBCC) Summit and the World Conference of the International Union of Health Promotion and Education as well as global UN fora and think tanks
 - Continued dissemination in the grey literature and/or publication in professional peer-reviewed journals both within public health and the wider field of social and behavior change. At a global level, to date over 25 international journal articles and supplements in both the American Journal of Tropical Medicine and Hygiene (AJTMH) and Ethiopian Medical Journal have already been published on the work of the CGPP. A sample of the range of peer-reviewed articles is listed below; but there is more to be told:

Bisrat F, 2019. "Endeavors to improve immunization uptake in Ethiopia," The Ethiopian Journal of Health Development, 33 (Special Issue).

Haydarov et al., 2016. "Evidence-Based Engagement of the Somali Pastoralists of the Horn of Africa in Polio Immunization: Overview of Tracking, Cross Border, Operations, and Communication Strategies," Global Health Promotion (online), July 2016.

Coates EA, Waisbord S, Awale J, Solomon R, Dey R, 2013. "Successful polio eradication in Uttar Pradesh, India: the pivotal contribution of the Social Mobilization Network, an NGO/UNICEF collaboration". Global Health Science Practice 1: 68-83.

Weiss, et. Al., 2011. "Outcomes of polio eradication activities in Uttar Pradesh, India: The Social Mobilization Network (SM Net) and CORE Group Polio Project (CGPP)," BMC Infectious Diseases – Open Access- 2011.

Potential Lessons learned to be documented should also include, but are not limited to:

- exit strategies can be obtained from Nepal, Bangladesh, Angola and India

Example: A key element in the decision to close the Nepal project was the fact that all community-based polio eradication efforts supported by the CGPP are actually implemented by Nepal MOH Female Community Health Volunteers (FCHVs) who have been trained in polio eradication concepts and interventions by CGPP staff. All of the training curricula and materials have been transferred to the MOH, which manages all other aspects of the FCHVs' training. It was anticipated that the MOH will maintain and expand the CGPP training that promoted participation in immunization and AFP surveillance.

- entry processes and opportunities into Afghanistan that can provide new insights about community-based work, using an adapted Secretariat model; and
- absorption of social mobilization networks into government and/or other systems as experienced in Ethiopia and India, with an emphasis on highlighting the pros and cons of such efforts, what is required for successful fusion.

Annex – Interview Guide for In-depth Interviews

1. What are the major contributions of the program to polio eradication over the last 18 years? Over the last grant cycle?
 - a. What are the defining contributions in each country program?
 - b. How have these contributions contributed to GPEI objectives and eradication efforts?
2. What have been the main contributions of the Secretariat Model?
 - a. How would you describe the model? How is it different than just coordinating different NGOs? How are the numerous NGOS managed and coordinated?
 - b. How have the components of this model provided a foundation for the success of CGPP?
 - c. What would be the value for applying this model to other programs in other countries? How could this be done?
3. How has CGPP programming lead to behavioral change in focal communities?
 - a. What types of behavior change (K,A,S,P) has CGPP contributed to?
 - b. What behavior changes (K,A,S,P) have been sustained over time?
 - c. What social and behavior change strategies have been effective in bringing about the change and why?
 - d. What have been the major obstacles in facilitating the change?
 - e. How can the project target these and others to ensure they are changed and sustained going forward?
 - f. What behavior change indicators should be added to the program? What changes in behavior should programming target over the life of the program?
4. What are the main “deliverables” from the investment in the Project over the years?
5. How has USAID’s investment in CGPP contributed to polio eradication?
 - a. What would the extra costs/years to GPEI have been in CGPP was not participating?
 - b. What interventions have had the most “bang for the buck”?
 - c. Where have investments made the most long-term impacts?
6. What should the project be doing now to lay the groundwork for success over the next 4.5 years, and for successful transition?
 - a. What components of the program should be transitioned? How?
 - b. What are the suggestions for other programs that could benefit from the knowledge, resources, and strategies of the CGPP?
 - c. How could the lessons and infrastructure of the project be applied to another area of public health and development? What topical areas would make sense?

7. Has the program made large strides in meeting key program objectives and indicators based on the log-frame?
8. What have been the strengths/advantages and weaknesses/disadvantages working with CGPP in the polio eradication effort?
9. In your opinion, what would not have been achieved if they hadn't been involved/ what has been their added value?
10. What specific lessons should be transferred from the CGPP experience to other public health initiatives and/or emergencies?
11. How effective has been coordination with the CGPP as a partner?
12. Given that CGPP works in areas where they may be the only partner present, what additional support in partner coordination is needed?

