

CORE GROUP POLIO PROJECT

Annual Report FY19

OCTOBER 1, 2018 TO SEPTEMBER 30, 2019



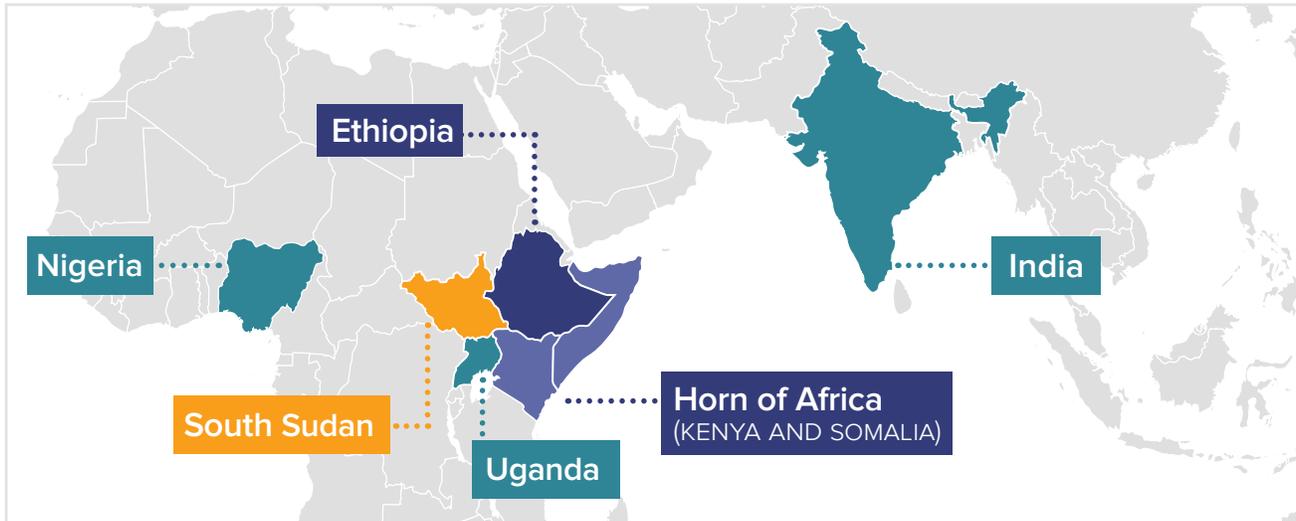
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Executive Summary



Despite the declaration of the eradication of Type 3 Wild Polio Virus, it is somewhat difficult to feel overly optimistic about global polio eradication in 2019. Cases of wild polio virus increased significantly in Pakistan and a ban by the Taliban on WHO and door-to-door campaigns continue to impede progress in Afghanistan. Additionally, numerous outbreaks of circulating vaccine-derived polio virus have spread throughout Africa and parts of Asia. The global situation looks bleak and in need of new solutions and increased vigilance. This is a critical moment.

Notwithstanding these global setbacks, the CGPP in FY2019 made some very notable contributions to polio eradication and diseases surveillance in India, Ethiopia, South Sudan, Nigeria, Kenya, Somalia and Uganda. As the culmination of nearly three years of writing, working and planning, the Project published 14 articles in a journal supplement in *The American Journal of Tropical Medicine and Hygiene* entitled “Impact, Innovation, and Inclusion of Civil Society Organizations in Polio Eradication: The CORE Group Polio Project Story.” The journal project was led by our Technical Advisors for Communication and Monitoring and Evaluation with external senior support from Professor Henry B. Perry of Johns Hopkins University with many of our country staff contributing articles as first-time authors. It is a fine product and a strong example of documentation as a part of the transition process.

Additionally, in Ethiopia, Kenya and South Sudan, we expanded the Project’s focus to include community-based surveillance for a broader range of diseases with new funding from Global Health Security Agenda (GHSA) and Ebola Preparedness at USAID. With support and oversight provided by a new Senior Advisor for GHSA and GHSA advisors at the Secretariat level in Ethiopia and Kenya, the GHSA portion has made impressive strides in training community mobilizers and informants to identify and notify signals and signs of zoonotic diseases such as animal die offs using the same platform and project supervision structure established over the years for polio eradication and Acute Flaccid Paralysis surveillance.



The Project conducted two workshops in Kenya in 2019 to build the capacity of senior and midlevel CGPP staff in communications, the Care Group Model, writing, budgeting and monitoring and evaluation. These workshops were also an opportunity to share best practices among CGPP staff from different countries and build greater Project cohesion.

At the country level, the Project continued to provide important social mobilization support to supplemental immunization activities (SIAs) ensuring high levels of campaign coverage. Throughout the seven implementation countries, the CGPP provided technical guidance and support to strengthen immunization systems resulting in improved population immunity for polio. Community mobilizers, volunteers and key informants continued to identify and report about four of ten of all AFP cases in Project areas.

The Project's 19,000-plus frontline workers reached 2.1 million households with key health education messages on immunization and AFP surveillance. Frontline workers and Project staff supported the vaccination of 4,037,044 children during supplemental immunization campaigns. The CGPP continued its tradition of capacity building by training 13,611 frontline and health workers to strengthen the health systems that provide routine immunization, supplemental immunization activities, and community-based surveillance.

At the regional and global level, the Project continued to engage with polio eradication leaders to ensure that the civil society and community perspectives championed by this Project have a voice in global, regional and national policy making.

The road to polio eradication has been longer and harder than we expected at the outset and it is presently difficult to see the end of the journey. In this context, the CORE Group Polio Project draws upon years of experience, knowledge and skill to keep pressing on to achieve the task we started twenty years ago.



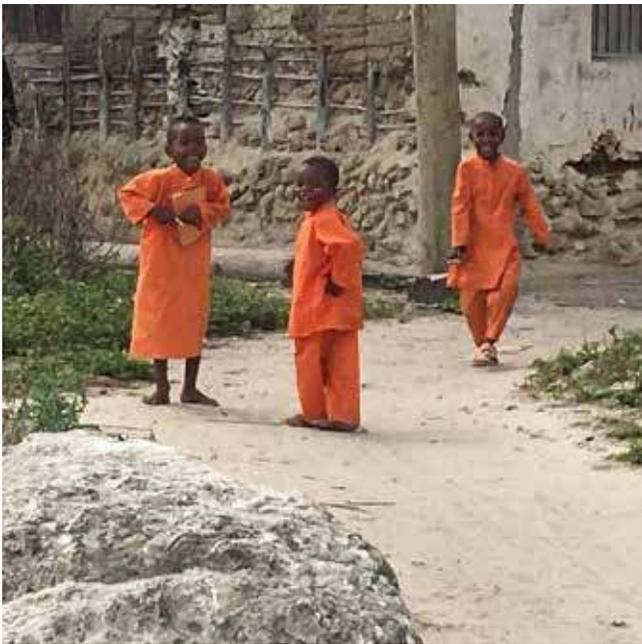
Lee Losey

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CORE Group Polio Project*



Acknowledgments

This report was developed with the contributions of many people, starting with the submission of annual reports from 9 international NGOs and 20 national and local NGOs in seven countries. The Secretariats consolidated these partner NGO reports into country reports. The final global CGPP report was written by Lydia Bologna, the CGPP Communications Technical Advisor, and Kathy Stamidis, the CGPP M&E Technical Advisor. Lee Losey, the CGPP Deputy Director and Technical Lead, supplied overall guidance. Since 2017, Graphic Designer Gwendolyn Stinger has provided the design and format of the annual report.



School boys walk to class in Lamu, Kenya.

Objectives



In Kenya's Wajir South, CGPP volunteers wade through flooded fields to deliver vaccines.

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



COUNTRY REPORT:

India

In 1999, India's efforts to end polio seemed impossible, constrained by widespread mistrust of the oral polio vaccine (OPV), a history of poor campaign monitoring and pockets of low immunization coverage. To break through these barriers, CGPP India engaged all levels of government, other development partners, and, most importantly, the chronically neglected populations who were most affected by the disease. CGPP India developed multipronged strategies to empower communities through the SMNet's Community Mobilization Coordinators (CMCs), who met personally with families resistant to immunization and caretakers of under-immunized children. Using multiple strategies, particularly user-friendly reporting and monitoring systems and well-tested behavior change communication approaches, community mobilizers successfully reduced resistance and convinced families of the vaccine's safety and effectiveness. These efforts contributed to the 2014 declaration of a polio-free India.



A mobilizer refers to a community map before leaving for house visits in Moradabad.

In FY19, more than 900 community mobilizers contributed to maintaining the country's high OPV3 coverage and population immunity. They conducted individual and group outreach to mobilize communities to participate in polio SIAs, and vaccinate their children. They took part in the timely tracking of newborns, pregnant women and children under five. They met with mothers, fathers, adolescents, government field workers and religious leaders. They held polio rallies, children's fun classes on immunization and hand washing, barber meetings, and healthy baby shows to reach static and mobile populations in high-risk areas.

CGPP India works through 10 partners – three international and seven local NGOs – in 12 districts in Uttar Pradesh (UP), Nuh district in Haryana, and two districts in Assam. CORE Group India supports community mobilization for polio and other vaccine-preventable diseases and addresses related issues of hygiene and nutrition. The CGPP reached nearly 400,000 families and vaccinated more than 300,000 children during four supplementary campaigns. This is especially critical given the risk of the country's geography: WPV cases in adjoining Pakistan skyrocketed by nearly 800% at the end of 2019.

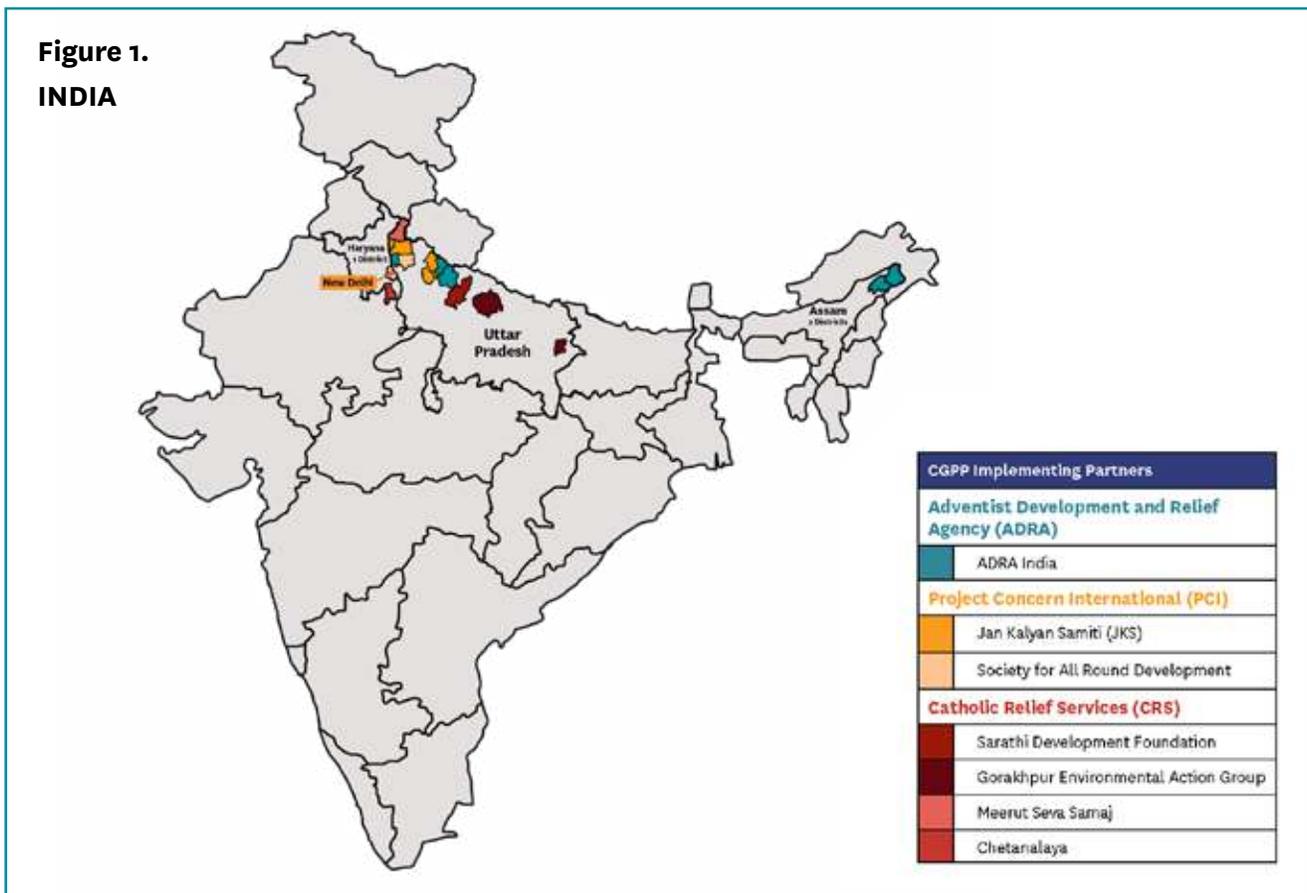


1 Build effective partnerships with PVOs, NGO(s), and international, national and regional agencies involved in polio eradication

During FY19, CGPP India partnered with three international NGOs: Adventist Development and Relief Agency (ADRA), Catholic Relief Services (CRS) and Project Concern International (PCI) and seven local NGOs - ADRA India, Chetanalaya, Gorakhpur Environmental Action Group, Jan Kalyan Samiti, Meerut Seva Samaj, Sarathi Development Foundation and Society for All Round Development (Figure 1). PCI selected local NGO People’s Action for National Integration (PANI) for project implementation in Moradabad, which began activities on June 1, 2019.

Partners met to review project interventions, progress, and challenges in data validation, involvement of barbers, timely immunization, Accredited Social Health Activist (ASHA) training, the withdrawal of CMCs and Sakhis (known as friends of CMCs), urban immunization and new initiatives in Assam and Mewat.

CGPP India organized and facilitated numerous meetings with government health officials and other leading partners. Likewise, implementing partners took part in divisional, district and sub-district level meetings





conducted by government and development partners. Notable take-aways from these meetings were:

- At the request of the state immunization officer and CGPP India, CRS agreed to hold mobilization activities in an area of the UP that had not been previously served by community mobilizers. The Haryana government, afterward, recognized the high-quality work and invited the CGPP to establish a two-tier SMNet throughout Nuh district to work toward improving the low immunization coverage.
- ADRA noted that most blocks have observed considerable improvement in timely vaccination; other blocks have achieved coverage above 65% based on improved RI micro-planning and message dissemination.
- CGPP India is part of a research team funded by the Sabin Vaccine Institute to assess the level of vaccine hesitancy in Nuh district where immunization coverage is known to be far below the national average. Levels of hesitancy will be assessed in association with perceptions about vaccines among health workers. The findings will subsequently inform the development of tailored interventions aimed at improving vaccine confidence and knowledge of government health workers.

Additionally, CGPP India hosted senior-level managers from USAID in Nuh in December 2018 to observe operation of the Khushi Express, an information van to promote immunization and sanitation in rural villages. CGPP India Secretariat Director Dr. Roma Solomon participated in the India Expert Advisory Group on Polio Measles and Rubella (IEAG-MR), presented a business transition plan to the CORE Group Board of Directors, and served as a panelist at the CORE Group’s spring conference, addressing “The Role of Gender and Religion in Social Behavior Communication in Muslim Societies.” The conference also featured the book launch of *“Influencing Change: A Documentation of CORE Group’s Engagement in India’s Polio Eradication Programme.”*



CGPP India Secretariat Director Roma Solomon, left, and Lisa Hilmi, executive director of CORE Group, officially launch “Influencing Change.”



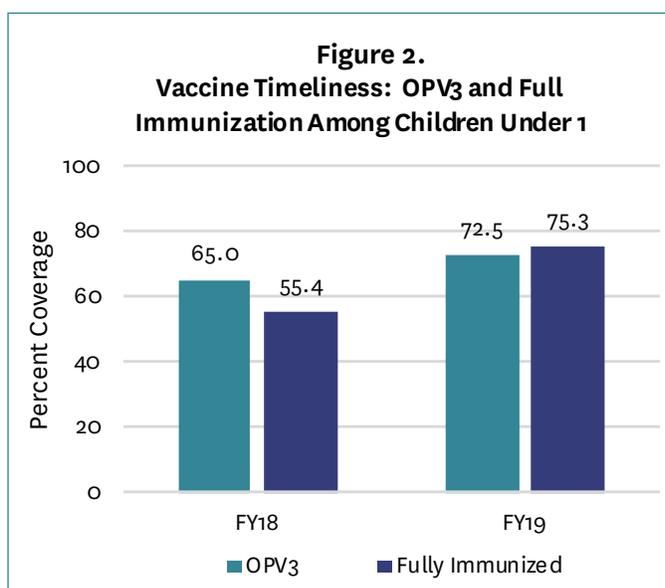
2 Support PVO/NGO efforts to strengthen national and regional immunization systems to achieve polio eradication

In consonance with government population health priorities, CGPP India focuses on the primary goal of maintaining high population immunity against polio and other vaccine-preventable diseases. In this context, CGPP India contributed to national, state, district and sub-district level meetings, including the Immunization Action Group (IAG) and task force meetings of state, district and block levels. Furthermore:

- Block Mobilization Coordinators and District Mobilization Coordinators (BMCs and DMCs) assisted government medical officers by providing current data on mobile High-Risk Groups (HRGs) for developing accurate microplans. Nomads, slum dwellers, and hard-to-reach areas are part of this target group encompassing 373 sites located in 15 blocks. As a result, there was a notable increase in the number of activities carried out by CMCs, convening 343 group meetings and 4,874 one-on-one contacts in FY19, compared to 290 group meetings and 3,391 one-on-one contacts the previous year.
- In all, CGPP-trained BMCs and DMCs monitored 6,948 RI sessions.
- CGPP partners supported the government's launch of the measles-rubella (MR) vaccine and pneumococcal conjugate vaccine and participated in the Intensified Mission Indradhanush.

In FY19, 911 community mobilizers reached 399,328 families, including 301,428 children under five. CMCs facilitated 27,594 meetings (including meetings with parents, Village Health Sanitation and Nutrition Committees, and barbers) and held 250,385 one-on-one interactions with mothers and fathers of target children, influencers, and religious leaders.

Ensuring timely vaccination is of paramount importance. CMCs work tirelessly persuading caregivers to follow the prescribed schedules for OPV and other routine immunizations. These efforts have yielded several significant successes in the reporting period, with a large upswing in the timeliness of OPV3, OPVo, and fully immunized children (3.5 to 11 months). The timeliness of OPV3 increased in children 3.5 to 11 months to 72.5% from 65.0% in FY18 (Figure 2). The percentage of fully immunized children in the same age category shot up to 75.3% from

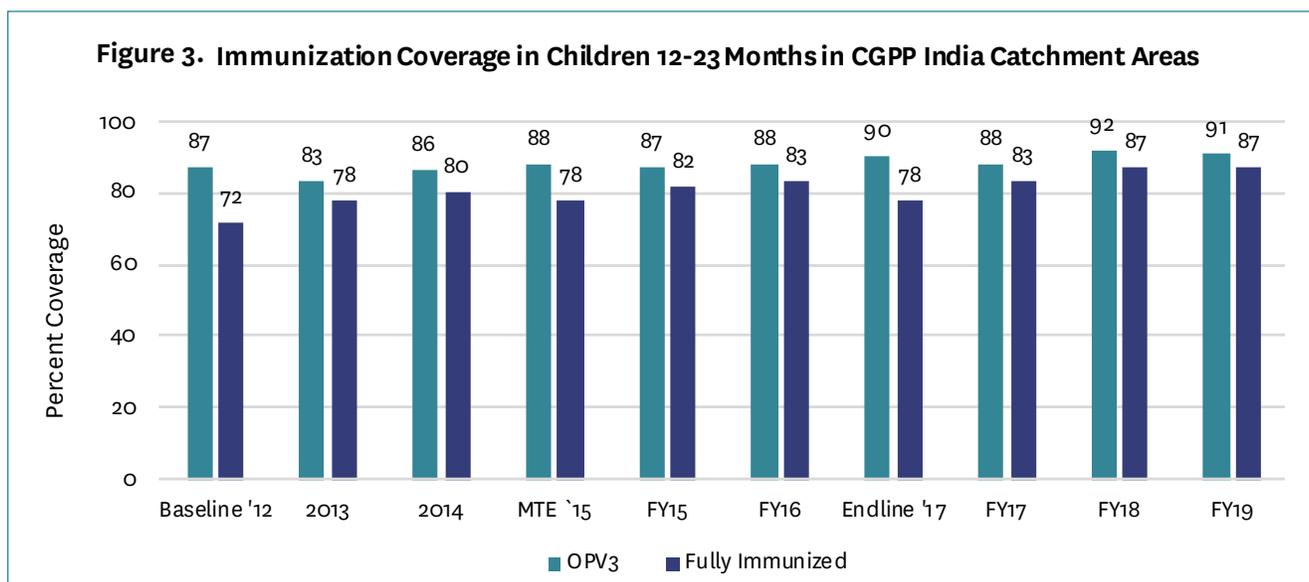




A Block Mobilization Coordinator addresses a family living in a brick kiln area.

55.4% in FY18. On average, 84.5% of children under one year received polio birth dose in FY19. No notable differences were detected between timeliness or coverage between boys and girls under one year.

Routine immunization rates remain high in CGPP project implementation areas, with the coverage of OPV3 and full immunization remaining above 90% in children 12-23 months. OPV3 coverage among children in this age category dipped to 90.8% in FY19 from 91.5% in FY18 (Figure 3). The coverage was slightly lower





A CMC conducts a data validation exercise.

among males than females - 89.9% compared with 91.7%, respectively. The coverage in project areas remains dramatically higher than the most recent overall state level coverage of 72.8% in UP (NFHS-4). The percentage of children 12-23 months who were fully immunized also remained high at 87.4%

The percentage of zero dose (never vaccinated children) remains at 0% in CGPP implementation areas (according to a 2018 CMC register analysis). The percentage of children 12-23 months with 8+ doses of OPV in CGPP catchment areas tipped the 80% target rate, moving slightly to 80.9% in FY19. There were slight differences in the percentage of immunized children by gender: 81.6% of girls were immunized compared with 80.3% of boys.

Training

Along with the implementing partners, CGPP India conducted four separate trainings, reaching 1,087 people. A training of master trainers was conducted with 47 selected DMCs and BMCs in July 2019. Implementing partners conducted a training for CMCs on polio and new vaccines under routine immunization, communication strategies, and the use of data in decision making. A total of 936 CMCs was trained during these sessions. Additionally, the CGPP held a three-day residential training for CGPP interventions and activities in June and July 2019; a total of 104 sub-regional coordinators, DMCs, MIS Coordinators, and BMCs attended the training. In addition, CGPP India supported the training of 2,276 ASHAs and ASHA supervisors through a session held for government frontline workers from the National Health Mission.



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

Four polio supplementary immunization activities (SIAs) were conducted in the catchment districts, averaging 99.5% campaign target coverage. National Immunization Days (NIDs) were held in March and April 2019. Sub-national immunization days (SNIDs) were held in June and September 2019.

On average, 86.0% of children under five years from CMC areas received OPV through 1,149 polio booths (fixed site vaccination sites) during each SIA. Booth coverage in CMC areas was 89.5%, nearly twice the 46.0% rate reported by non-CMC areas in CGPP implementation districts.

A total of 300,151 under-five children were vaccinated in CGPP implementation areas in FY19. On average, 7.5% of children were missed from CMC areas during each SIA; the September 2019 SIA reported the lowest (6.1%) proportion of missed children.

The downward trend in the percentage of missed houses continued in FY19. On average, house-to-house vaccination teams in the CMC areas visited about 400,329 households during each SIA, with an average of 4.0% of houses missed (Table 1). The percentage of missed houses has dropped steadily from 5.8% in FY08. It also remains lower in CMC areas compared to non-CMC areas (4.7% missed).

Zero percent of children have never been vaccinated, and 80.9% of children have received at least 8 doses of OPV.

Of the 911 community mobilizers, 837 worked with HRG populations. Community mobilization among HRGs lead to notable increases in numbers of vaccinated children in FY19. Approximately 7,000 more vaccinations were delivered to high-risk groups in FY19 compared with results from FY18 (Table 2).

Table 1. Average Percentage of Missed Houses During Polio Campaigns in FY19 in CGPP Implementation Areas

Year	CMC Area	Non-CMC Area
FY08	5.6	5.7
FY09	5.8	5.9
FY10	6.1	6.1
FY11	5.9	6
FY12	5.9	6.3
FY13	5.4	5.7
FY14	5.2	5.7
FY15	5.1	5.8
FY16	4.9	5.4
FY17	4.4	4.7
FY18	4.2	4.8
FY19	4.0	4.7

Table 2. Number of children vaccinated from CGPP high-risk groups (HRGs) in Uttar Pradesh in 2019

Vaccination	Number of Children Vaccinated	
	FY18	FY19
SIA vaccination	11,074	15,474
OPV0	71	94
OPV1	3,750	4,240
fIPV1	1,838	2017
OPV2	3,351	3,848
OPV3	3,057	3,465
fIPV2	1,592	1,515
OPV Booster	4,474	5,348
TOTAL	29,207	36,001



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

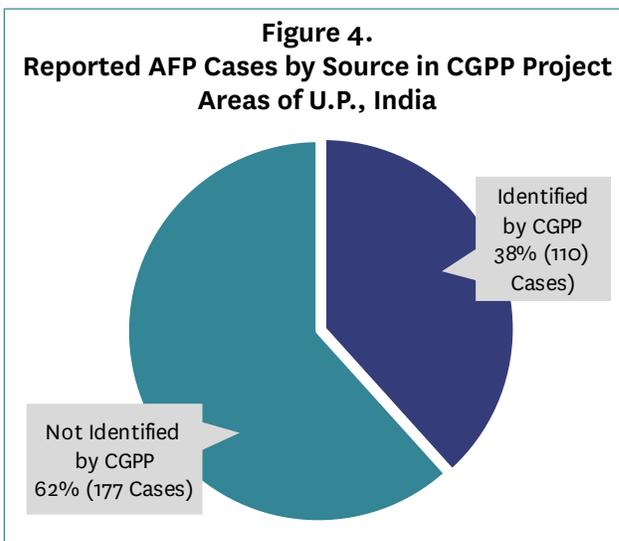
According to AFP surveillance indicators reported in week No. 45 of 2019, the aggregated Non-Polio AFP rate (NPAFPR) for the entire state of Uttar Pradesh was 13.2 per 100,000 children under 15 years. On average, the districts covered by CGPP in India reported the NPAFPR of 14.3, up from 13.9 in FY18. Among the 12 CGPP districts, Mau reported the lowest rate at 6.2; Sambhal reported the highest rate at 21.3.

CGPP CMCs are trained and sensitized to look for AFP cases in their respective areas and ensure timely reporting to the nearest health facility. There was a total of 287 non polio AFP cases reported in CGPP implementation areas. Of these, 110 (38.3%) were reported by CGPP including CMCs/BMCs (Figure 4). A total of 26 AFP cases among HRGs (including mobile and nomadic populations) were identified from the CGPP India catchment areas.

According to AFP surveillance indicators reported in week No. 45 of 2019, the statewide aggregated adequate stool collection rate (2 stool specimens collected within 14 days of onset of AFP) for UP was 87%. All of the CGPP India districts maintained over 75% adequacy rate with an average 85.9% stool adequacy. Among the 12 districts of CGPP India, the highest rate was reported from Mau district (93%) and lowest from Shamli district (78%). There are no silent areas in the CGPP districts. The CGPP participated in 36 meetings and reviews of AFP surveillance to support the country’s surveillance system.



A Khushi Express disseminates immunization messages in Assam’s tea gardens.





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

CGPP documented several interventions through publication in FY19. Jointly with The Communication Initiative, CGPP India published “Influencing Change” which details the development and delivery of key communication interventions. The India team published three articles in the American Journal of Tropical Medicine and Hygiene: *Involvement of Civil Society in India’s Polio Eradication Program: Lessons Learned; Effective Partnership Mechanisms: A Legacy of the Polio Eradication Initiative in India and Their Potential for Addressing Other Public Health Priorities*; and, *Effectiveness of a Census-Based Management Information System for Guiding Polio Eradication and Routine Immunization Activities: Evidence from the CORE Group Polio Project in Uttar Pradesh, India*. Additionally, Deputy Director Jitendra Awale presented a paper at the APHA in November 2018 entitled “Addressing inequity by reaching marginalised groups to improve immunization coverage - Lessons from India Polio Eradication Program for health system strengthening and universal coverage.” BCC Advisor Rina Dey conducted a special BCC training for the CGPP Kenya and Somalia Secretariat and implementing partners in Nairobi. Ms. Dey also took part in a panel discussion on “Restoring Trust in Vaccines” hosted by the Center for Strategic and International Studies (CSIS).

Community members, ASHAs and ANMs dance together in the tea gardens of Assam after a group meeting.



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

Dr. Solomon attended the WHO meeting for Supporting Polio Transition in Countries and Globally: A Shared Responsibility in Montreux, Switzerland in November 2018.

Transition and Legacy CGPP India’s legacy plan continues to focus on building the capacities of ASHAs to sustain mobilization for immunization.

COUNTRY REPORT:

Ethiopia



During the reporting year, three cases of circulating vaccine-derived polio virus type 2 (cVDPV2) were detected in the Somali Region of Ethiopia where polio immunization coverage is low and the risk of continued transmission is high. All of the cases were reported from the Bokh district in Dollo Zone, a pastoralist community consisting of families who move across borders for short periods in search of water and grazing land for their cattle.

The cVDPV2 cases were linked to the outbreak in adjoining Somalia. CGPP Ethiopia launched an outbreak response by sharpening its community-based surveillance and social mobilization approaches. The Organization for Welfare Development in Action (OWDA), a local NGO that works in the Somali Region, and the CGPP Ethiopia Secretariat recruited a new group of Community Volunteers (CVs) to push immunization promotion and disease detection activities. Current CVs were re-trained to reinforce previous skills and knowledge. The Ethiopia team additionally provided both technical and logistical support during the mOPV2 campaigns, pairing with polio partners to implement well-coordinated campaigns. To ensure that no child along or across the borders was missed, CGPP Ethiopia mapped major crossing points and established transit point vaccination sites.



Community Volunteers respond to the cVDPV outbreak in the Somali Region.

Since 2001, CGPP Ethiopia has been supporting polio eradication initiatives in hard-to-reach pastoralist and semi-pastoralist border areas. The team works in insecure, high-risk areas affected by unrest. In FY2019, CGPP Ethiopia employed the use of 11,547 trained CVs and Health Development Army Leaders (HDALs), reaching 5.4 million persons with routine and supplementary immunization campaigns, community-based disease surveillance and house-to-house health education activities to track and register pregnant mothers, newborns



and defaulter children. Their work contributed to a rebound from last year's drop in immunization coverage to now match the rates from 2017. CVs also identified the highest number of newborns for immunization since 2016 and, in 2019 alone, reported 58% of AFP cases and 83% of measles cases in CGPP areas. The last case of Wild Polio Virus (WPV) was reported six years ago. The Africa Regional Certification Commission (ARCC), an independent body of polio experts, declared Ethiopia a polio-free country in June 2017.

In 2019, CGPP Ethiopia assumed a broader mandate through the Global Health Security Agenda (GHTSA) and retrained its workforce to include disease threats beyond polio and those critical to local, national, and global health security.

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

CORE Group Ethiopia contributed to polio eradication and routine immunization efforts in 85 border districts, or woredas, across the border regions of Gambella (13 woredas), SNNP (13 woredas), Oromia (11 woredas), Somali (28 woredas) and Benshangul-Gumuz (20 woredas). The CGPP CVs and HDALs reached 2,859,346 people in 901,018 households.

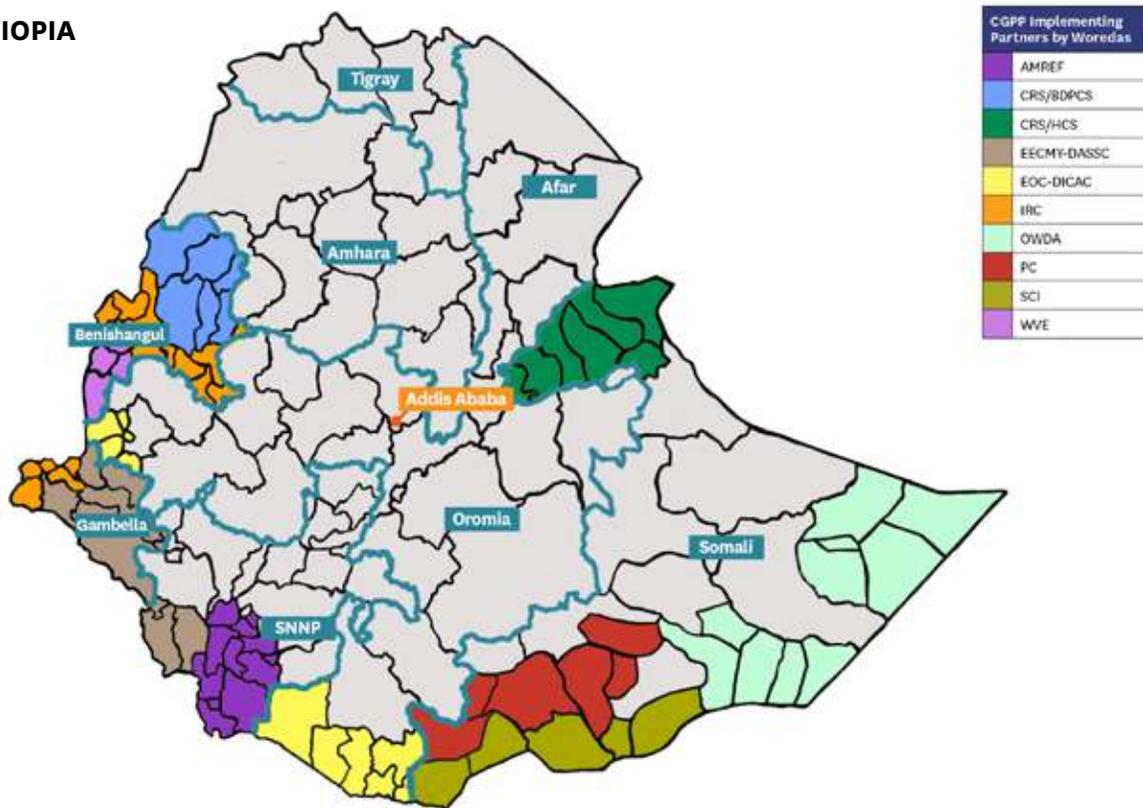
The Consortium of Christian Relief and Development Associations (CCRDA) hosts the Ethiopian Secretariat. CGPP Ethiopia provided sub-grants through CCRDA to five international organizations: Amref Health Africa, Catholic Relief Services, International Rescue Committee, Save the Children International and World Vision and four local NGOs: Ethiopian Evangelical Church Mekane Yesus, Ethiopian Orthodox Church, Pastoralist Concern (PC), and the Organization for Welfare Development in Action (OWDA) (Figure 1).

As CGPP Ethiopia is an instrumental actor in immunization and surveillance programs, the Secretariat contributes to various working groups at the national and regional levels. In FY19, CORE Group Ethiopia was involved in meetings held by the Inter-Agency Coordination Committee (ICC), EPI Task Force (EPI-TF), One Health Steering Committee (OHSC), National Emergency Operation Center (EOC), M&E Technical Working Group (M&E TWG), Communication Technical Working Group (CTWG), WHO quarterly EPI and Surveillance reviews, as well as numerous MoH and regional forums.

The CGPP Secretariat held its regular mid-year and annual review and planning meetings. Varied agenda items were discussed, such as assessments of partner progress, programmatic goals, and budgets. The mid-year meeting reviewed global status of eradication and discussed the Integrated Supportive Supervision checklist and explained the Care Group Model of behavior change. The annual meeting focused on progress reports and the development of FY2020 activities and budgets with government officials from regional health bureaus, and zonal and woreda health offices.



Figure 1.
ETHIOPIA



Global Health Security Agenda (GHSA)

Between April and September 2019, CGPP-GHSA teams trained and re-oriented polio partners to prepare for an expanded scope: from vaccine-preventable diseases to One Health. Partners were asked to include priority zoonotic diseases (rabies, brucellosis, and anthrax), as well as unusual health events into their community-based surveillance, outreach and education, and preparedness activities.

Specific actions included:

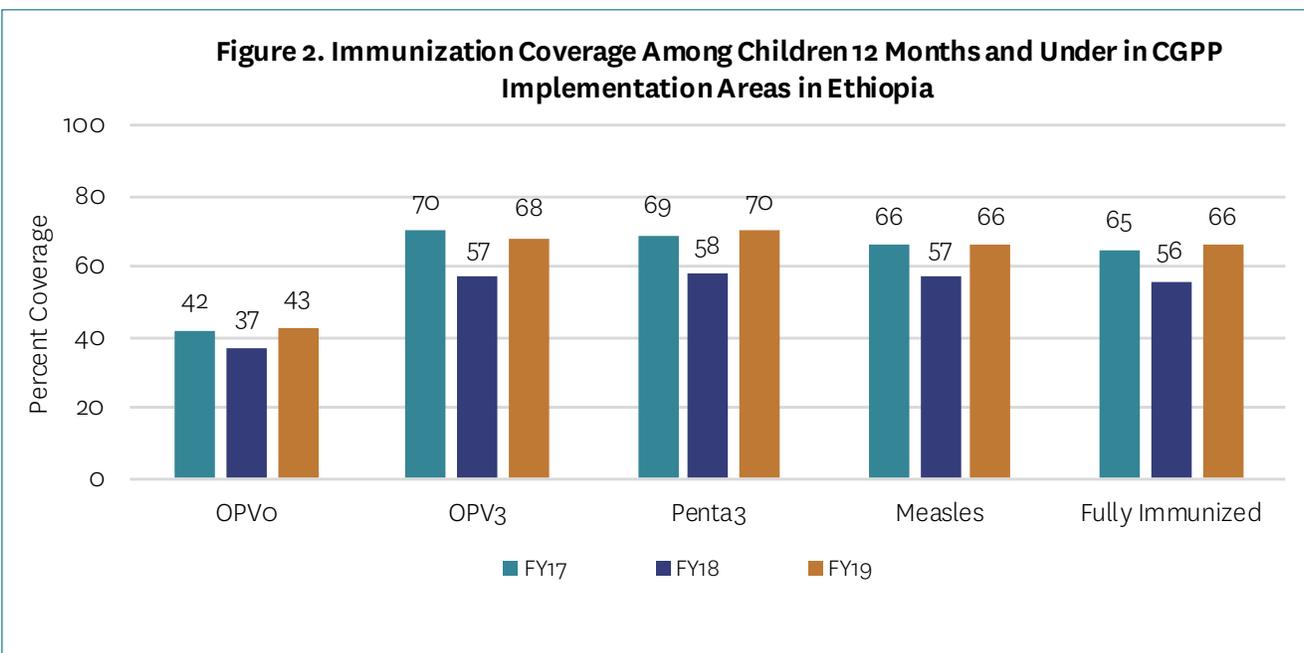
- CGPP-GHSA revitalized the Woreda-level EPI taskforce to convert to a One Health Committee and included zoonotic diseases, ensuring local-level ownership and sustainability of the program.
- Training materials and reporting tools were overhauled to include priority zoonotic diseases and unusual health events. This significant undertaking required translation and verification in multiple languages.



- A total of 168 participants were enrolled in the Training-of-trainers on One Health CBS of all 85 border districts. Participants included human and animal health professionals from government as well as partners' staff. These trainers will go on to train community-level volunteers, Health Extension Workers (HEWs), and animal health assistants by January 2020.
- The Secretariat joined the National One Health Steering Committee and participated on the Risk Communication Subcommittee so that the experiences and insight gained from partner implementation can be translated back to the national level and used to strengthen health security planning and programming.

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

Following a decline in routine immunization coverage in FY18, the CGPP strengthened its efforts to promote timely and complete immunization, track defaulters, and provide comprehensive immunization and child health information to parents. CGPP Ethiopia expanded its reach to cover 4,491,163 families. In FY19, the CGPP Ethiopia utilized 11,547 CVs/HDALs to reach 901,018 households - 2,859,346 people through house-to-house health education visits. Volunteers covered a total of 597,142 children under five years, 74% of the targeted project implementation area.

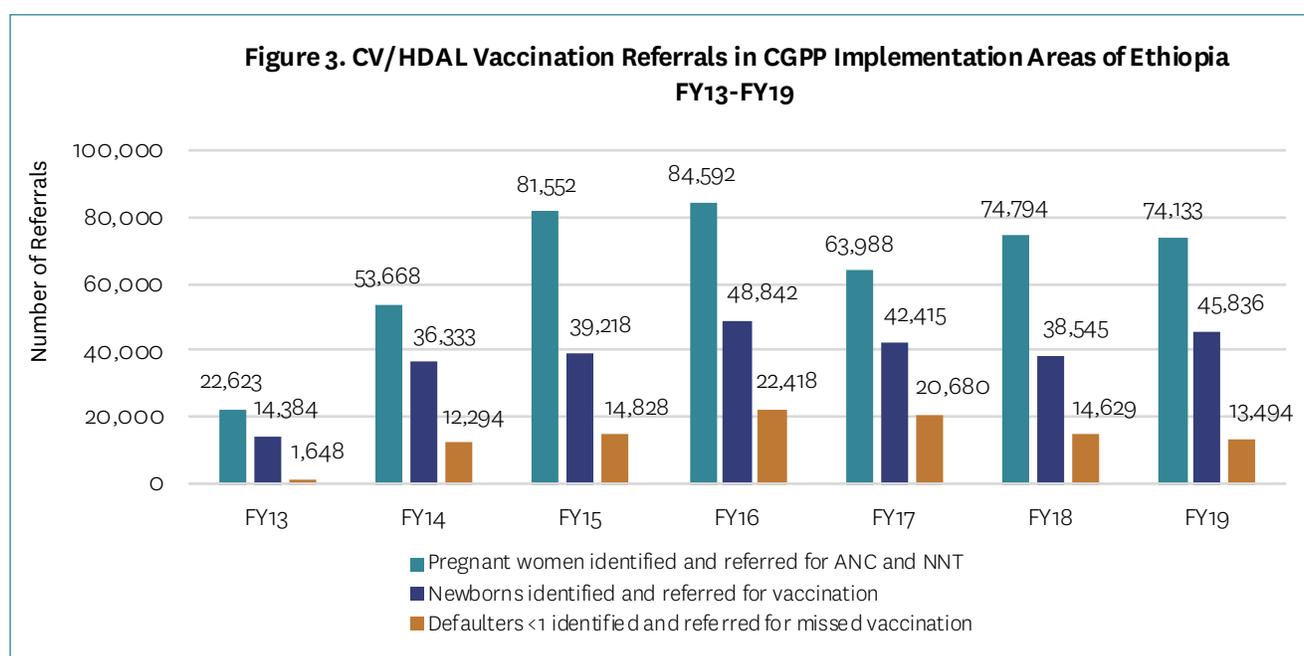




These strong social mobilization and health education efforts yielded positive results. Ethiopia recorded notable coverage gains across all antigens in CGPP project areas (Figure 2). Coverage in children under one year for OPV0, OPV3, Penta3, measles, and the percentage of fully vaccinated children increased in FY19. OPV0 and OPV3 coverage in children climbed from 37% to 43%, and from 57% to 68%, respectively. The FY19 rates closely mirrored the FY17 rates. (Political instability, sporadic unrest, and service interruption in project areas contributed to weaker results in FY18.) OPV0 coverage remained low, however, due to the high percentage of home births. The percentage of fully immunized children climbed significantly to 66% in FY19, from 56% in FY18.

Over the last ten years, the predominately female (88.5%) cadre of CVs, HDALs, and HEWs have strengthened the routine immunization system through regular house-to-house health education sessions and social mobilization activities during routine and supplementary immunization campaigns. During these visits, they refer pregnant women, newborns, and defaulters for vaccinations and other healthcare services. In FY19, CVs/ HDALs tracked and referred 74,133 pregnant women for immunization services and prenatal care, and 45,836 newborns and 13,494 defaulters for immunization. Since FY13, CVs/HDALs have referred 820,914 pregnant women, newborns, and defaulters under one for vaccination (Figure 3).

The CGPP also provided material and technical support to ensure a properly functioning cold chain and social mobilization for vaccination uptake. The CGPP Ethiopia distributed 88,143 liters of fuel for refrigerators and motorcycles, and maintained 86 refrigerators and 21 motorbikes.





CGPP Implementing Partner IRC supports an SIA in Gambella.

Cross-Border Collaboration

CGPP Ethiopia expanded activities to strengthen AFP detection and reporting, cross-border information exchange, and synchronization of supplemental immunization activities. During the fiscal year, a total of 11 cross-border committees, one per district, convened on a regular basis. CGPP staff attended nine cross-border health committee meetings during FY19. Representatives from eleven woredas in the Somali and Gambella regions (Gambella and Gode towns) participated in two CGPP-organized cross-border meetings. During the reporting period, 112 cross-border points were mapped using ODK. The mapped transit points in Aysha and Assosa woredas resulted in the administration of 1,222 doses of routine immunization antigens in FY19 (Table 1).

Table 1. FY19 Transit Point Routine Immunization

Antigen	Transit Point Vaccination	
	Aysha	Assosa
OPVo	101	52
OPV3	150	156
Penta1	71	214
Penta3	150	154
Measles	89	85
Total	561	661

Training

The CGPP Secretariat and implementing partners organized 163 training sessions for 2,945 participants (1,530 females and 1,415 males) during the reporting period to improve routine and supplemental immunization and strengthen the surveillance system. The CGPP and partners trained 759 HEWs and 394 Health Workers (HWs) on community-based surveillance and newborn tracking (NBT), immunization in practice (IIP), Interpersonal Communication (IPC), and cold chain management. Additionally, the



Secretariat and its partners organized CBS and NBT training for 1,646 CVs/HDALs, and trained 146 religious, clan and political leaders on the importance of immunization and disease surveillance activities. CGPP Ethiopia identifies and trains leaders from multiple religious beliefs and backgrounds to influence mothers to promote vaccine uptake, and to create demand and participate in AFP surveillance. These religious leaders share key messages through various church-sponsored programs, like Sunday preaching, conferences and community tea and coffee programs.



A pastor in Abobo woreda in Gambella Region administers OPV.



A Joint Supportive Supervision is conducted at the Qaloan Health Center located in Galadi woreda in Dollo Zone.

With the MOH and UNICEF country office, the CGPP conducted the first Vaccinology Course from December 4-8, 2018 in Bishoftu. The five-day basic training included 21 participants from the CGPP Secretariat and partners, the MoH EPI team, WHO and UNICEF.



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

The Secretariat supported two rounds of bOPV SIAs and one round of measles campaigns during FY19. In addition, the CGPP Secretariat, along with partner OWDA, participated in two rounds of synchronized cVDPV2 outbreak response in the Dollo Zone of Somali Region. A total of 1,219,966 children under five were vaccinated through supplemental immunization, approximately 400,000 more than last year. The January and April SIAs reached 1,081,260 children with vaccinations; 138,706 under-five children were vaccinated with mOPV2 in the two outbreak response rounds. Strong cross-border planning with partners resulted in synchronization of both polio SIAs, the outbreak response, and the measles campaign. Notably, transit point vaccination was carried out at eight sites in Dollo Zone for the mOPV2 campaigns, vaccinating a total of 907 children. Mapping of transit and crossing points were crucial to this achievement.



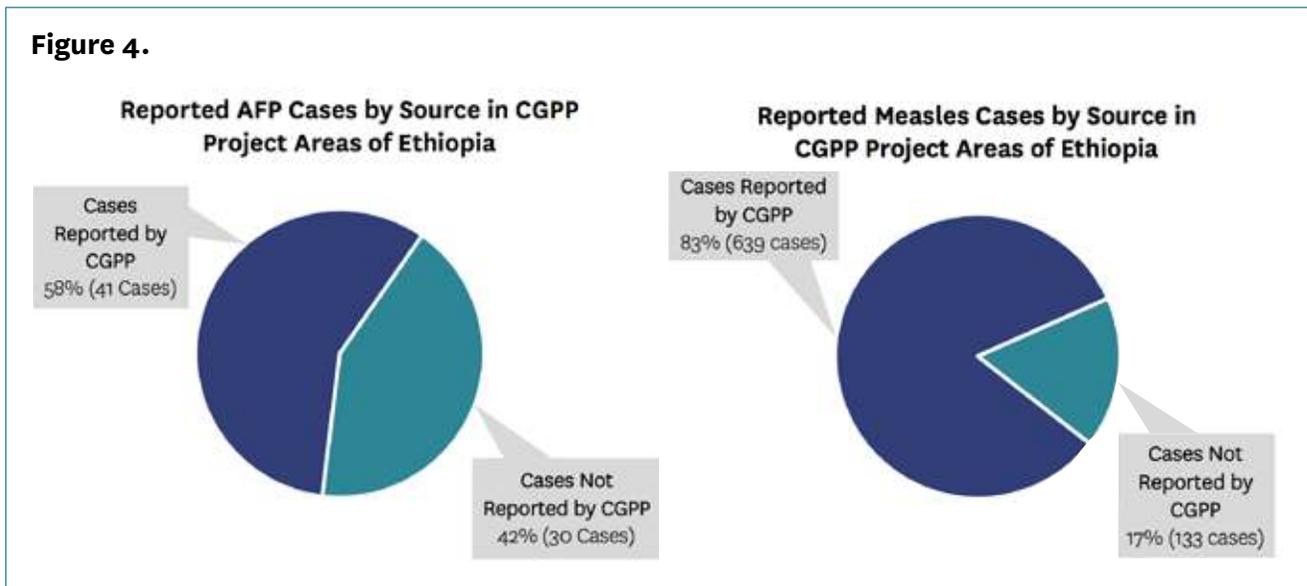
CGPP Implementing Partner Pastoralist Concern provides campaign support to reach a nomadic family.

On average, 95% of the target children were reached during each campaign round, with the percentage of zero dose children declining from 1.8% to 0.65%. The CGPP provided supervision, technical support, and materials to ensure successful outreach and campaigns. Overall, 121 central and field level staff were involved in pre-, intra- and post-campaign activities. Moreover, 62 vehicles and 10,238 liters of fuel were used to transport vaccinators and vaccines to the field for campaigns. Over four thousand (4,605) CVs and HDALs supported the campaigns through social mobilization and as vaccination team members.



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

The robust surveillance system established by the CGPP throughout project implementation areas took on new importance due to the cVDPV2 outbreak. The CGPP continued its legacy in community-based surveillance for AFP, neonatal tetanus, and measles, also providing a strong link between health facilities and the community. In project implementation areas, the Non-Polio AFP rate (NPAFPR) was 3.24 per 100,000 children 15 years and under, considerably higher than the national rate of 2.4. Two silent areas were identified due to issues of violence and inaccessibility.

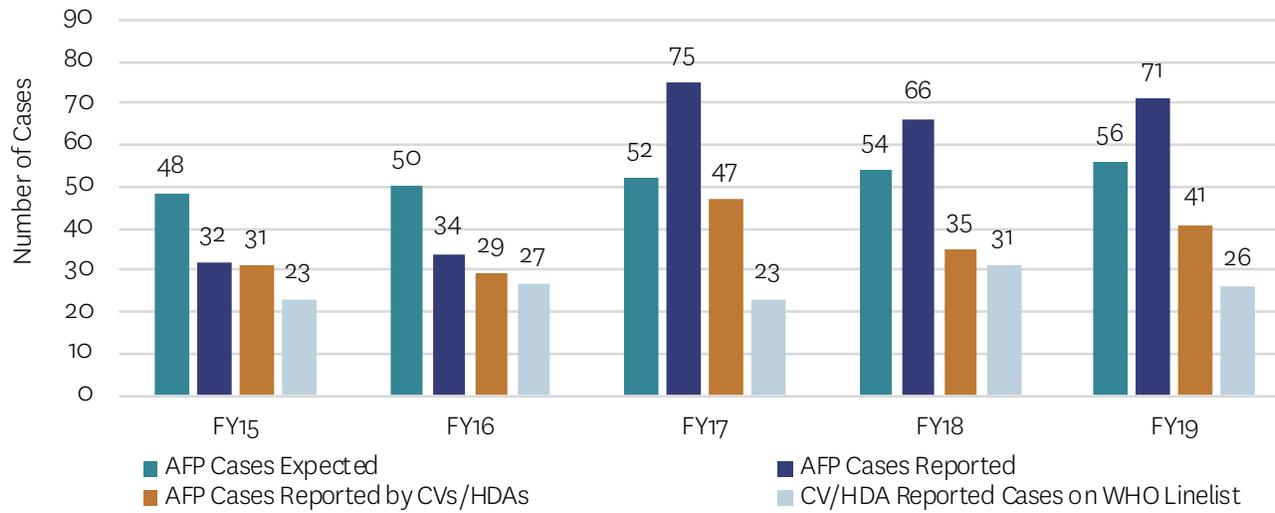


Project areas reported 71 AFP cases during the reporting period; 58% of these cases were reported by CGPP-trained CVs/HDALs (Figures 4 & 5). All NPAFP cases were reported within 14 days of symptom onset. The CGPP continued to make inroads with tracking of nomadic and pastoralist communities. Of the AFP cases reported, 27 (38.0%) were reported among nomadic populations.

The Ethiopia team remained the primary contributor to measles surveillance, reporting 83% of measles cases in the project catchment area (Figure 4).



Figure 5. CVs/HDALs Contribution to AFP Case Identification and Reporting in CGPP Implementation Areas of Ethiopia



The project participated in more than 12 times the number of surveillance meetings, workshops, and reviews of facility records to ensure a reliable and sensitive surveillance system in FY19 (347) compared to FY18 (28).



Community Volunteers announce an immunization campaign in Gambella.



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

CGPP Ethiopia had a banner year, developing a total of nine peer-reviewed articles and presenting at 12 international and regional conferences, up from eight forums in 2018. The team wrote six articles for a special edition of The Ethiopian Journal of Health Development and three articles in a special supplement of the American Journal of Tropical Medicine and Hygiene. The AJTMH supplement featured *The CORE Group Polio Project’s Community Volunteers and Polio Eradication in Ethiopia: Self-Reports of Their Activities, Knowledge, and Contribution*; *Improvements in Polio Vaccination Status and Knowledge about Polio Vaccination in the CORE Group Polio Project Implementation Areas in Pastoralist and Semi-Pastoralist Regions in Ethiopia*; and *Trust, Communication, and Community Networks: How the CORE Group Polio Project Community Volunteers Led the Fight against Polio in Ethiopia’s Most At-Risk Areas*.

To improve program impact, CGPP Ethiopia collected qualitative data from 24 health facilities. The Secretariat and partners conducted 24 in-depth interviews, 115 observations and 118 exit interviews in the Somali and B/Gumuz regions. Findings will be released in FY20.

Additionally, to encourage the use of technical and social mobilization materials at the local levels, CGPP Ethiopia revised the “Community-based Surveillance Training Manual for Targeted Diseases and Signals” to reflect the addition of three priority zoonotic diseases for use by CVs. The Secretariat prepared and distributed 1,200 flip books in local languages, nearly 3,000 pages of reporting formats, and 286 social mobilization materials.



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

Since transition efforts began in June 2016, CGPP Ethiopia has been a leader in developing plans to strengthen community-based surveillance and immunization activities while working to transition resources to the government. CGPP Ethiopia has contributed to the development of the Polio Transition Plan and the process to map assets. Funding for the polio transition has not yet been secured by the Ethiopian government.



A vaccinator marks a house during an SIA in Gambella Region's Adobo woreda.

COUNTRY REPORT:

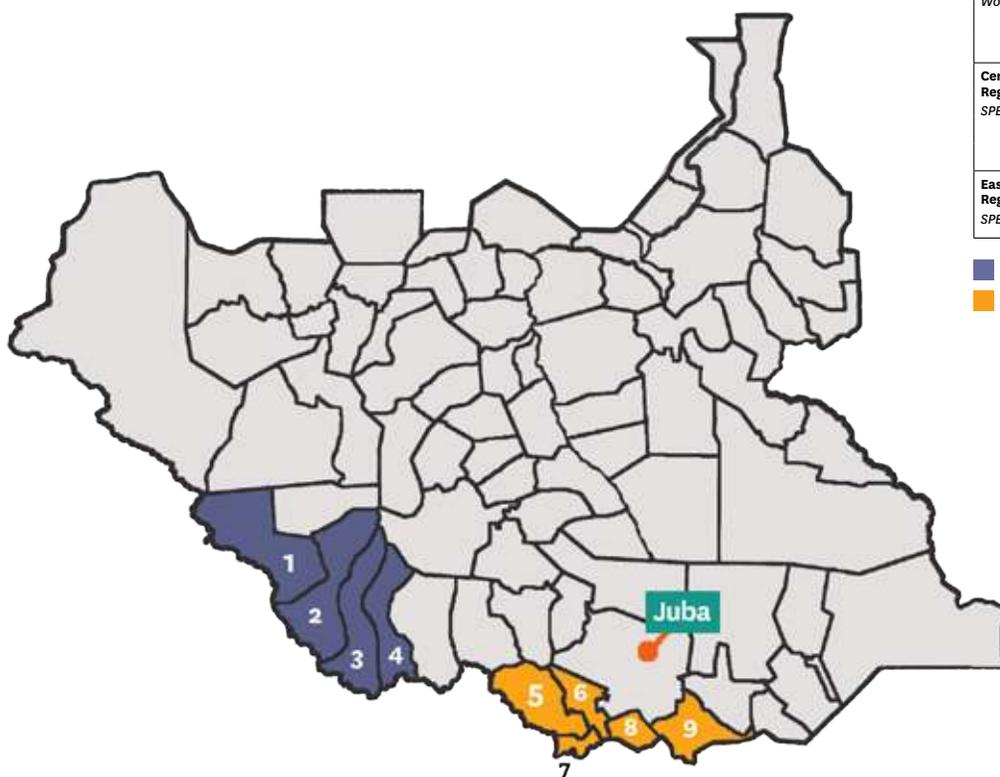
South Sudan



In FY19, CGPP South Sudan achieved remarkable success for measuring the quality of all three polio campaigns and for sustaining a robust community-based polio surveillance system. Despite several extraordinary challenges during the reporting period, including transition of cornerstone activities, the CGPP managed to support 100% of the Independent Campaign Monitoring (ICM) activities across the country and report 85% of all AFP cases in the project focal areas.

CGPP South Sudan made several significant adjustments during the reporting period. The Project transitioned BMGF-funded surveillance work to local NGOs that were recruited and trained by the CGPP. In early 2019, the Secretariat re-focused its community-based surveillance (CBS) activities from Unity, Upper Nile, Jonglei and parts of Kapoeta and Magwi in Eastern Equatoria State to nine high-risk counties in three southern Equatoria States bordering Kenya, Uganda and the Democratic Republic of Congo (DRC) (Figure 1). Additionally, the Secretariat expanded its community-based surveillance to include two global health threats: Ebola Virus Disease (EVD) and measles.

Figure 1.
SOUTH SUDAN



CGPP Implementing Partners by County		
Western Equatoria Region <i>World Vision</i>	1	Tambura
	2	Ezo
	3	Nzara
	4	Yambio
Central Equatoria Region <i>SPEDP</i>	5	Yei
	6	Lainya
	7	Morobo
	8	Kajo-Keji
Eastern Equatoria Region <i>SPEDP</i>	9	Magwi

■ World Vision South Sudan (WVSS)
■ Support for Peace and Education Development Program (SPEDP)



Irrespective of the signed September 2018 peace agreement, conflict has been a constant theme, creating a volatile security environment across the country due to inter-communal violence. The protracted Civil War left the national health system fragile and health facilities either destroyed or inaccessible. There has been massive displacement of more than 1.98 million people internally, and the exodus of more than 2.2 million people to the neighboring countries of Uganda, Ethiopia, Sudan, Kenya, DRC and Central African Republic, according to the United Nations High Commissioner for Refugees (UNHCR). The country is also hosting 291,824 refugees from Sudan and DRC. UNHCR anticipates that humanitarian needs will continue to rise with 2,723,006 South Sudanese becoming refugees by 2020.

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

During the first quarter of FY19, CGPP South Sudan collaborated with five national NGOs to implement project activities in four states, 36 counties and 236 payams. The Secretariat recruited and deployed 36 County Supervisors and 236 Payam Assistants, and identified a network of 3,464 community key informants. CGPP South Sudan directed the work of Livewell, Children Aid South Sudan (CASS), Christian Mission for Development (CMD), Universal Network for Knowledge and Empowerment Agency (UNKEA) and Support for Peace and Education Development Program (SPEDP) (Table 1).

Table 1. National NGO partners and distribution of counties in the first quarter of FY19

National NGO Partner	Number of Counties	States	Distribution of counties
Livewell	7	Jonglei	Duk, Twic East, Bor South, Pibor, Boma
		Eastern Equatoria	Kapoeta East, Magwi
CASS	6	Upper Nile	Maban, Melut, Malakal, Baliet, Akoka, Panyikang*
CMD	5	Jonglei	Piggi, Fangak, Nyirol, Ayod, Uror
UNKEA	6	Jonglei	Pochalla, Akobo
		Upper Nile	Ulang, Nasir, Maiwut, Longochuk
SPEDP	13	Upper Nile	Fashoda, Renk, Manyo
		Unity	Rubkona, Guit, Koch, Panyijar, Manyo, Mayendit, Leer, Abiemnhem, Mayom, Pariang
Total	37	4	37

*Project activities were not implemented in Panyikang County due to active fighting.



CGPP South Sudan works closely with the Ministry of Health (MoH), WHO, UNICEF and other partners. The Secretariat participated in three technical working groups (TWGs): the National Expanded Program on Immunization (EPI), the National Ebola Virus Disease (EVD) Surveillance and the EVD Community Based Surveillance (CBS) subgroup for EPI. The Secretariat also participated in both the national and state EVD task force, EVD-EPI Surveillance as well as the Inter-Agency Coordination Committee (ICC).

In February 2019, the CGPP Deputy Director Dr. Samuel Rumbe presented to a regional joint cross-border health conference on One Health in Lodwar, Kenya (Turkana County.) The Project also supported the attendance of four State Ministry of Health officials from Kapoeta East County. The One Health conference explored current approaches and documented challenges and opportunities in integrating human and animal health in the Ateker region of South Sudan, Uganda, Ethiopia and Kenya. Participants developed a joint work plan to address Integrated Disease Surveillance and Response (IDSR), Routine Immunization (RI) services and other notifiable diseases.

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

CGPP South Sudan conducted country-wide ICM to assess the quality of the country's three polio immunization campaigns. ICM, which is also known as post-campaign evaluation (PCE), aims to provide an objective independent source of rapid and reliable quantitative data for each round of polio campaigns, and to guide corrective actions to improve the quality of the subsequent campaign rounds.

For each of the three campaigns held in FY19, the CGPP provided training for campaign monitors and collected, analyzed, and shared data. The CGPP observed best practices, compiled comprehensive results, addressed challenges and provided recommendations, including immediately actionable data on campaign quality, reasons for missed children, and the identification of poorly covered areas for mop up operations. Polio partners and the government of South Sudan extracted specific county data for future operational use, particularly to improve micro-planning for subsequent campaigns.

The CGPP hired 77 Central Supervisors and 530 school teachers as independent campaign monitors. The Central Supervisors are recruited and trained centrally by CGPP in Juba and then deployed to the counties to recruit and train teams of school teachers. Central Supervisors manage the data collectors and ensure the coordination of ICM activities and data transmission.

WHO guidelines served as a framework for implementation of campaign monitoring in South Sudan, which requires that a minimum of 50% of counties that participate in campaigns be monitored after each round. CGPP reached more than 73% of counties with ICM during each of the campaigns with highest coverage reported in November 2018 (Table 2).



Table 2: PCE In-house Survey Findings by Indicator

	Nov. 2018 SNID	Mar 2019 SNID	April/May 2019 NID
# of counties where SIA was implemented	46	52	75
# counties where PCE was implemented by CGPP	40	38	57
% counties with SIAs reached by PCE	87.0%	73.10%	76.0%
# household surveyed during PCE (house to house)	6,801	5,740	9,320
Total children surveyed	17,718	14,008	23,423
Total children finger marked	14,756	12,464	21,250
Vaccination coverage by finger mark	83.3%	89.0%	90.7%
Social mobilization coverage	85.7%	89.8%	86.3%
% missed children	16.7%	11.0%	6.8%
% zero dose children	9.5%	9.8%	6.8%

In the three campaigns combined, 21,861 households and 55,149 children below the age of five years were surveyed through ICM in-house surveys. Overall, each of the campaigns surpassed 80% coverage for both vaccination and social mobilization. However, only the April/May campaign reached the 90% vaccination coverage target set by the South Sudan MoH. Additionally, there was a downward trend in missed children and zero dose children. In both the November and April/May campaigns, the most common reason for missed children was that the vaccination team did not visit the home.

CGPP conducted out-of-house ICM surveys with a total of 17,387 children following the three campaigns. The out-of-house survey results closely mimicked in-house results. The April/May campaign was the only campaign that reached the 90% target (6,659/7,260, or 91.7%, children surveyed had finger marks); November 2018 coverage was 79.9% (4,015/5,027) and March 2019 coverage was 89.4% (3,495/5,100).

Community Mobilization

The CGPP supported mobilization activities to create awareness and support community members to seek services during the November 2018 polio National Immunization Days (NIDs), which were jointly implemented by the National MOH, WHO and UNICEF. During this activity, the project recruited and trained 120 community social mobilizers in five counties, reaching 3,086 community members. Megaphones, religious leaders and health workers were the most common sources of campaign information.

Children vaccinated in CGPP catchment areas

The MOH targeted 274,524 children under five in the seven CGPP focal counties of Magwi, Kapoeta East, Pibor, Pochalla, Ayod, Akobo and Duk. Planned campaigns were implemented in November 2018, March 2019, and



April/May 2019. In November, 266,854 children under five (97.2% of the target) were vaccinated. The March 2019 campaign was limited to four counties (Nasir, Longochuk, Maiwut and Ulang) due to currency-related issues; nonetheless, 87.2% of the reduced target population was reached. The April/May subnational campaign reached 273,493 under 5's (99.6% of the target) (Table 3).

Cross-Border Health Initiative

The borders of South Sudan are porous with frequent movement between countries, posing a serious risk for re-emergence or re-importation of polio virus. Until December 2018, South CGPP maintained Special Vaccination Posts (SVPs) along the Kenya border in Nadapal (Kapoeata East County) and along the Uganda border in Nimule and Panjaala (Magwi County). During this only active quarter in FY19, 1,283 children under five (594 males and 689 females) received OPV. The high numbers of children receiving OPV in October could be attributed to an influx of returnees from Uganda upon the signing of the peace agreement in the previous month (Table 4).

Table 3. FY19 Campaign Coverage in South Sudan

Campaign Date	Coverage in CGPP areas	Children Vaccinated	Children Targeted
Sub-National Polio SIA November 2018	97.2%	266,854	274,524
Sub-National Polio SIA March 2019	87.2%	105,062	120,191
National Polio SIA April/May 2019	99.6%	273,493	274,524

Table 4. Children Vaccinated through Special Vaccination Posts Supported by CGPP

Month	Children under 5 vaccinated		
	M	F	Total
October	340	428	768
November	122	96	218
December	132	165	297
Total	594	689	1,283

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

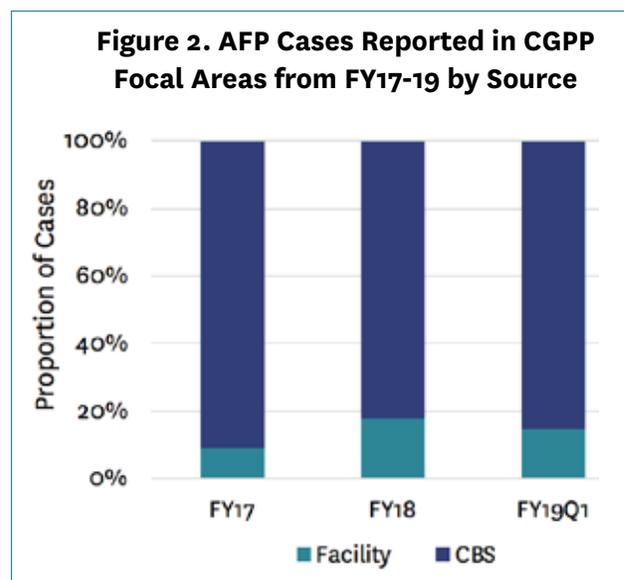
In October 2015, CGPP South Sudan designed and implemented a new and highly effective community-based surveillance system in the northern conflict states. The CBS system combined components of active community-based AFP case surveillance and behavior change, utilizing community volunteers to cover a much larger area to supplement surveillance by health facilities. In its final quarter (FY19Q1), the CGPP CBS system grew to 3,736 actors, including 3,646 unpaid key informants (KIs) at the community level. KIs were monitored by a cadre of paid supervisors – Payam Assistants and County Supervisors. The CGPP achieved tremendous success by creating and maintaining a CBS system that identified most AFP cases in project areas, reduced the



Independent monitors verify the immunization status of children under five during the November 2019 polio campaign using the open data kit application.

number of silent counties from 18 to 1, and increased the Non-Polio AFP rates (NPAFPRs). By the end of BMGF funding on December 31, 2018, the CGPP attained coverage of 36 counties in four states (Jonglei, Unity, Upper Nile and Eastern Equatoria) or 45% of all counties in the country. In addition, the project reached more than 2.8 million children under the age of 15 years in the four states, or 47% of the total population of the catchment areas. Final progress details may be found in the [CGPP end of project report](#). The impact of this initiative was fully explored by CGPP South Sudan in a peer-reviewed article entitled [Evaluation of the Functionality and Effectiveness of the CORE Group Polio Project’s Community Based Acute Flaccid Paralysis Surveillance System in South Sudan](#). The article was published in the American Journal of Tropical Medicine and Hygiene in October 2019.

Clearly, the CGPP surveillance system has been effective in insecure environments and where the population has limited access to health facilities. The CGPP system strongly outperformed the facility-based surveillance system in focal counties. Roughly 82% of cases were reported by the community through in FY17, FY18, and FY19 (Q1) (Figure 2). The AFP rate in CGPP counties was 6.1 per 100,000 children under 15. The country-wide contribution can be seen in the proportion



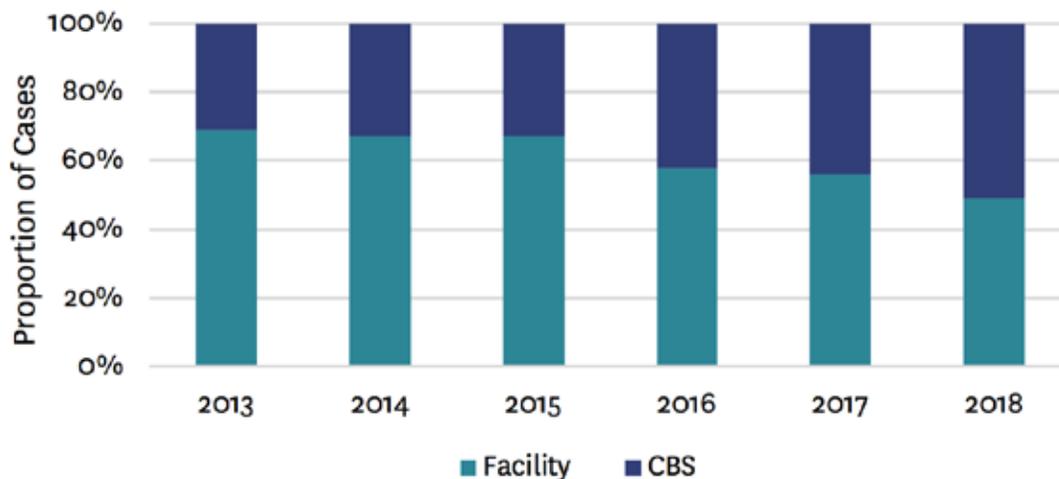


The CGPP South Sudan State Coordinator delivers stool samples of suspected AFP cases to Juba.

of cases reported by the community when compared to health facility reporting. As the CBS system was strengthened by the CGPP, the proportion of cases reported by CBS drastically climbed from 2013 to 2018.

Although CGPP's geographic scope was limited, the impact of strengthened CBS had a national impact. CGPP contributed to a notable shift from an AFP reporting system dominated by facility-based reporting to one in which more than half (51%) of AFP cases were reported by the community (Figure 3).

Figure 3. South Sudan Country-wide Sources of AFP Case Reporting from 2013-18





While the 2018 national indicators for polio show promising results, they also mask the enormous vulnerability at the sub-national level. For instance, the surveillance data for Week 26 in 2019 indicated 12 of the country's 80 counties as silent (not reporting suspected AFP cases). Most of these counties are located along the South Sudan border with Kenya, Uganda, Sudan and Ethiopia.

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

In September 2019, CGPP South Sudan supported the process of pre-certification documentation by chronicling activities from 2016. These activities included best practices on the establishment and maintenance of SVPs, regional and local cross-border meetings, ICM and the use of community-based surveillance to improve sensitivity in conflict-affected and hard-to-reach areas. Previously, the Project contributed to drafting and reviewing the South Sudan National Transition Plan for the Polio Eradication Initiative from 2017 until its May 2018 completion.

COUNTRY REPORT:

Nigeria



In August 2019, Nigeria reached the three-year mark without a case of Wild Polio Virus Type 1 (WPV1) anywhere in the country, positioning Nigeria for polio-free certification in mid-2020. Even so, the country deferred any premature celebration by stepping up surveillance efforts to ensure the absence of WPV1 and investing resources to extinguish 80 circulating vaccine-derived polio virus Type 2 (cVDPV2) outbreaks across the country during FY19. The flareups stemmed from insufficient coverage for inactivated polio vaccine (IPV) through Routine Immunization, low uptake of vaccinations in inaccessible areas due to insecurity, and pockets of vaccine rejection. CGPP Nigeria responded with technical assistance for multiple planned Outbreak Responses (OBRs) and scheduled Supplementary Immunization Activities (SIAs), supporting the vaccination of nearly five million under-five children.



A CGPP team visits Yobe's Toshia settlement during an SIA. The settlement is located near the border of the Niger Republic.

The CGPP Nigeria team concentrates on 32 Local Government Areas in the states of Borno and Yobe in the North East and Kaduna, Katsina and Kano in the North West. During FY19, a corps of 1,841 female Volunteer Community Mobilizers (VCMs) recorded 3.4 million encounters with hard-to-reach and vulnerable populations. VCMs mobilized communities through interventions such as 633,517 house-to-house visits as well as 5,295 compound meetings, community dialogues and advocacy visits to influencers. Trainings on Interpersonal Communication (IPC) skills, proper use of the VCM registers for data collection, and active case search contributed to 99.99% of children under one in project areas receiving OPV0 in the reporting period. Moreover, CGPP-trained VCMs have contributed to a substantial increase in OPV3 coverage rates in children 12-23 months - from 80% in 2017 to 89.7% in 2019. There has also been a significant reduction in missed children from 1.5% to 0.2% during the same period.



Religious beliefs continue to account for the primary reason behind noncompliance, despite consistent social mobilization and behavior change communication efforts. To counter cases of noncompliance, CGPP Nigeria expanded one of its most effective strategies – the Iftar intervention - from one state to all five states. Scaling up this strategy resulted in the vaccination of 93% of missed children in non-compliant households.

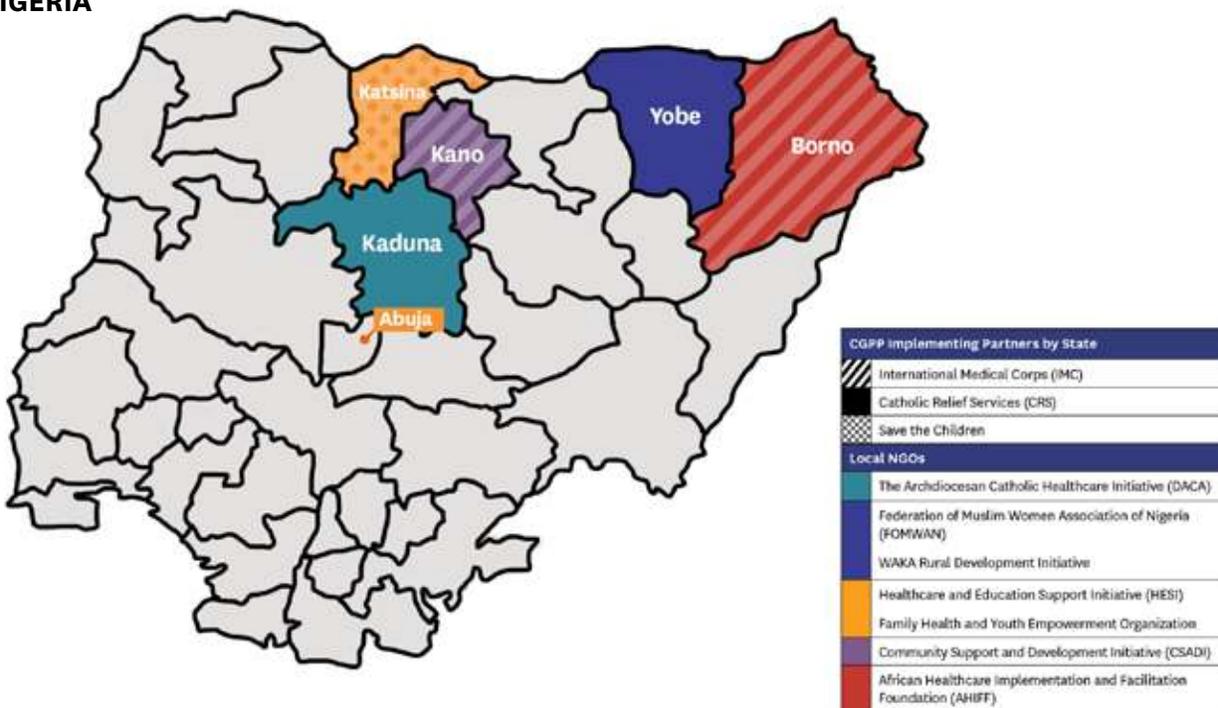
1 Build effective partnerships with PVOs, NGOs, and international, national and regional agencies involved in polio eradication

Three international NGOs implemented activities in FY19: International Medical Corps (IMC) in Borno and Kano states; Catholic Relief Services (CRS) in Yobe and Kaduna states, and Save the Children International (STC) in Katsina state. Under supervision of the IMC, CRS, and STC, seven national NGOs operated in the five states: Archdiocesan Catholic Healthcare Initiative (DACA) in Kaduna; Community Support and Development Initiative (CSADI) in Kano; Family Health and Youth Empowerment (FAHYE) and Healthcare Education and Support Initiative (HESI) in Katsina; Federation of Muslim Women Association of Nigeria (FOMWAN) and WAKA Rural Development Initiative in Yobe state and African Healthcare Implementation and Facilitation Foundation (AHIFF) in Borno (Figure 1). IMC, the implementing partner in Borno, terminated AHIFF in February 2019 due to finance and compliance issues.

CGPP Nigeria works in close collaboration with the national and state emergency operations centers to ensure its activities and plans are in line with the National Polio Eradication Emergency Plan (NPEEP) of the National Polio Emergency Operations Center (NEOC). The NPEEP is developed annually and drives the country's polio eradication efforts and aims to strengthen the Routine Immunization (RI) program (coordinated by the National Routine Immunization Coordination Center, or NERICC.) In addition to the NEOC, Nigeria CGPP provides technical support to the High-Level Advocacy Team (HiLAT), the Inter-agency Coordination Committee (ICC) and the Northern Traditional Leaders Committee on PHC Service Delivery (NTLC) for conducting advocacy and behavior change at all levels. CGPP Nigeria works closely with WHO, CDC, UNICEF, Rotary and other polio partners. The National Primary Health Care Development Agency (NPHCDA), which oversees the NEOC, recognized the CGPP Nigeria and other partners for keeping Nigeria free from WPV for the past three years with an award for exemplary performance.



Figure 1.
NIGERIA



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

The CGPP Nigeria cadre of volunteers is comprised of VCMs, Volunteer Ward Supervisors (VWSs), and Community Informants (CIs). Each group of volunteers has their own prescribed set of activities. VCMs engage communities through house-to-house mobilization, imparting messages of vaccination benefits, tracking pregnant women and newborns, reminding parents to take their children for routine immunizations and referring defaulters for vaccination. The VWSs provide supervision of activities planned by VCMs, organize compound meetings and community dialogues, and verify data collected in registers. Community Informants assist VCMs in identifying and reporting AFP cases in their community. CIs are well-established members of their communities who regularly interact with multiple community members. Traditional healers, patent medicine vendors, bone settlers, and herbalists double as CIs.

The number of program volunteers decreased by approximately 175 to 3,086 (including VCMs, VWSs, and CIs) during FY19, yet their actual reach and activities were expanded. The reduction in volunteers was the result



of re-shuffling settlements to ensure that VCMs with smaller numbers of households were re-allocated additional households. Thirty-nine LGACs supervised 1,841 all-female VCMs and 217 VWSs to reach 633,517 households, approximately 30,000 more than FY18 (Table 1). Project volunteers covered a total of 843,579 children under five. They also engaged with communities in group settings through community dialogues, advocacy visits with influencers, and naming ceremonies, leveraging community events to vaccinate groups of children. In FY19, CGPP volunteers held 5,295 group meetings. These efforts led to continued increases in OPV0 and OPV3 coverage over the Project’s life and sustained high coverage in FY19 (Figure 2). OPV3 coverage rose from 88.4% to 89.7% in children 12-23 months, jumping nearly ten percentage points since the FY17 baseline value of 80%. Improvements in timeliness were also achieved, with OPV3 coverage in children under 12 months rising from 98.2% to 99.2%. VCMs track pregnant women and attend naming ceremonies, or “Suna,” to ensure OPV birth dose in the first two weeks of life, contributing to 99.99% of children under one in project areas receiving OPV0 in FY19.

Table 1. Numbers of CGPP VCMs, VWSs, LGACs, and CIs

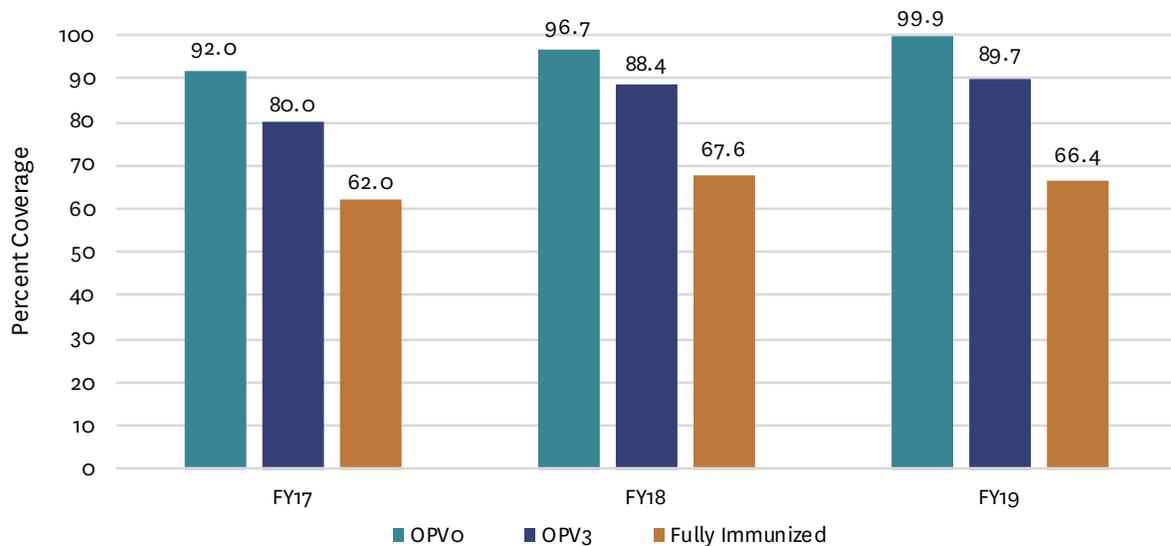
State	Number of VCMs		Number of VWSs		Number of LGACs		Number of CIs	
	M	F	M	F	M	F	M	F
Borno	0	413	28	43	6	4	259	118
Yobe	0	780	43	35	8	3	224	89
Kano	0	325	24	6	9	3	325	161
Kaduna	0	100	0	10	0	2	50	25
Katsina	0	223	0	28	2	2	160	95
TOTAL by Gender	0	1,841	94	122	25	14	488	540
TOTAL	1,841		217		39		1,028	



VCM Binta Ahmad in Kano State's Rimin Gado LGA visits with a mother and her newborn.



Figure 2. Immunization Coverage in Children 12-23 Months in CGPP Catchment Areas in Nigeria



While polio vaccination coverage remained high, the percentage of fully immunized children 12-23 months dipped to 66.4% from 67.6%. Coverage was reported slightly higher in boys compared to girls for OPV3 (91.5% vs. 87.9%) and for fully immunized children 12-23 months (67.5% vs. 65.3%). The percentage of zero dose children 12-23 months fell from 0.52% to .001% in FY19.



A young girl receives a vaccination during a health camp in Kano, Nigeria in July 2019.



Huda Hussain, a traditional healer who works in Kano State's Nasarawa LGA, serves as a Community Informant.

Of the five focal states, Borno presents unique challenges to reach children. In Borno, insecurity caused by Boko Haram is the primary factor for limited access to eligible children for vaccination; Marte and Abadam LGAs remain completely inaccessible to vaccination teams. Children cannot be reached on more than 100 islands in the Lake Chad basin region (Niger, Chad and Cameroon) that are used as active operational bases by Boko Haram. “However, insecurity is a rising problem in other parts of the country where armed robbery, kidnapping and communal clashes are occurring,” according to the November 2019 IMB report.

To increase support, productivity, and quality of services provided by these frontline workers (including LGACs, VWSS, VCMs, and CIs), CGPP Nigeria rolled out the “Rubdugu Supportive Supervision (RSS).” The model was developed by CGPP Katsina to address technical issues more comprehensively than traditional Supportive Supervision, which focuses on just one technical area. Under the Rubdugu model, technical input covers all thematic areas in one visit by the entire State team. In addition to implementing RSS, CGPP Nigeria leveraged opportunities to improve the quality of immunization campaigns, increase vaccine uptake, and reduce immunization resistance among populations in the focal states by engaging key stakeholders such as traditional, political, religious, and female leaders and philanthropists, to influence positive behavior change and build sustainability by building political commitment at the LGA and Ward levels.

Trainings

CGPP Nigeria conducted 21 types of trainings for 7,465 participants (1,021 males and 6,444 females) including 3,429 volunteers (482 males, 2,947 females) during FY19. CGPP provided training for frontline workers, supervisors, and LGA and state-level personnel prior to each SIA round. These trainings addressed



microplanning, data quality and transmission, surveillance, social mobilization, and noncompliance management skills. Between SIAs, trainings focused on building capacity for surveillance, social mobilization, and defaulter tracing. Additional trainings for community volunteers centered on BCC, IPC skills, immunization information, and polio plus (including WASH and nutrition). CGPP Nigeria participated in and provided support for trainings conducted by the state governments to prepare for non-polio SIAs for meningitis and measles campaigns.

Cross-Border Activities

CGPP Nigeria coordinated cross-border campaigns along Borno and Yobe States, synchronizing eight campaigns (100%) in Borno and seven (87.5%) in Yobe. In the border areas of Monguno and Ngala LGAs in Borno, 219 volunteers conducted compound meetings, advocacy sessions, community dialogues and house-to-house visits in Internally Displaced Persons (IDP) camps to ensure that newly arriving populations received vaccinations.

Eight cross-border committee meetings were held in Ngala and Monguno during FY19; CGPP attended two of the cross-border meetings in Yobe (border LGAs in Borno were inaccessible.) During the cross-border meetings in Yobe, discussions addressed new approaches and best practices to reach children in border and nomadic settlements in the Lake Chad basin region. Three sub-committees (social mobilization, surveillance, and data) met regularly through the fiscal year. Two functional transit vaccination posts were maintained in project areas.

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

During FY19, 843,579 children were immunized through eight SIAs (six NIPDs and two OBR campaigns) in the project areas. Eight local immunization days in Borno and seven in Yobe that were coordinated across borders as well. As a result of intense CGPP social mobilization and behavior change communication activities, noncompliance and vaccine rejection due to fear of OPV safety, religious beliefs, child sickness and parental refusals have decreased significantly across the CGPP focal states. The average percentage of missed children during SIAs dropped from 1.5% in FY17 (and 0.8% in FY18) to just 0.2% in FY19 (Figure 3). On average, each SIA reached 99.9% of the target children under five years, up from 94% in FY18. Nearly all, or 99.9% of children one year and younger in project areas, have received at least 7 doses of OPV through campaigns and routine immunization. Employing the strategy of directly observed oral polio vaccination (DOPV) was a contributing factor to reaching eligible children in non-compliant households.



Religious beliefs remain the most prominent reason for noncompliance in many focal communities, despite consistent social mobilization efforts. CGPP Nigeria successfully expanded the use of the Iftar strategy to all five focal states in FY19: 93% of missed children (3,063 of 3,294 children) from non-compliant households were successfully vaccinated.

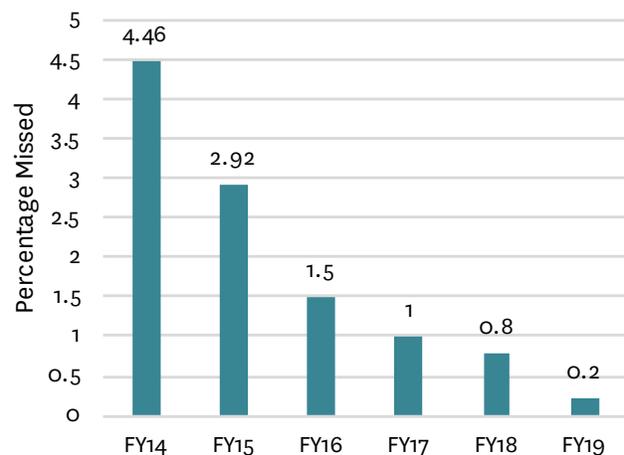
The CGPP provided technical implementation support to state teams in focal and non-focal states during all 18 scheduled SIAs and mOPV2 OBR campaigns throughout the country. The CGPP deployed senior technical staff to support and participate in the OBR Management Support Teams (MSTs) in five campaigns in April, May, and June (Table 2). MSTs provide guidance and technical support to the states and are viewed as representatives of the National EOC.

CGPP Nigeria supported various OBRs, IPDs and fractional IPV campaigns in the project areas of Borno, Yobe, Kaduna, Katsina and Kano states and in the non-project areas of Sokoto, Kwara, Adamawa, Zamfara, Kebbi and Niger states. In the Southern region, the national EOC assigned CGPP team members to the Senior Management Support Team (SMST). The SMSTs were deployed to support SIA campaigns in Oyo, Ogun, Lagos, Ekiti, Ondo, Rivers, Ebonyi, Anambra and other non-focal states.

Table 2. Country-wide Outbreak Response Activities Supported by CGPP Senior Technical Staff by Location

April 11-17	OBR in Northern States: Kaduna, Jigawa, Sokoto, Bauchi, Zamfara, Borno, Adamawa, Taraba
May 18-21	OBR (first round) in South Western States: Ekiti, Lagos, Ogun, Ondo, Osun, Oyo
May 23-29	OBR in breakthrough transition state: Borno, Yobe, Kwara, Niger, and part of Kano
May 25-28	OBR in Kano, Borno
June 17-21	OBR (second round) in South Western States: Ekiti, Lagos, Ogun, Ondo, Osun, Oyo

Figure 3. Average Percentage of Missed Children in CGPP Focal Areas of Nigeria During SIAs FY14-FY19



Note: The axis only denotes 0%-5%



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

Surveillance was stepped up in FY19 as Nigeria moved towards certification and worked to extinguish 80 cVDPV2 outbreaks. At the request of the EOC, the CGPP provided technical staff to support surveillance in focal and non-focal states. In May 2019, CGPP technical staff participated in a Surveillance Peer Review of Benue and Kogi states in the North Central Region, Bayelsa state in the South Region and Enugu State in the South East. In August 2019, PEI Documentation and Peer Review were conducted in the South Region’s Rivers state and in Sokoto, located in the West region.

CGPP VCMs along with 1,028 community informants act as well-trained community-based surveillance agents in the CGPP focal areas. Additional CIs were recruited in Yobe, Borno, and Kaduna during FY19. VCMs and CIs report suspected AFP cases to VWSs, who refer cases to the LGAC. LGACs then report to the Disease Surveillance Notification Officer (DSNO) who begins an investigation. A total of 191 suspected AFP cases were detected by the CGPP VCM and CI network throughout the fiscal year in focal LGAs; 43 (23%) of these cases were certified true AFP cases and assigned an EPID number by LGA DSNOs (Table 4). The CGPP does not cover all wards in the 33 focal LGAs and VCMs, therefore, serve only a small number of focal wards. However, surveillance data is reported for the entire LGA and is unavailable separately for specific CGPP focal wards. Despite covering a relatively small area, the CGPP community-based surveillance network reported 16% (43 of 277) of AFP cases given an EPID number in the focal LGAs (Figure 4). The AFP rate in project areas was 9.8% in FY19, with a 94% stool adequacy level - well above the 80% target.

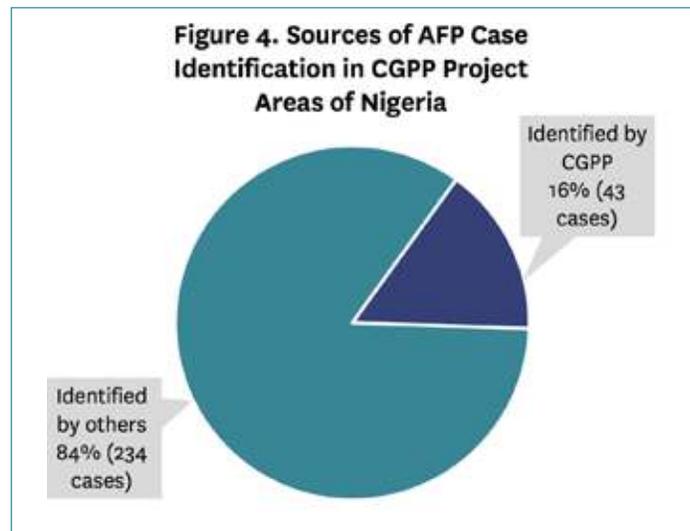


Table 4. AFP Detection and Report in CGPP focal LGAs

	Detected in CGPP focal area	Given EPID Number in CGPP focal area	Detected in the whole LGA	Given EPID Number in whole LGA
Borno	34	7	289	100
Kaduna	13	3	100	26
Katsina	85	20	184	51
Yobe	17	8	83	68
Kano	42	5	179	32
Total	191	43	835	277



The CGPP participated in 321 meetings, workshops and reviews of facility records to strengthen AFP surveillance. Sessions included training workshops and meetings with DSNOs, surveillance working groups at the national and state levels, and with CIs. Additionally, the CGPP supported the National Surveillance Peer Review Assessment and Documentation team to ensure proper documentation for certification. Specifically, the CGPP Surveillance staff from the national and state level provided technical assistance and capacity building to key states to rectify all identified surveillance gaps.

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

In May 2019, Secretariat Director Dr. Samuel Usman attended the CORE Group Health Practitioner’s Conference, participating in a panel discussion on “The role of gender and religion in social behavior communication in Muslim societies.” Dr. Usman also presented a poster on “Delivering Immunization Services Through Innovative Partnership and Community Health Approaches.”

CGPP Nigeria published two articles in the special supplement of the American Journal of Tropical Medicine and Hygiene: *The CORE Group Partners Project in North East Nigeria: Community Engagement Strategies to Combat Skepticism and Build Trust for Vaccine Acceptance* and *Contributions of Volunteer Community Mobilizers to Polio Eradication in Nigeria: The Experiences of Non-governmental and Civil Society Organizations.*



A woman pauses outside a home in Kano State.



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

CGPP Nigeria is a member of the high-level National Polio Transition Technical Task Team (PT4). The group is responsible for the country's transition of polio assets in three main areas: surveillance and OBR, RI, and primary health care revitalization. The CGPP provided technical assistance to finalize the Polio Transition Business Case as well as to develop standardized protocol for conducting SIAs at the national level. Development of a communication strategy to identify key segmented audiences and stakeholders for potential engagement is a key next step. CGPP Nigeria will continue with government partners to roll out the Community Health Influencers, Promoters and Services (CHIPS).



COUNTRY REPORT:

Horn of Africa *(Kenya and Somalia)*

Due to the emergence and spread of circulating vaccine-derived polio virus type 2 (cVDPV2) in adjoining Ethiopia and Somalia, CGPP Horn of Africa (Kenya and Somalia) supported numerous campaigns and outreach responses to contain circulating flareups, raise immunization coverage levels and increase surveillance efforts for resource-poor mobile border populations. At the regional level, these intensive coordinated efforts reached more than 1.6 million children with polio vaccination and 1.3 million people with social mobilization activities. These populations are challenged by communal clashes and insurgent attacks, and they are chronically deprived of access to strong health services.

The CGPP works with a network of Community Mobilizers (CMs) that supports structured community-based health volunteers (CHVs) along the migration pathways of Kenya, Somalia, Ethiopia, and South Sudan. In FY19, CORE Group Kenya and Somalia trained more than 1,200 community volunteers to provide outreach services through 117 health facilities located in both countries.

Beginning in April 2019, CGPP Kenya expanded its polio portfolio by integrating the Global Health Security Agenda (GHSA) and retrained its workforce to include community-based surveillance of disease threats beyond polio, including priority zoonotic diseases, in the six high-risk Kenyan counties. This will bridge global health security efforts with the final stages of polio eradication by building on existing partnerships and use of the trained polio workforce to help prevent, detect, and respond to new infectious disease threats, especially at the community level.

In FY19, the Project began implementing the time-tested Care Group Model of behavior change education on a small scale in Kenya and Somalia. The approach involves organizing neighborhood mothers' groups facilitated by "lead mothers," who share key family health education modules with pregnant women and mothers of children under five. Through this cascading peer-to-peer education approach, new mothers who are mentored by the lead mothers, continue sharing new knowledge with other women.



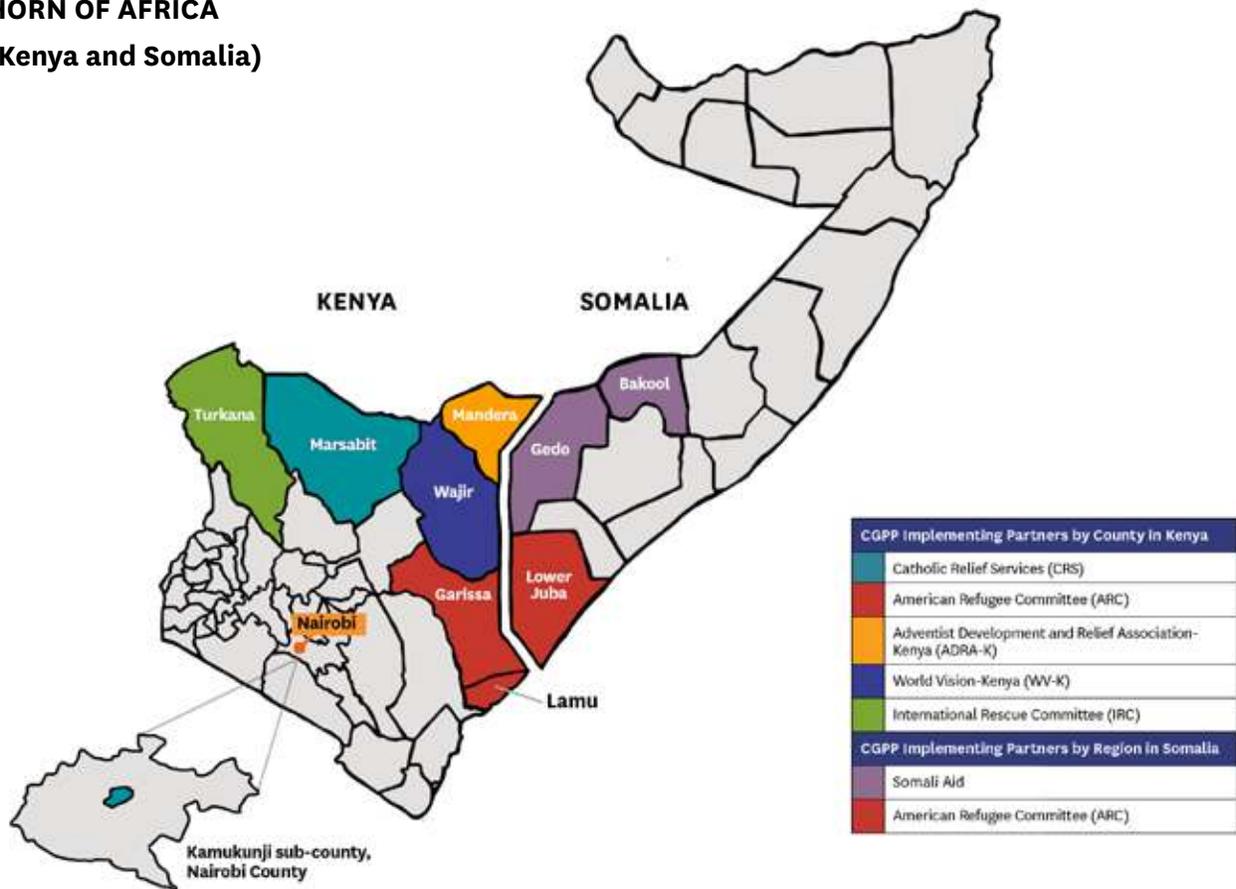
CGPP volunteers navigate a flooded area in Kenya's Wajir County to deliver vaccines.



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

The CORE Group HOA team supports a total of 117 health facilities: 90 health facilities in Kenya’s six border counties plus Nairobi County and 27 health facilities in Somalia’s three regions bordering Kenya and Ethiopia. The Project implements services through five international NGOs: American Refugee Committee (ARC), International Rescue Committee (IRC), Catholic Relief Services (CRS), World Vision-Kenya (WV-K), Adventist Development and Relief Agency-Kenya (ADRA-K) and Somali Aid, a local organization (Figure 1.)

Figure 1.
HORN OF AFRICA
(Kenya and Somalia)





Kenya

The CGPP supports six border counties in Kenya - Garissa, Lamu, Wajir, Mandera, Marsabit and Turkana, and Kamukunji sub-county in Nairobi County, which is home to populations of Somali and Ethiopian refugees. In all, 99 CMs and 942 CHVs support 90 health facilities. In FY19, CGPP HOA in Kenya:

- participated in 29 coordination meetings at national levels such as bi-weekly partners meetings, tripartite meetings, and the 2019 USAID Annual Kenya Family Health Symposium in Nakuru
- held 13 community sensitization forums on community-based polio and zoonotic disease surveillance forums in Mandera, Turkana, Garissa, Lamu, Marsabit, and Kamukunji
- participated in four USAID coordination meetings including CG-GHSA forums.
- conducted the CGPP Kenya and Somalia annual project review and planning workshop



Senator Harold Kipchumba, a polio survivor and Kenyan National Polio Ambassador, administers Oral Polio Vaccine during the launch of the bOPV campaign from July 13-17, 2019 in Mombasa, Kenya.

Somalia

With 20 CMs and 153 CHVs, the CGPP supports nine border districts, up from six last year, in Lower Juba, Gedo and Bakool regions through 27 health facilities – 10 more facilities over FY18. The Project promotes coordination among key stakeholders, immunization, and surveillance in high-risk, hard-to-reach border populations in a total of 186 villages, or 38 additional villages compared to the last reporting period. Specifically, CGPP HOA in Somalia:



- supported and participated in monthly health and polio sub-cluster coordination meetings in Dollow (Gedo) and Afmadow (Dhobley in Lower Juba region) districts
- held seven coordination meetings with the MOH Jubaland state of Somalia, FMOH-Somalia and WHO field colleagues on AFP surveillance and immunization services and attended two national ICC meetings
- conducted five joint supervisory meetings and monthly cross-border meetings with WHO, MOH, and NGO partners in Dollow (Gedo) and Dhobley (Lower Juba region)



A Care Group meets in the Belet Hawa district in Somalia.

Global Health Security Agenda (GHSA) in Kenya

Between April and September 2019, CGPP-GHSA teams trained and re-oriented polio partners to prepare for an expanded scope: from vaccine-preventable diseases to One Health. Partners were asked to include priority zoonotic diseases (rabies, brucellosis, trypanosomiasis, rift valley fever, and anthrax), as well as unusual health events into their community-based surveillance, outreach and education, and preparedness activities.

Specific actions included:

- CGPP-GHSA identified 19 One Health focal persons at the county level and supported the focal persons to re-energize One Health Committees for local-level ownership and sustainability in Marsabit, Mandera, Garissa and Turkana.
- Training materials and digital reporting tools were overhauled to include priority zoonotic diseases and unusual health events. This significant undertaking required extensive consultation from government as well as other GHSA implementing partners.



- Over 130 participants completed the Training-of-trainers program on One Health community-based surveillance in all six counties. Participants included human and animal health professionals from government as well as partners’ staff. These trainers will go on to train 1,730 community mobilizers, community-health volunteers, and animal health assistants by March 2020.
- The Secretariat provides technical support to the Zoonotic Disease Unit and participates in multisectoral meetings addressing cross-border animal health, as well as events-based surveillance, so that the experiences and insight gained from partner implementation can be translated back to the national level and used to strengthen health security planning and programming.

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

CGPP HOA trained CMs to support the national cadre of Community Health Volunteers (CHVs) in Kenya and Somalia. CHVs are selected by their communities and live in the areas where they work. They deliver a variety of health education messages and make linkages to health facilities. CHVs collect information and data on health that is reported to health facilities and is included in the sub-county, county, and national health information systems. CGPP CMs work closely with the CHVs and provide health education, conduct AFP surveillance, and mobilize communities to vaccinate their children. CMs and CHVs report to a Community Health Assistant (CHA), a health worker based at the health facility to which they are linked.

Kenya

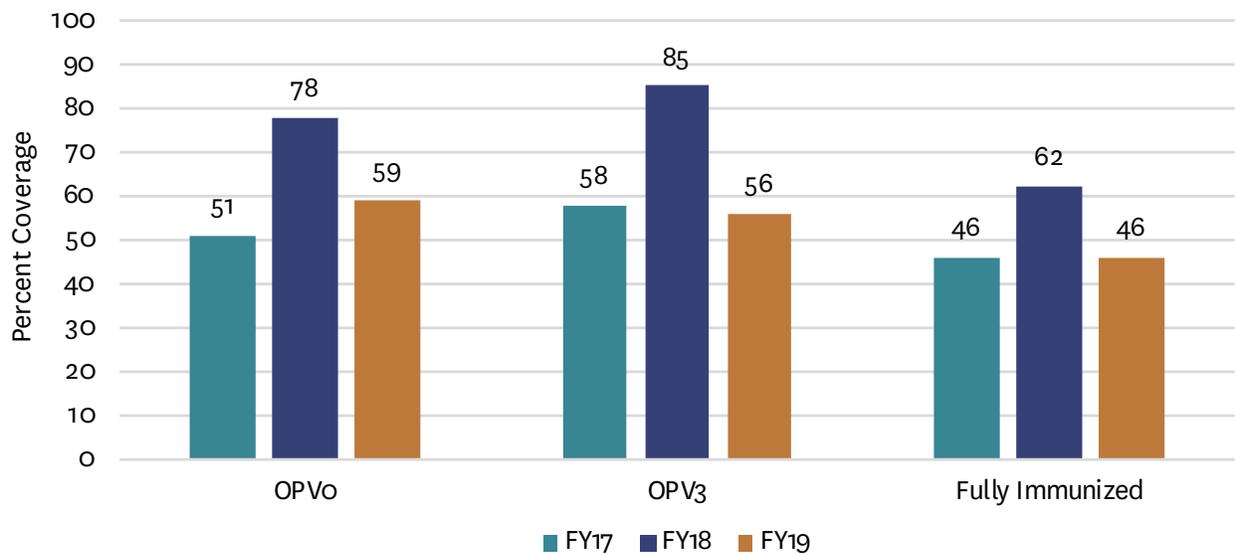
The project supported 90 border health facilities to conduct 1,456 outreach clinics for hard-to-reach and nomadic settlements along Kenya’s borders. During these outreach activities, 30,274 children were vaccinated, and immunization defaulter tracing was conducted for 7,668 under-five children. Volunteers covered 85,947 households with 515,684 people including 95,401 children under five. The project’s 99 community mobilizers (85% male) and 942 CHVs reached (Table 1) a total of 488,215 people with social mobilization and polio messages. Community mobilizers held 1,027 one-on-one meetings and 130 group meetings with community leaders, community members, and caregivers in project areas between June and September 2019. To further ensure vaccine quality

Table 1. Location of CGPP Community Mobilizers in Kenya

County	Male	Female	Total
Turkana	18	1	19
Marsabit	13	5	18
Wajir	15	1	16
Mandera	22	0	22
Lamu	4	2	6
Garissa	11	1	12
Kamukunji	1	5	6
Total	84	15	99



Figure 2. Immunization Coverage in Children Under 1 in CGPP Focal Areas of Kenya



and availability, CGPP supported cold chain equipment maintenance by county and sub-county MOH teams in Turkana, Marsabit, Lamu, and Garissa.

Routine Immunization coverage rates in project areas appear to have declined across indicators from FY18 rates. Data show OPV3 and OPVo coverage dropped from 85% to 56% and 78% to 59%, respectively; the percentage of fully vaccinated children under one also declined from 62% to 46%. While flooding, insecurity, vaccine stockouts, strikes by nurses in some counties and large nomadic migrations due to the mid-year drought could be contributors to small declines in coverage, it should be noted that the FY18 administrative data had quality issues stemming from denominator calculations and other factors. The data is likely unreliable due to the sharp uptick in FY18 and sharp decline in FY19. The FY19 data is on par with the FY17 data, showing a small increase in the percentage of children with OPVo, small declines in the percentage of children under one with OPV3 and the same percentage of immunized children under one (Figure 2). The percentage of zero dose children under one was 1% in FY19.

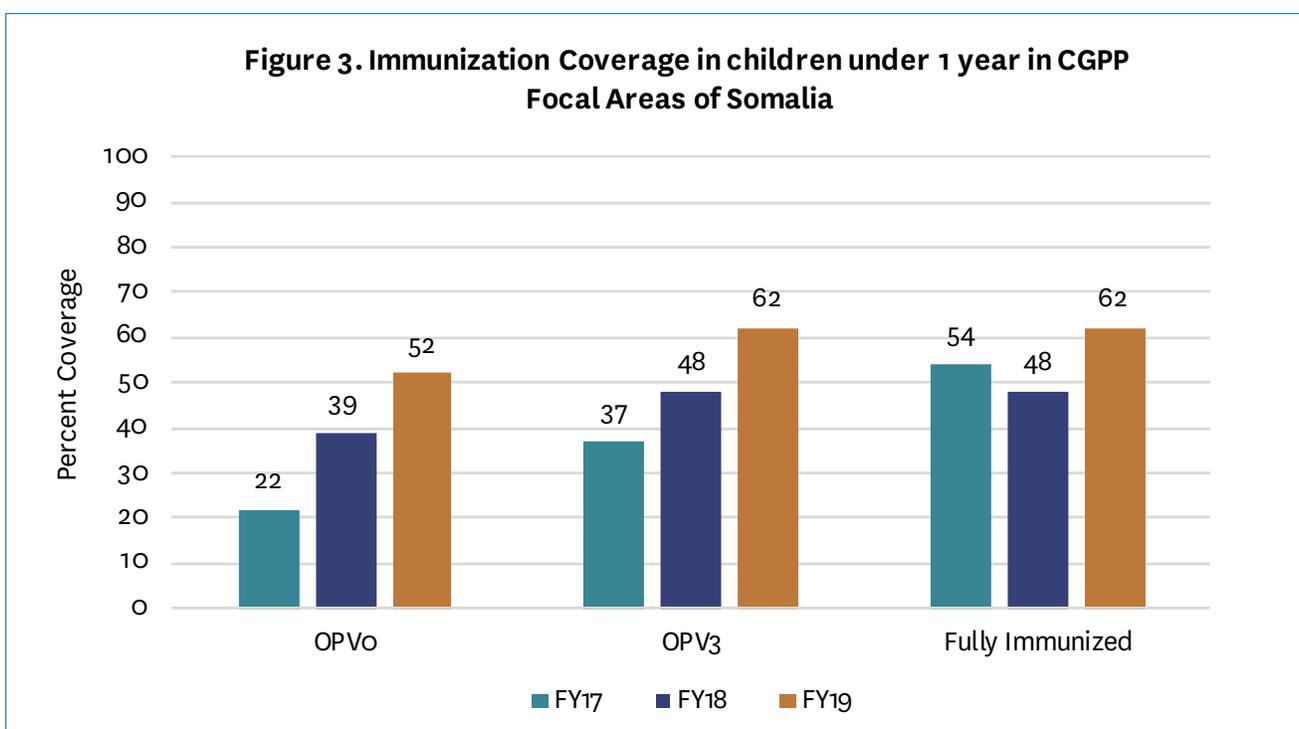
Somalia

CGPP Somalia's 20 CMs and 153 CHVs supported 27 border health facilities in Gedo, Bakool, and Lower Juba regions. They conducted 902 integrated outreach sessions in hard-to-reach nomadic communities, vaccinating 19,765 children under five. The CMs/CHVs also led 174 group meetings on Advocacy, Communication and Social Mobilization (ACSM,) held 41 community dialogue forums, and conducted



defaulter tracing for routine immunization, identifying 612 defaulters. CMs/CHVs visited 91,141 households, reaching 873,170 individuals with immunization and AFP surveillance messages.

Steady progress was made in routine immunization coverage in CGPP project areas of Somalia. Compared to last year, the percentage of children under one with OPV3 and OPVo made notable gains to 62% (from 48%) and 52% (from 39%); the percentage of children under one who are fully immunized grew from 48% in FY19 to 62% (Figure 3). The percentage of never-vaccinated or zero-dose children is 2%.



Cross-Border Health Initiative

In collaboration with the WHO HOA coordination office, CGPP Kenya and Somalia conducted mapping of border settlements, points of interest, and Internally Displaced Persons (IDP) camps within 15 kilometres of the Kenya/Somalia and Kenya/Ethiopia borders. The mapping informed planning for both routine immunization outreach and synchronization of SIAs. As a result, 35,885 children were vaccinated at nomadic and border crossing points during the October and July SIAs.

CGPP HOA participated in three international Cross-Border Health Coordination Forums. The CGPP conducted the first forum, The Kenya-Uganda-South Sudan-Ethiopia Cross-Border Health Coordination Meeting, for 73 participants from the MOH (Veterinary officials), WHO, UNICEF, and NGOs from the Ateker Region (Turkana



and Marsabit Counties in Kenya, Kapoeta County in South Sudan, Moroto District in Uganda and South Omo zone in Ethiopia) to discuss human and animal disease surveillance and immunization. The Turkana Cross-Border Coordination Meeting, dubbed “One People, One Health, One Future,” focused on topics related to the coordination of immunization services, disease surveillance, animal health, and trade and peace. The Joint Cross-Border Coordination Meeting in Hargeisa, Somalia convened to discuss the cVDPV2 outbreak in northern Somalia and the Somali region of Ethiopia. The main theme was strengthening community-based AFP surveillance especially in pastoralists and transboundary communities. The third Joint Cross-Border Coordination Meeting was organized by CGPP Ethiopia and the WHO HOA office. CGPP Kenya and Somalia provided technical leadership and co-chaired the workshop, which discussed synchronized polio campaigns between Ethiopia and Somalia.

In addition, CGPP Project areas in Kenya and Somalia held regular meetings of local cross-border health committees. In Kenya, there are six functional cross-border health committees, one in each CGPP focal county (plus Kamukunji). Each committee meets at least once per quarter and is comprised of seven to ten members including the County Health Director/Regional Medical Officer, County/Regional disease surveillance officers, EPI Manger, data managers, WHO representatives, and a sub-County/District MoH official. CGPP staff attended 24 cross-border health committee meetings during FY19. These meetings focused on ensuring that all children, particularly those in nomadic and pastoralist communities, were reached with vaccinations. In Somalia, there were two cross-border committees that met regularly in project areas during FY19. These committees held 12 meetings during the year; CGPP, WHO, international and local NGOs, and the MoH participated in these meetings. There were 271 functional special vaccination posts and 25 functional border and transit posts in CGPP Somalia project areas.

A history of successful outcomes of past cross-border meetings were explored in a peer-reviewed article, [*Preventing Importation of Poliovirus in the Horn of Africa: The Success of the Cross-Border Health Initiative in Kenya and Somalia*](#). The paper was featured in a special supplement of the American Journal of Tropical Medicine and Hygiene in October 2019.

Training in HOA

The CGPP HOA conducted nine trainings for 741 people (415 CMs/CHVs and 326 health workers) on surveillance, social mobilization, the Care Group Model, immunization, and microplanning. The CGPP provided four trainings related to surveillance for AFP and other diseases. The CGPP provided training on AFP surveillance, defaulter tracing and social mobilization through a refresher training in Kamukunji for 315 CMs/CHVs in Kenya and trained 15 healthcare staff on AFP surveillance through a separate training in Gedo region (Somali Aid). The CGPP provided integrated disease surveillance and RI microplanning training for 30 health care managers in the Jubaland State MoH (Somalia). In Marsabit and Wajir counties, CGPP conducted a training on microplanning for RI with 86 health care workers.



The Care Group Model was introduced in Kenya and Somalia during the second half of the reporting period. The CGPP oriented 62 health workers and 75 CMs/CHVs in Somalia and 25 lead mothers in Nairobi (Kamukunji).

CGPP India BCC Advisor Rina Dey trained 19 CGPP partner and Secretariat staff on BCC. A separate follow-up training was conducted by UNICEF for 16 partner staff.

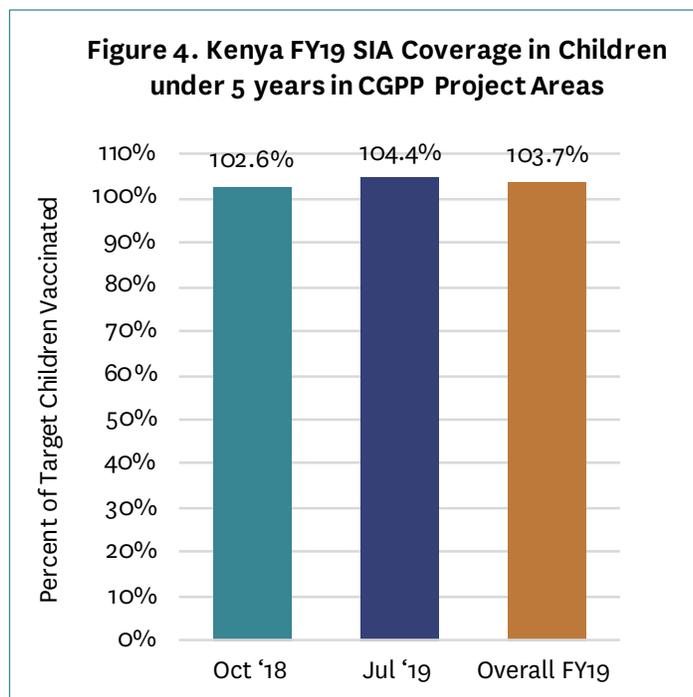
3 Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunization

CGPP HOA supported six polio SIAs in the border areas of Kenya and Somalia to facilitate the vaccination of 1,612,815 children during FY19. Additionally, the Project reached 1,361,385 people in Kenya and Somalia with AFP surveillance and immunization health messages.

Kenya

The CGPP provided technical and logistical support in six high-risk counties plus project areas of Nairobi during the October 2018 and July 2019 bOPV SIA campaigns. The CGPP supported 62 special vaccination teams for border and nomadic communities. Overall, 1,189,310 doses of OPV were administered to children under five, 42,640 above the target. The two campaigns together reached 103.7% of the targeted under-5 children (Figure 4). On average, 1% of houses and 3% of children under five were missed during both campaigns.

In Wajir, CGPP partners provided support for a measles campaign from March 16-23 for children aged 6-59 months. This campaign vaccinated 99,011 children under five years, or 104% of the targeted 94,759 children.

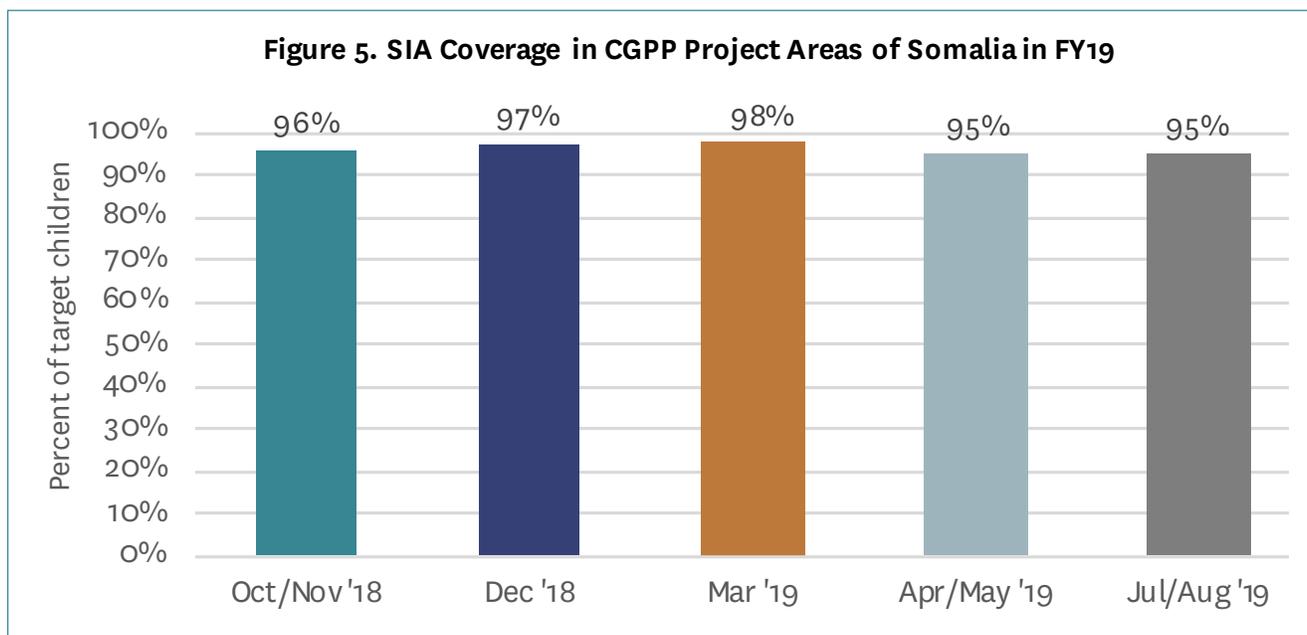


CGPP HOA conducted Independent Campaign Monitoring (ICM) of the October 2018 campaign to determine 97% coverage.



Somalia

The CGPP, in collaboration with the MOH, WHO, and other partners, provided technical and logistical support for five polio SIAs in the project areas of Lower Juba, Gedo, and Bakool regions. Cumulatively, the campaigns reached 484,038 under-five children, or 96.2% (ranging from 95-98%) of the target (Figure 5). On average, 2% of houses and 3% of children were missed.



The CGPP supported 18 extra teams during the polio campaigns, focusing on mobile and hard-to-reach populations. As a result, 11,483 children were vaccinated at major crossing points and other hard-to-reach areas. Social mobilization activities reached 34,926 households and 244,482 people with polio-related messages; 27 CMs worked in border areas or along transit routes.

The CGPP HOA project team participated in 23 SIA review and planning meetings with WHO Regional Polio Officers, District Medical Officers and other key health partners to ensure the strength and reach of the polio campaigns.



4

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

Kenya

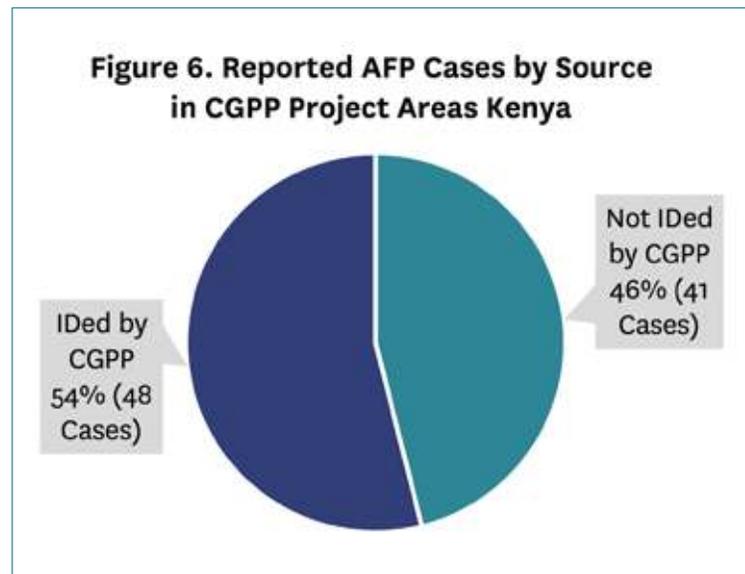
The surveillance indicators in CGPP project areas remain strong. The Non-Polio AFP rate (NPAFPR) overall in Kenya was 2.65 per 100,000 children under 15 years. Six of seven project focal counties had AFP rates higher than the national average, ranging from 3.8 in Turkana to 8.3 in Marsabit. Lamu East dropped below the national average with an AFP rate of 2.4 per 100,000 children under 15 years.

A total of 89 AFP cases were reported from CGPP project areas in Kenya; of these, 48 AFP cases (54%) were reported by CGPP CMs/CHVs (Figure 6). Of the 89 cases, 70 (79%) were reported from nomadic communities. High stool adequacy was maintained at 95%. Most cases were identified among mobile and hard-to-reach populations. This is a testament to the strong networks of communication and disease surveillance within nomadic communities.

The CGPP supported meetings, workshops, and facility-based data review meetings to improve surveillance in project areas. The project procured and supplied 1,345 IEC materials to border health facilities. To strengthen the community-based surveillance system, CGPP CMs/CHVs conducted active case search during social mobilization activities, reaching 12,116 households. Additionally, 93 traditional healers were briefed on AFP surveillance.

Somalia

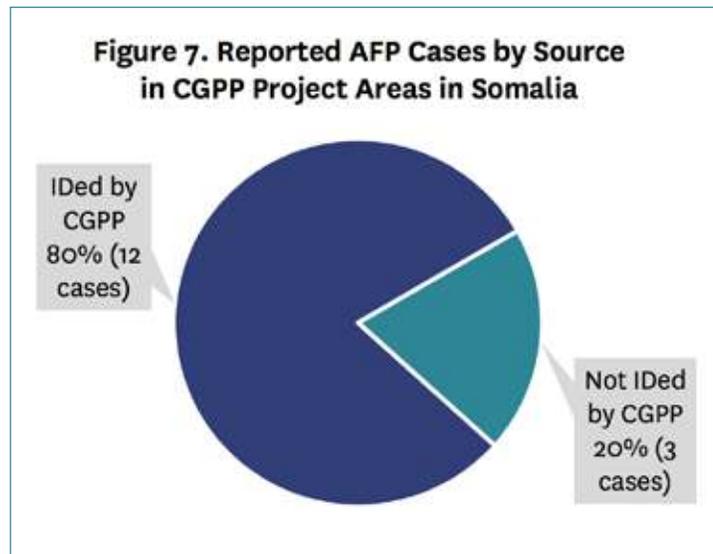
Surveillance indicators also remain high in project areas of Somalia. The overall NPAFPR in Somalia was 5.5 per 100,000 children under 15 years. By contrast, AFP rates in CGPP project areas were higher – 5.8 in Gedo, 8.1 in Lower Juba, and 6.4 in Bakool (per the WHO report for week 49). A total of 15 AFP cases were reported in CGPP project areas in Somalia, of which 12 AFP cases (80%) were reported by CGPP CMs/CHVs (Figure 7) and all originated from nomadic communities. The stool adequacy rate remained high at 97%.





There were two silent project areas.

CGPP participated in 138 meetings, workshops and reviews of facility records on AFP surveillance. The team supported 64 community dialogue sessions with religious leaders, village chiefs, elders, traditional birth attendants and traditional healers.



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

The CGPP HOA made 32 presentations at numerous regional and international forums, including the 18th HOA TAG, the ARCCC, and Outbreak Response Assessment (OBRA) meetings to highlight the Cross-Border Health Initiative. CGPP teams from Kenya, Somalia, Ethiopia and South Sudan participated in the WHO Data



Residents of Mandera County participate in a community dialogue meeting.



Management and GIS Workshop in Nairobi. In Kenya, CGPP officers and regional and county MOH officials conducted 17 joint supervisory meetings; the Secretariat conducted joint support supervision of all ARC-implemented project sites along the border of Garissa County in Kenya and Lower Juba in Somalia. Led by county disease surveillance officers and EPI managers, partners in Somalia conducted seven joint MOH and CGPP quarterly supervisory visits for strengthening disease surveillance and RI activities.

Project field staff in Kenya submitted weekly updates through Open Data Kit (ODK)-based reporting. In Somalia, field staff used Kobo Collect to submit weekly progress reports to the Secretariat and DHIS2 data to the regional level.

6 Support PVO/NGO participation in either a national and/or regional certification activity

In November 2018, CGPP HOA presented on the Cross-Border Health Initiative to the ARCC in November 2018. Afterwards, the Project supported a two-day workshop for the Kenya MOH and partners to review the ARCC recommendations. The Project has established a Cross-Border Health Initiative with committees meeting monthly to strengthen coordination along and across borders to better serve transboundary nomadic populations.



As part of the broader polio transition plan, the Project will continue to leverage existing partnerships and relationships, community networks and connections, and cross-border health structures for implementation of the GHSA, focusing on community-based preparedness and response to diseases of pandemic impact such as zoonotic diseases.

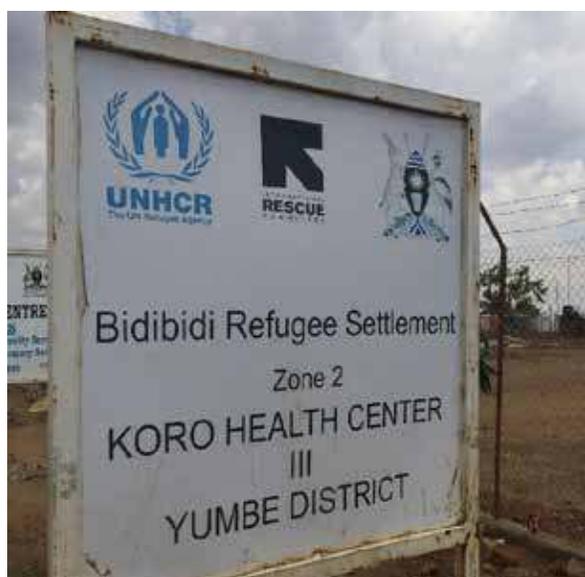
Local NGO SomaliAid implements the Care Group Model in the Gedo Region. The lead mothers will cascade the training to the 12 mothers who each represent one neighborhood group.

COUNTRY REPORT:

Uganda



In FY19, the CGPP launched community-based surveillance activities in four districts of northern Uganda to improve detection, reporting and investigation of AFP cases among refugees from South Sudan and host communities. These four districts are located near border crossing points and refugee settlements, including the Bidibidi Refugee Camp that houses a quarter million South Sudanese. In all, Uganda hosted about 850,000 South Sudanese refugees, or 59% of all refugees and asylum seekers during the reporting period. Refugees cited insecurity, lack of food and access to basic services, such as education and healthcare, as the main reasons for flight, according to the United Nations High Commissioner for Refugees (UNHCR).



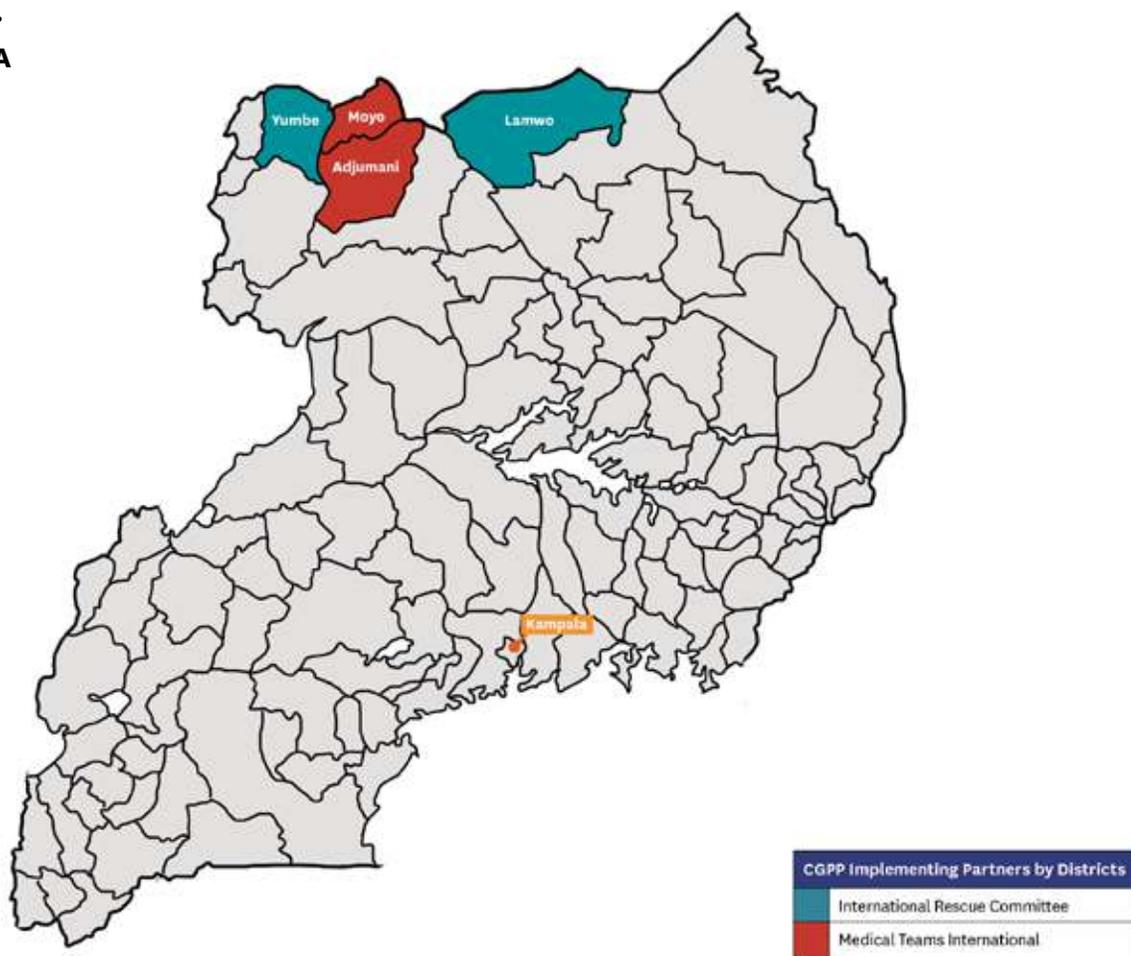
Uganda has a progressive, open-door policy for refugees, providing plots of land for housing and farming and access to multi-sectoral services. Central to government policies based on fairness and equity, resources are shared between local and refugee communities. Similarly, the new CGPP program was launched at the request of the Ugandan government to benefit the influx of refugees as well as the host communities by strengthening the Ugandan Integrated Disease Surveillance and Response (IDSR) system at the community level. This is done by establishing a Community Based Disease Surveillance (CBDS) system utilizing existing Village Health Teams (VHTs) and recruiting community leaders in refugee settlements to work as key informants (KIs); both groups look for and report on suspected cases of AFP to enhance traditional facility-based surveillance. This general approach was pioneered by CGPP Ethiopia and then later adapted by CGPP South Sudan.

Community mobilizers are engaged in both active and passive disease surveillance. They comprise prominent members of society, such as VHTs, community leaders, religious leaders, market vendors, barbers and opinion leaders. VHTs act as the primary contact for village-level health needs. VHTs engage



and empower villages in broad ways, reaching the community through house-to-house visits, community dialogue, sessions of maternal and child nutrition groups or service points such as food distribution sites. They meet with mothers, adolescent girls, barbers, market vendors, religious and cultural leaders. They conduct contact tracing and provide referral and linkages to health facilities. Key informants, on the other hand, are identified to support the community-based surveillance system. Local council members, religious leaders, opinion leaders, clan leaders and elders passively look for and report on suspected cases of AFP to greatly enhance the sensitivity of traditional facility-based surveillance.

Figure 1.
UGANDA





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

In collaboration with the District Local Governments, two international NGOs implemented project activities during FY19 in four northern Uganda districts (Figure 1). Medical Teams International (MTI) reached 194,943 children under the age of 15 through surveillance in 19 settlements in Adjumani and one settlement in Moyo district. International Rescue Committee (IRC) reached 408,668 persons under 15 years of age through surveillance in Yumbe district and 64,357 children under 15 in Lamwo district. Both partners supported health facilities and referral services in and around refugee settlements. Quarterly review meetings were led by regional CGPP staff and attended by members from IRC, MTI, District Local Governments and MOH to discuss implementation progress and challenges. Both partners attended routine inter-agency coordination meetings and worked closely with other health partners for training, case investigation, review meetings, and supervision.

International Rescue Committee

To build capacity of the surveillance network, IRC trained 844 individuals during FY19. VHTs were trained to conduct effective polio-related health education sessions and defaulter tracing. In Yumbe, IRC conducted two trainings for 224 VHTs on community-based AFP surveillance and campaign activities for NIDs and SNIDs; 334 VHTs participated in the same training in Lamwo. A separate training for health workers on community-based surveillance, detection of vaccine-preventable diseases, and reporting reached 144 health workers in Yumbe and 42 health workers in Lamwo. WHO, in collaboration with the MOH and the Lamwo District Local Government, conducted a joint CBDS refresher training for 300 VHTs. IRC conducted monthly mentoring of health workers at 17 health facilities in Lamwo. IRC identified, recruited, and trained 100 key informants, including local council members, religious leaders, opinion leaders, clan leaders, women leaders and elders.

In the Bidibidi settlement located in Yumbe, 1,705 VHTs and 11 Health Assistants conducted social mobilization through home visits, reaching 197,207 people in 88,078 households. The Health Assistants and Project Officer conducted 354 sessions with key polio and AFP messages at community meetings, dialogues, outreach services, and food distribution, nutrition and immunization service points. To strengthen active surveillance through IDSR, health workers at transit centers and the Lokung collection center screened newly arriving refugees for malnutrition, tuberculosis and HIV and traced defaulters by providing polio vaccine to catch up on missed doses. Defaulter tracing was carried out by VHTs during routine household visits in their communities/villages, resulting in 3,600 defaulters traced during this project period.



Medical Teams International

Alongside two NGOs - Alliance Forum for Development and Plan International – MTI trained and facilitated 592 VHTs to conduct surveillance and health promotion activities, reaching 408,785 people with social mobilization messages. With support from UNHCR, 476 VHTs and 48 KIs in Adjumani and Moyo and nearby host villages were equipped with kits containing a bicycle, raincoat, umbrella, back bag, torches, gumboots and reporting tools. MTI supported the District Health Office to conduct weekly EPI outreaches in hard to reach areas and provided support for child health days in October 2018 and April 2019, and three multi-antigen catch-up campaigns. Additionally, MTI supported cold chain management systems, supportive supervision visits, vaccine fridge maintenance and transportation and redistribution of vaccine antigens to all health posts and outreach points.



The Public Health Officer in Moyo's Palorinya Settlement meets with community mobilizers.

At the field level, MTI trained 532 VHTs (325 male, 206 female) on community-based disease surveillance. MTI also conducted four VHT quarterly review and performance review meetings in 48 health facilities in Adjumani and 40 health facilities in in Moyo. In all, MTI held 544 monthly meetings with religious leaders, community volunteers, VHTs and mothers to address integrated CBDS and event reporting, success and challenges in active search for AFP cases, integrated community outreaches in EPI, defaulter tracking and nutrition activities in the communities. In collaboration with the District Diseases Surveillance Department, nine radio talk shows were broadcast to 500,000 potential listeners with polio surveillance and immunization messages.



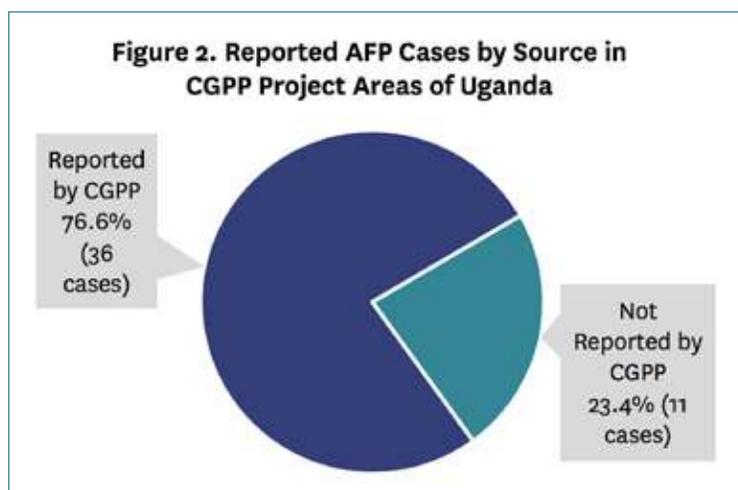
② Support PVO/NGO efforts to strengthen acute flaccid paralysis case detection (and reporting and detection of other infectious diseases)

The combination of CBDS and IDSR has strengthened district surveillance systems by increasing the numbers of active case searches, defaulter tracing, and health education sessions during routine household visits in the CGPP focal districts. In all, 2,331 VHTs and 148 KIs reached 605,992 people with social mobilization messages and 703,439 children under 15 through surveillance; 85% of all VHTs are men.

The Project structure calls for CGPP-trained VHTs and KIs to conduct case surveillance within the implementation area and report any identified cases to local health facilities. The AFP rate in CGPP focal areas in northern Uganda was 6.68 per 100,000 children under 15 years. Mobilizers reported 36 of the 47 cases (76.6%) in the Project catchment areas; 23.4% (11/47) were identified among refugees populations (Figure 2). All Non-Polio AFP (NPAFP) cases were reported within 7 days of paralysis. In Lamwo, the CGPP transported all stool samples of eight suspected NPAFP cases to the Uganda Viral Research Institute (UVRI); results were negative, but three cases of rubella were confirmed.

CGPP partners focused building a strong network of key informants, sensitizing communities to signs and symptoms of AFP and conducting AFP surveillance, and providing strong supportive supervision,

mentorship and review meetings to strengthen the capacity of VHTs, health workers, and health facilities. VHTs used their planned house to house visits as an access points for active case search. They provided communities with messaging on AFP surveillance and immunization during regular health education sessions conducted during community meetings and during market days. In FY19, they reached 605,992 people with social mobilization activities and messages related to AFP surveillance and immunizations.



Cross-border Collaboration

Two regional cross-border meetings were held in June and September 2019 in Gulu and Elegu border areas to discuss the integrated surveillance in Uganda and in South Sudan. Representatives from five districts (Moyo, Adjumani, Gulu, Amuru and Nwoya) strategized with South Sudan's Ministry of Health to implement and



strengthen district and regional surveillance systems to detect cases of AFP and other reportable diseases. No collaborative cross-border activities towards polio eradication were conducted in Yumbe or Lamwo.

Training, Supervision, and Mentorship

CGPP facilitated 17 training sessions for 1,376 participants: 1,190 VHTs, and 186 health workers and health facility personnel. Training topics included integrated community-based surveillance, vaccine-preventable diseases, case reporting, cold chain and vaccine storage. IRC conducted three trainings in Yumbe - two for VHTs on AFP surveillance and NID/SNID activities, and one community-based disease surveillance workshop for health facility staff. MTI held three trainings - two on integrated community-based disease surveillance and event reporting in Moyo and Adjumani, and one refresher training for VHTs in Moyo. These trainings were designed to act as a framework for improving the community and facility-based surveillance systems in program areas.

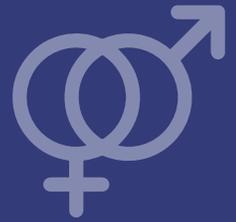
Additionally, CGPP provided mentorship of health workers to improve knowledge on immunizations, vaccine preventable diseases, case detection and reporting, and vaccination. VHTs and community leaders held monthly meetings in their respective villages with public health officers and health facility in-charges to review performance and conduct refresher training on case definitions, identification, and referral protocols. CGPP partners facilitated district-led quarterly support supervision of health centers. Cold chain monitoring, on-the-job mentorship, and development of health facility microplans to ensure timely vaccination of children were among the focus areas during these support supervision visits.

CGPP partners conducted 151 review meetings to ensure strong surveillance, reporting and case identification. IRC conducted 63 review meetings with VHTs, health and laboratory workers, and health facility staff. MTI conducted quarterly review meetings in 88 health facilities with VHTs and health personnel. Review meetings with health workers provided a space to share achievements and challenges. Monthly facility surveillance team review meetings included clinicians, data clerk, laboratory workers, and health assistants.

Challenges and Future Focus

The CGPP retains a small footprint in Uganda, operating with a small budget and without an in-country Secretariat. MTI and IRC have made demonstrable progress given these constraints. Challenges consist of low community awareness on AFP, a lack of IEC materials for AFP surveillance activities, a frequently non-functional cold chain, and inadequate logistical support (predominately motorcycle and fuel availability). These factors impede VHT motivation and ability to carry out active case search and mobilization. There is a need in the new year for additional VHTs, KIs and health workers, and for more training on IDSR to support surveillance activities.

Gender Analysis



Gender norms and dynamics affect power, decision making, control of resources, and access to health care in the locations where the CGPP operates. While women are primarily responsible for childcare and rearing, they often do not have access to family resources or have the power to make decisions about health-seeking behaviors. Instead, male heads of households typically hold the power to allocate resources for healthcare and other services, and they make decisions that impact the family. This paradigm often leads to mothers who hold information yet lack power to make health decisions for their children, and fathers who make decisions without adequate knowledge or understanding. Additionally, interactions with the opposite gender and movement through the community are often dictated by gendered cultural and religious norms. This power and knowledge imbalance, in addition to other gender-related access issues, have traditionally created challenges for polio immunization programs, including the CGPP.

Vaccination coverage remains comparable among girls and boys in CGPP program areas. However, gender norms related to roles, behavioral expectations, and decision making do impact vaccination access and program implementation. The CGPP endeavors to empower women to be leaders and decision makers in their families and communities and to promote equity in access to polio immunization.

Female Empowerment and Linkages

During FY19, the CGPP engaged its predominately female volunteer network to reach and empower community women with education on immunization, health, and positive behavior change. Women were engaged through mother's groups and one-on-one contacts, which provided a safe and supportive space to impart information and address questions and concerns. Community volunteers also provided linkages to immunization, health care, nutrition, and other services within the community, both creating demand for immunization and health services and removing barriers.

The impact of empowerment extends beyond beneficiaries to directly benefit community volunteers themselves. While most volunteers do not get paid, the CGPP provides small stipends (in some countries) and incentives such as branded clothing, umbrellas, bags, and other useful items. The benefits of their role greatly supersede these tangible items, however. Most women in CGPP communities do not have the opportunity to engage in work outside of the home. Community Volunteers, however, carry out important functions outside of their household duties. Female community volunteers, who are selected by their communities, report gains in confidence, community respect and recognition, as well as having a broader life purpose. Volunteers gain new skills and capacities through training opportunities and supportive supervision.

Examples from the field:

- In Kenya and Somalia, the CGPP piloted the Care Group model of behavior change education. The model aims to empower women in focal communities with knowledge, peer support, and concrete skills to improve decision making related to the health of their children. The CGPP trained “lead mothers” to deliver bi-weekly modules on immunization and child health to their neighbor groups, comprised

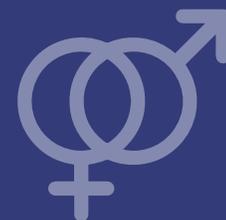


of pregnant women and mothers with children under 5 years. The mothers support each other on decisions related to breastfeeding, child rearing, immunization, and women's health.

- In Ethiopia, CGPP leveraged the relationships of CVs/HDALs with mothers to provide defaulter tracking and referrals. CVs/HDALs provided information about antenatal (ANC) care, immunization, and child health and linked mothers to services. In FY19, volunteers in Ethiopia referred 74,133 pregnant women for ANC follow-up and vaccination.
- In South Sudan, CGPP involved traditional birth attendants and female leaders in the community-based disease surveillance system as key informants. These women had frequent contact with women and children in the community.
- In India, CGPP engaged mothers through various interactive communication tools during IPC sessions and group meetings. Tools included behavioral charts, games and printed communication materials.



Lead mothers in the Belet Hawa, Gedo Region, in Somalia attend a training session on the Care Group model.



Male Engagement and Support

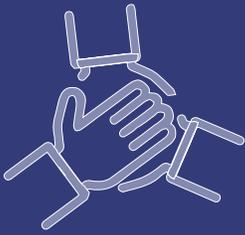
Women often lack power to control decisions about their own health, such as birth spacing, antenatal care, labor, delivery, and newborn care. The CGPP engages men in focal communities to build understanding through couple's communication and to educate men about issues impacting women and children. Ultimately, these interventions are designed to engage men to help with the empowerment of women. This is done through male peer educators, men's/fathers' groups, and the engagement of male religious and traditional leaders.

Examples from the field:

- In Nigeria, the CGPP piloted a new male peer educator intervention in two LGAs in Yobe. CGPP identified and selected men from the community who were viewed as role models to serve as peer educators. They received training on the benefits of immunization, couple's decision making, and positive health seeking behaviors and transmitted up these lessons to other men in their communities during scheduled visits and through other venues. Peer educators encouraged men to discuss immunization with their wives, and to present their children for immunization. Due to its success, the Kaduna State Government adapted this initiative for use in other state health projects.
- In India, the CGPP continued to build upon the barber shop initiative, which was first implemented two years ago. Barber shops have been identified as spaces where men gather and share information. In FY19, this "safe space" was leveraged to reach men with immunization education through barbers, who received training by the CGPP on health education.
- In Kenya and Somalia, the CGPP conducted training of religious and traditional leaders among the nomadic pastoralist communities and in peri-urban settlements to provide positive health education to counter rumors related to vaccination, particularly during health dialogue days and religious sermons.



The men of the Sunomari settlement (Bulatara ward) in Nigeria's Yobe state convene for a community dialogue.



The CGPP Global Secretariat

The virtual U.S.-based global Secretariat, also referred to as headquarters, is hosted by two international NGOs – Catholic Relief Services (CRS) and World Vision (WV) – as well as the CORE Group, which is an association of more than 100 NGOs and a sub-grantee of the CGPP. WV supports the position of Director and provides administrative, financial, and grants and contracts compliance. CRS supports three positions: Deputy Director and Technical Lead as well as the Technical Advisors for Monitoring and Evaluation and Communications. The Senior Advisor for Global Health Security is hosted by the CORE Group.

The Global Secretariat Technical Assistance Team:

Frank Conlon, Director (WV)

Lee Losey, Deputy Director and Technical Lead (CRS)

Dr. Sarah Paige, Senior Advisor, GHS (CORE Group)

Dr. Kathy Stamidis, Technical Advisor, Monitoring and Evaluation (CRS)

Lydia Bologna, Technical Advisor, Communications (CRS)

Elsa Berhane, Program Manager, Health, Program Quality and Impact (WV)

Judy Ross, Senior Finance Officer (WV)

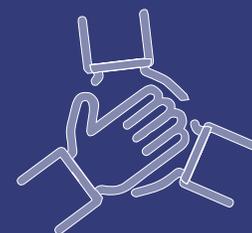
Grace Buck, Senior Grant and Contract Officer (WV)

Highlights of global/headquarter contributions and achievements

Representation – Advocating for stronger partnerships

Since 1999, the CGPP has effectively advocated for the inclusion of civil society at numerous global and regional meetings. High-level representation during FY19 included contributing to the 18th HOA TAG meeting in Nairobi; presenting at the Polio Partners Meeting in Geneva; leading a well-attended session at the CORE Group's Global Health Practitioner Conference in Bethesda, Maryland, on 'The Role of Gender and Religion in SBCC in Muslim Societies' with directors from Kenya/Somalia, India and Nigeria; participating in the GPEI Independent Monitoring Board (IMB) in London; and, attending the WHO ceremony in Geneva for the certification of the global eradication of WPV3. Additionally, CGPP global staff participated in numerous remote and in-person meetings with USAID, UNICEF and other key polio eradication partners.

The Director and the Deputy Director and Technical Lead traveled extensively to provide technical assistance to the country teams. In northern Uganda, they supported the roll out of the newest project initiative whereby community members receive training to search and report for AFP cases in refugee camps and their host communities. In Kenya and Ethiopia, they strategized with the new Senior Advisor for Global Health Security to expand the CGPP's focus to include community-based surveillance for key zoonotic diseases to strengthen Global Health Security. In South Sudan, the team re-designed surveillance activities for inclusion of Ebola Virus Disease and re-structured implementation areas to focus on the country's southern borders. In polio-free



India and soon-to-be certified polio-free Nigeria, the directors met with partners and conducted field visits to provide recommendations for continuous improvement and innovation.

Monitoring and Evaluation – Determining impact and assessing achievements

The Technical Advisor for Monitoring and Evaluation continued to develop global quarterly updates to assess all project indicators by distilling country-level data and providing narrative context. She streamlined the annual data reporting process and maintained the Project’s annual indicator data. In 2019, she directed the work of several consultants. The Technical Advisor determined key evaluation questions and managed a three-person external evaluation panel to review the life of the project from 1999 through 2019. The external evaluation included country visits, interviews with key stakeholders and program staff, and in-depth review of project documents. The evaluation was completed in late 2019. She also provided technical support to consultants for the development of an article entitled “The Critical Role of Community Volunteers in Polio Eradication in Last Mile Settings in Africa and Asia.” The article will be published in *Global Health: Science and Practice* in mid-2020.

Communications – Sharing results, ideas, best practices and lessons learned

The Project published a 14-article journal supplement in *The American Journal of Tropical Medicine and Hygiene* entitled “Impact, Innovation, and Inclusion of Civil Society Organizations in Polio Eradication: The CORE Group Polio Project Story.” The journal project was led by the Technical Advisors for Communications and Monitoring and Evaluation with external support from Senior Scientist Dr. Henry B. Perry of Johns Hopkins University with contributions from 40 authors from India, Ethiopia, Nigeria, Kenya, South Sudan, Malawi and the United States. Shortly after publication, a special launching event of the journal supplement was held at the CORE Group’s Global Health Practitioner Conference in Nairobi. At the same conference, the Technical Advisors presented a process coined SEEDPOD, a 7-step process for encouraging global health practitioners to publish in peer-reviewed journals.

With support from the CORE Group’s team of communications and knowledge management experts, the CGPP increased its visibility through the promotion of Project contributions and achievements through Voice of America, Devex, Kenyan television and other media outlets. The CORE Group also supported the re-design of the Project’s webpage, which is housed on its website.

Additionally, the Project conducted two workshops in Kenya in 2019 to build the capacity of senior and midlevel CGPP staff in communications, the Care Group Model of behavior change, writing, budgeting and monitoring and evaluation. These workshops served as an opportunity to exchange ideas and share best practices among CGPP staff from different countries.





Our Partners

GLOBAL SECRETARIAT OR HQ NGOs *since 1999*

1. World Vision (WV)
2. Catholic Relief Services (CRS)
3. CORE Group



CGPP INDIA *since 1999*

Secretariat Host – Project Concern International (PCI)

International NGOs

1. Adventist Development and Relief Agency (ADRA)
2. Project Concern International

National/Local NGOs*

1. ADRA India
2. Chetanalaya
3. Gorakhpur Environmental Action Group
4. Jan Kalyan Samiti
5. Meerut Seva Samaj
6. Sarathi Development Foundation
7. Society for All Round Development

* On June 1, 2019, local NGO People's Action for National Integration (PANI) began CGPP activities in Moradabad under PCI.



CGPP ETHIOPIA *since 2001*

Secretariat Host - The Consortium of Christian Relief and Development Associations (CCRDA)

International NGOs

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

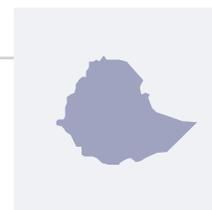




ETHIOPIA *(continued)*

National/Local NGOs

1. Ethiopian Evangelical Church Mekane Yesus
2. Ethiopian Orthodox Church
3. Organization for Welfare Development In Action (OWDA)
4. Pastoralist Concern



CGPP SOUTH SUDAN *since 2010*

Secretariat Host – World Vision

National NGOs (implementing partners during the first quarter of 2019)

1. Children Aid South Sudan (CASS)
2. Christian Mission for Development (CMD)
3. LiveWell
4. Support for Peace and Education Development Program (SPEDP)
5. Universal Network for Knowledge and Empowerment Agency (UNKEA)

In early FY19, World Vision-South Sudan and SPEDP transitioned activities to nine high-risk counties in three southern Equatoria States.



CGPP NIGERIA *since 2013*

Secretariat Host- Catholic Relief Services

International NGOs

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

National/Local NGOs

1. Archdiocesan Catholic Healthcare Initiative (DACA)
2. Community Support and Development Initiative (CSADI)
3. Family Health and Youth Empowerment (FAHYE)





NIGERIA *(continued)*

4. Federation of Muslim Women Association of Nigeria (FOMWAN)
5. Healthcare Education and Support Initiative (HESI)
6. WAKA Rural Development Initiative
7. African Healthcare Implementation and Facilitation Foundation (AHIFF)*

*AHIFF was terminated by Implementing Partner IMC in February 2019 due to finance and compliance issues.



CGPP HOA (Kenya and Somalia) *since 2014*

Secretariat Host - American Refugee Committee (ARC)

Kenya

International/National NGOs

1. Adventist Development and Relief Agency - Kenya (ADRA-K)
2. American Refugee Committee
3. Catholic Relief Services
4. International Rescue Committee
5. World Vision-Kenya (WV-K)

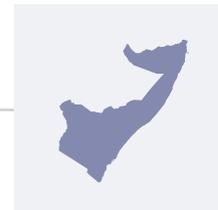
Somalia

International NGO

1. American Refugee Committee

Local NGO

1. Somali Aid



CGPP UGANDA *since 2018*

International NGOs

1. International Rescue Committee
2. Medical Teams International (MTI)



Acronyms



ADRA	Adventist Development and Relief Agency	cVDPV	Circulating vaccine-derived poliovirus
AFP	Acute Flaccid Paralysis	cVDPV2	Circulating vaccine-derived poliovirus type 2
AJTMH	American Journal of Tropical Medicine and Hygiene	cVDPV3	Circulating vaccine-derived poliovirus type 3
AMREF	Health Africa African Medical and Research Foundation	DHO	District Health Office
ANC	Antenatal Care	DMC	District Mobilization Coordinator
ANM	Auxiliary Nurse Midwife	EOC	Emergency Operation Center
APHA	American Public Health Association	EPI	Expanded Program for Immunization
ARC	American Refugee Committee	ERC	Expert Review Committee
ASHA	Accredited Social Health Activist	EVD	Ebola Virus Disease
AVW	African Vaccination Week	GAVI	The Vaccine Alliance
BCC	Behavior Change Communication	GCSP	Government Contracted Service Provider
BMC	Block Mobilization Coordinator	GHSA	Global Health Security Agenda
bOPV	Bivalent Oral Polio Vaccine	GPEI	Global Polio Eradication Initiative
CBHC	Cross-Border Health Committee	HDAL	Health Development Army Leader
CBHI	Cross-Border Health Initiative	HEW	Health Extension Worker
CBDS	Community-Based Disease Surveillance	HMIS	Health Management Information System
CBS	Community-Based Surveillance	HOA	Horn of Africa
CCRDA	Consortium of Christian Relief and Development Associations	HRG	High Risk Group
CGPP	The CORE Group Polio Project	HTR	Hard to Reach
CHIPS	Community Health Influencers Promoters and Services	IAG	Immunization Action Group
CHV	Community Health Volunteer	IBR	In Between Round
CI	Community Informant	ICC	Interagency Coordinating Committee
CM	Community Mobilizer	ICM	Independent Campaign Monitoring
CMC	Community Mobilization Coordinator	IDP	Internally Displaced Person
CRS	Catholic Relief Services	IDSR	Integrated Disease Surveillance and Response
CV	Community Volunteer	IEC	Information Education and Communication



IGAD	Inter-Governmental Authority for Development	RSS	Rubdugu Supportive Supervision
IIP	Immunization in Practice	SAGE	Strategic Advisory Group of Experts on Immunization
IMB	Independent Monitoring Board	SIA	Supplementary Immunization Activity
IMC	International Medical Corps	SMNet	Social Mobilization Network
IP	Implementing Partner	SNID	Subnational Immunization Day
IPC	Interpersonal Communication	SOP	Standard Operating Procedure
IPD	Immunization Plus Day	SPHCDA	State Primary Health Care Development Agency
IPV	Inactivated Polio Vaccine	STC	Save the Children
IRC	International Rescue Committee	SVP	Special Vaccination Post
KI	Key Informant	TAG	Technical Advisory Group
LGA	Local Government Area	tOPV	Trivalent Oral Polio Vaccine
M&E	Monitoring and Evaluation	UNHCR	United Nations High Commissioner for Refugees
MOH	Ministry of Health	UNICEF	United Nations Children's Emergency Fund
mOPV2	Monovalent Oral Poliovirus Type 2	UP	Uttar Pradesh
MTI	Medical Teams International	USAID	United States Agency for International Development
NBT	Newborn Tracking	VCM	Volunteer Community Mobilizer
NC	Non compliance	VDPV	Vaccine-Derived Polio Virus
NEOC	National Emergency Operation Centre	VHT	Village Health Team
NGO	Non-Governmental Organization	VWS	Volunteer Ward Supervisor
NID	National Immunization Day	WHO	World Health Organization
NPAFPR	Non-Polio Acute Flaccid Paralysis Rate	WPV	Wild Polio Virus
NPHCDA	National Primary Health Care Development Agency	WPV1	Wild poliovirus type 1
OBR	Out Break Response	WASH	Water, Sanitation and Hygiene
OPV	Oral Polio Vaccine	WV	World Vision
PCI	Project Concern International		
PEI	Polio Eradication Initiative		
PPG	Polio Partners Group		
RI	Routine Immunization		

