



USAID
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Highlighting activities of USAID's CORE Group Polio & Global Health Security program-Kenya & Somalia

CORE Group Polio & Global Health Security Program

EDITORIAL

The Circulating Vaccine Derived Poliovirus type 2 (cVDPV2) outbreak amidst COVID-19 pandemic in the Horn of Africa (HOA).

As cases of COVID-19 surged in Africa, health services associated with the lockdowns and fear of COVID-19 has led to enormous numbers of immunization defaulters, and zero doses, HOA countries continue to experience an alarming increase in the number of reported cVDPV2 cases. Of the 16 African countries reporting cVDPV2 in 2020, five were from the HOA region. A total of 62 cases have been reported from Somalia, Ethiopia, South Sudan, Sudan, and Djibouti so far this year. HOA is an epidemiologic belt that is at high-risk for further transmission of cVDPV2 due to high cross-border movement, low population immunity, and surveillance gaps worsened by the COVID-19 pandemic.

The COVID-19-related burden on the health system and the decreased demand for vaccination based on physical distancing requirements, community reluctance, and nation-wide lockdowns and restricted movement has resulted in low AFP case detection and missed vaccination schedules for many susceptible individuals and communities from the vulnerable and underserved communities in the HOA and the potential for the outbreak of vaccine-preventable diseases.

Kenya reported the last case of cVDPV2, an environmental isolate, in April 2018. In Somalia, a total 9 cVDPV2 cases and 24 cVDPV2 positive environmental samples have been reported so far in 2020, with the date of onset of the most recent cVDPV2 being September 29, 2020. At the regional level, GPEI and partners conducted intensive, coordinated, synchronized outbreak response campaigns in November and December 2019. However, due to the COVID-19 pandemic, there was a disruption to the planned next polio campaigns, routine immunization, and AFP surveillance. CGPP will coordinate with the respective country MOHs, WHO and UNICEF to intensify AFP surveillance, especially in high-risk areas like informal settlements, to reach undocumented immigrants and isolated communities by mapping the high-risk regions. CGPP will conduct multi-dose catch-up immunization outreach campaigns targeting hard-to-reach and border communities. The outreach services will include the provision of Vitamin A and deworming. In the meantime, the GPEI partners must restore community trust in the health facilities as a safe environment to seek immunization services.

AFRICA CELEBRATES WILD POLIOVIRUS FREE STATUS!



"Eradicating wild poliovirus from Africa is a big deal! We congratulate the countries, ,heroic polio workers, and communities who kicked polio out of Africa. Looking forward to continuing to fight all polioviruses and achieving a world that is fully Polio Free." Ellyn Ogden, USAID Worldwide Polio Eradication Coordinator

On 25 August 2020, the independent Africa Regional Certification Commission (ARCC) declared the WHO African region Wild Polio Virus-free. The last case was reported in August 2016. WHO regions, and not individual countries, can achieve WPV-free certifications if there are no cases for three consecutive years. Nigeria was the last polio-endemic country in the region. Today, Pakistan and Afghanistan are the only remaining countries reporting WPV cases. While eradicating wild poliovirus from the WHO African Region is a significant achievement, 16 countries in African are currently experiencing cVDPV2 outbreaks.

The Kick Polio Out of Africa Campaign was launched in 1996 by the late Nelson Mandela. By then, it was estimated that WPV paralyzed 75,000 children in Africa each year.

"I wish this event did take place 55 years ago. I would have lived to my full potential and maybe become the army general that I dreamt of. As a child, I missed the fun of growing up, running, playing, and attending the nearest school in my village 8 miles away. "As a teen, I was always left behind as young lads went for adventure and hikes on the beautiful hills and valleys of Baringo, my home county in Kenya. The reality is that I am lucky to have survived though with a permanent disability," Senator Sen. Kipchumba Harold, Kenya's Polio Champion, during the vote of thanks at the virtual live stream of the celebration.

With the current disruptions by COVID-19 and the social-cultural and logistic challenges in enhancing routine immunization, and the number and scale of ongoing circulating vaccine-derived polio outbreaks across Africa, many children in Africa are still at risk. "The end of wild polio in Africa is a great day," WHO Director-General Tedros Adhanom Ghebreyesus said. "But as we all know, it's not the end of polio."

There is a need to keep the momentum and commitment from the donors, the global health community, and stakeholders to strengthen routine immunization programs, enhance community engagement, improve surveillance.

CORE Group Polio Project (CGPP), in partnership with the Ministries of Health of Kenya and Somalia, WHO and UNICEF, congratulates the continent for this momentous achievement. This remarkable achievement would not have been possible without the hard work, determination, and tireless efforts of frontline health workers and community volunteers.

COVID-19 outbreak disrupts community-based AFP surveillance in Kenya.

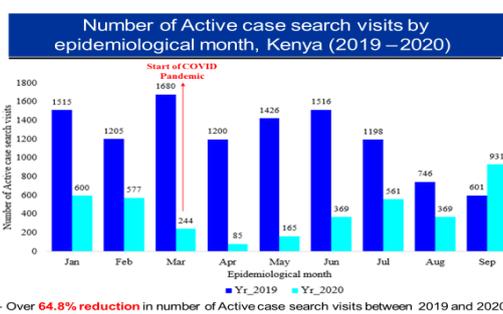
Somane Mohamed, Deputy Director CGP-GHS

Kenya has been declared wild poliovirus free and has stopped the cVDPV2 outbreak after conducting seven successful polio campaigns in the high-risk counties. Upon ending the outbreak, the Africa Regional Certification Commission (WHO-ARCC) advised the country to increase surveillance sensitivities for early detection and investigation of suspected AFP cases. In response, the national MoH moved to classify health facilities/surveillance reporting sites as either high priority, medium priority, or low priority based on several factors, e.g., the volume of the catchment population, risk status, and the likelihood of an AFP case visiting these sites, etc. With the support of partners, the disease surveillance officers held intensive active AFP case search and support supervisions at all the health facilities and reporting sites depending on the classification hierarchy. As a result, these activities improved the sensitivity of the country's surveillance system, leading to increased numbers of AFP cases and a reduction in the number of silent districts/sub-counties.

The first COVID-19 case was reported in Kenya on March 16, 2020. Due to a limited understanding on the mode of spread and prevention of the virus, there was panic in the communities and among health facility staff for fear of contracting the COVID-19 virus. Adding to this anxiety was the national government's inadequate preparation on health care staff training, health education modalities, and prepositioning of PPEs (personal protective equipment) at the counties/Sub counties. As a result, the government formed and maintains a national task force to coordinate outbreak control, which informed the lockdown (cessation movement) in the areas suspected to be hot spots in the country. The national task force provided pandemic prevention and control guidance, i.e., stopping nonessential movements, use of facemasks, physical/social distancing, suspension of large group training and meeting, and the need to work from home for non-essential workers.

The pandemic has brought all field activities to a standstill. The County government prioritized COVID-19 related activities while essential routine activities at health facilities continued, which affected community-based surveillance activities. The government instructed the counties bordering Somalia to enforce strict movement control to reduce the importation of the COVID-19 from Somalia; however, the porous border is still accessible. Community engagement activities, like large community dialogue sessions, training of community health volunteers, and school health sessions, are suspended due to social distancing but small group meeting are allowed if the team maintain 1meter physical distance in their sitting arrangements and wear face mask.

The MOH has shifted the energy to COVID-19 prevention and control, thus affecting implementation of activities at the health facilities and at the community levels, including immunization outreach sessions, training support, support supervisions/monitoring, community-based disease surveillance, active case search/social mobilizations etc



Training CHVs to improve health access to underserved communities in the Gedo region of Somalia.

Ibrahim Mohamud, Program Manager Somali-AID.

For the last two decades, protracted conflicts, political instability and weak health systems have presented considerable challenges to Somalia's health care delivery. The Gedo region shares a long, porous, and insecure border with Kenya and Ethiopia; constant attacks by insurgents, cyclical droughts, and famine have all impacted the delivery of health services to at-risk nomadic pastoralists and border communities. Health services are operated by local and International NGOs, which face daily security threats and erratic funding.

Notwithstanding the threats from non-state armed actors, such as existing inter-clan animosities, CORE Group Polio Project (CGPP) through its implementing partner Somali AID has established a robust community-based health initiative. This effort aims to improve access to immunization and other essential health services to reach vulnerable communities. As part of the initiative, Somali AID recruited and trained 135 Community Health Volunteers (CHVs) from 126 villages in the Gedo region in October 2015. Through trainings, the project has improved the capacity of these volunteers to deliver essential community health services, community-based surveillance of vaccine-preventable diseases, routine immunization, and Supplemental Immunization Activities (SIAs). CHV trainings focus primarily on reaching vulnerable community members with health education through risk and behavior change communication.



CHVs proudly display certificates of completion for training. The unpaid volunteers build up their skills to improve health outcomes for their communities

"The training has enriched our skills and enabled us to perform our duties as required. We do not do these things to get paid but rather build our skills and help the community. You can imagine what a young man can think of when idle." Abdi Muhumed, a community health volunteer during recent training in Dollow.

The unpaid CHVs are a key part of health facilities by conducting health post activities in their areas e.g., community mobilization for immunization, health promotion and assisting the health workers during outreaches. They work to disseminate health messages in the community through formal and informal meetings. Their impact is far-reaching. For example, many mothers now visit health facilities to safely deliver their babies, rather than opting to deliver at homes.

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Tracking nomadic pastoralists for vaccination in Afmadow District of Lower Juba region, Somalia.

Yussuf Abdullahi, Program Officer-CGPP/Alight (formerly Known ARC)

According to the United Nations Population Fund (UNFPA) Somalia country profile, nomadic pastoralists make up about 26% of Somalia's total population, with most nomads straddling the shared borders of Horn of African (HOA) countries. The nomadic pastoralist lifestyle, characterized by continuous movement of herders in search of greener pasture and water, is not well served by the conventional health system which relies on static health facilities in rural or urban settlements. As a highly vulnerable mobile population, they are hard-to-reach, marginalized, and underserved. Their situation is exacerbated by the inadequate health infrastructure and insecurity in Somalia.

Somalia has suffered many years of protracted conflicts, cyclic droughts, floods, and the inadequacy of government to reach many parts of the country with services. Controlling vaccine-preventable disease is still a challenge in Somalia resulting from low immunization coverage and vast pockets of inaccessible areas due to insecurity. The frequent outbreak of circulating vaccine-derived poliovirus (cVDPVs) in Somalia and the high number of AFP cases reported from the pastoralist communities in Somalia and other HOA countries illustrate the need to reach many unimmunized and susceptible children. cVDPVs can develop after prolonged replication of Oral Polio Vaccines (OPV), which requires neurovirulence and transmissible characteristics of Wild Poliovirus (WPV). cVDPVs can emerge in settings with low poliovirus immunity.

The fragile healthcare system is currently overwhelmed by the COVID-19 pandemic. Most of the health services in the hard-to-reach areas of Somalia are run by NGOs, with many of them reporting erratic and inadequate funding. The Kenya-Somalia border is porous, marked by harsh terrain, insecure, and inhibited by homogenous communities, especially the nomadic pastoralist who are regarded as drivers of the poliovirus, measles, among other communicable diseases. To interrupt the spread and importation of the poliovirus in HOA countries, the CORE Group Polio Project (CGPP) has focused on improving the access of immunization services to these at-risk, low-immunity mobile populations. The project has formed cross-border health committees in Kenya and Somalia in 2016 to support the border health facilities. The committees help monitor pastoralist movement, map their migratory routes, and link them to immunization outreach services and polio campaigns. CGPP has trained and deployed community mobilizers among the pastoralist communities to conduct social mobilization, community-based surveillance of vaccine-preventable diseases and immunization defaulter tracing. The project implements a motorbike model outreach, a low-cost integrated outreach and immunization defaulter tracing service that targets nomadic pastoralists. The motorbike model outreach is where the health facility hires a motorbike to transport the nurse and immunization supplies to outreach sites, which are mostly not accessible by a motor vehicle. These outreach services help improve the population's immunity of the nomadic children and the surveillance of vaccine-preventable diseases.

The project provides transport reimbursement to the community mobilizers to carry out routine social mobilization and defaulter tracing in the nomadic settlements.



A CGPP supported nurse vaccinates a nomadic child.



Community mobilizers sensitize nomadic pastoralist on upcoming polio campaign

38

Outreaches
in April-Sept 2020

1,824

US vaccinated

248

defaulters traced

IN BRIEF

CGPP Annual Planning and Review Workshop

The CORE Group Polio and Global Health Security Project (CGP-GHS) conducted its annual planning and review workshop from September 6-11, 2020 at the Reef Hotel in Mombasa, Kenya. The workshop brought together the CGP-GHS implementing partners' field staff from Kenya and Somalia to review the project performance for FY20 and plan for FY21. The partners' presentations highlighted key achievements, best practices/success stories, lessons learned, and challenges.



Maximizing the Polio Workforce to Support Integrated One Health Community-Based Surveillance in Border Regions of Kenya.

Abdirahman Ibrahim, GHSA Coordinator—CGP-GHS

Introduction

The CORE Group Polio-Global Health Security (CGP-GHS) is a multi-country, multi-partner initiative funded by USAID to support on-the-ground technical guidance to strengthen host country efforts to eradicate polio and to build country capacity to prevent, detect and respond to priority GHSA zoonotic diseases (Anthrax, Trypanosomiasis, Rabies, Brucellosis, and Rift Valley Fever) through a One Health (OH) approach.

Community-based surveillance and maximizing on existing polio workforce.

CORE Group has had a long implementation experience and a network of community volunteers in the border regions of Kenya/Ethiopia/Sudan/Uganda and Somalia through partnering with sub-national government and communities’ structures in those areas primarily aimed at building effective partnerships between CORE group, NGOs, National and County MoH, and local agencies involved in polio eradication and GHS activities. Strengthening the routine immunization systems, supporting efforts to enhance AFP/zoonotic case detection and reporting, and support timely documentation and use of information to improve the quality of polio eradication continuously.

In 2018, the CORE Group polio project got funding from USAID towards implementing and integrating Global Health Security (GHS) in its existing project implementing activities. An integrated One-Health strategy under CORE Group was designed to run on existing polio structure (NGOs, HF, and Communities) to strengthen, and expand the existing community capacities to prevent, detect and respond to threats with pandemic and epidemic potentials in a community-based surveillance One Health approach.

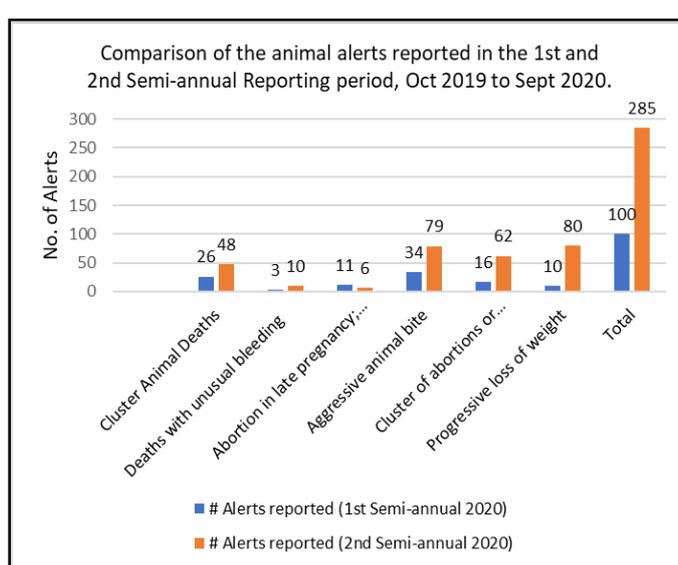
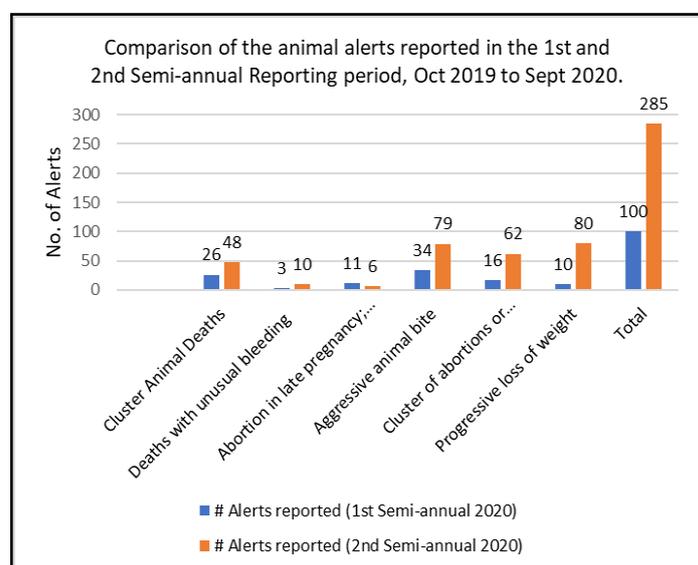
Methodology

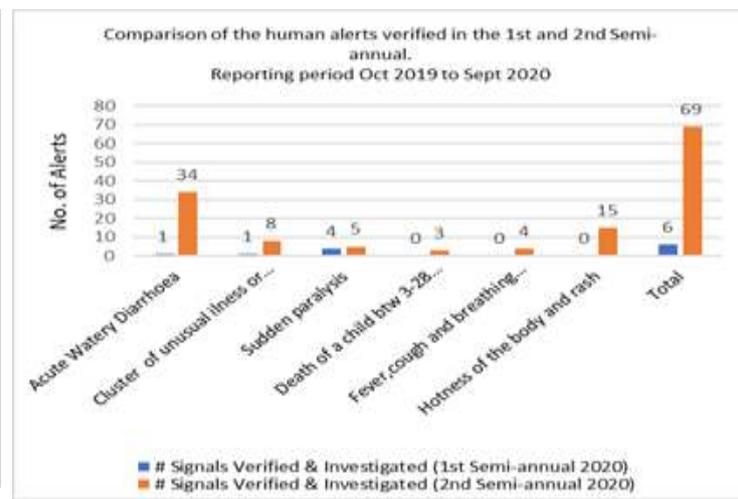
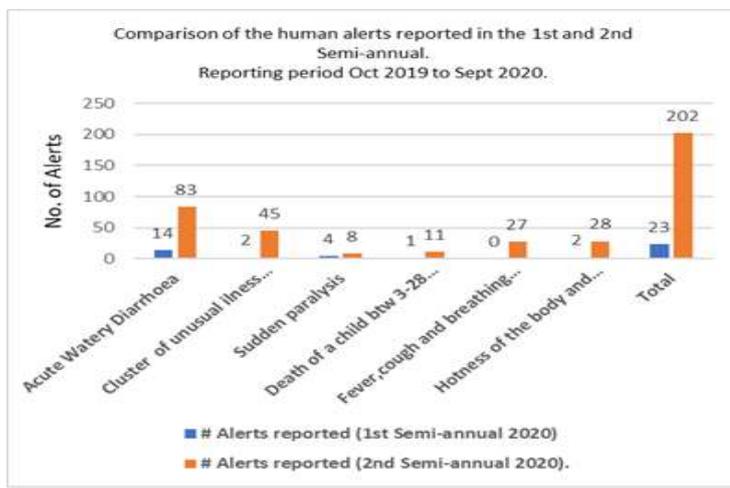
- Existing polio workforce realigned to One Health approach through training on Integrated One health community-based Surveillance. Additional workforce with a veterinary background was brought into the CBS surveillance systems through a Training of Trainers and cascaded model. National, County government, and partners were also taken through a sensitization training/meeting to build One Health culture and workforce programs.
- Establishing the One Health linkages. CGPP-GHS community volunteers partnered with local HFs and veterinary clinics to conduct an active case search on vaccine-preventable and priority zoonotic diseases.
- Use of technology in surveillance: Community Mobilizers (CMs), Community Disease Reporters (CDRs), use smartphones through the ONA platform (on ODK operating systems) to conduct active surveillance, submit alerts, and follow up to any human health alert or animal health alert.

Results

- Aligned and integrated One Health Workforce leading to a rapid uptake of the CBS for zoonotic diseases, including verified reports, were achieved.
- Increased identification, picking, and reporting of human and animal alerts. The table below shows the trends analysis.

COMPARISON OF ALERTS IN THE 2 SEMI-ANNUALS (Oct 2019 to March 2020 & April to Sept 2020)



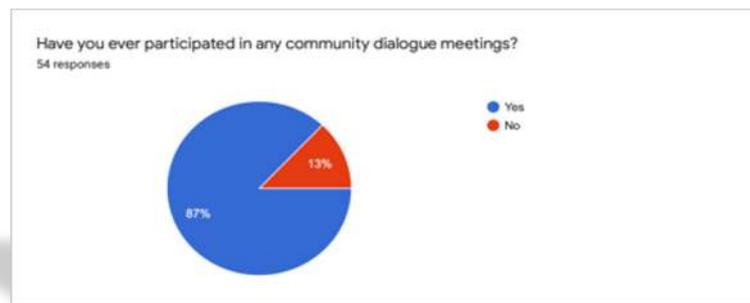
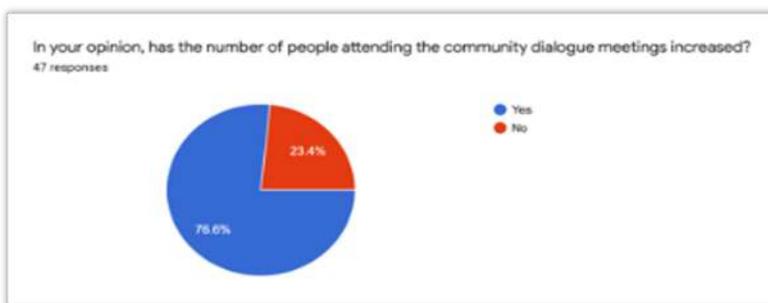


Partner coordination: The project established six One Health committees at the county level for implementing & monitoring One Health community-based surveillance activities.

- Through the CORE Group, it became possible to facilitate the county interim One Health Committees in developing the Turkana County One strategic health plan.
- A total of 12 visits with the full participation of One-health teams. The SCDSOs and SCVO led the supervision visits in their respective sub-counties, health facilities, community, and veterinary sites.

Community volunteers, supervisors & program officers on the impact & changes of community dialogues in the communities on priority zoonotic diseases:

Reasons for the increase in community dialogue participation (Feedback from Poll)



“Because of health education of the community on health issues which helps in improving communal trust.”

“Increased knowledge of signs and symptoms of 5 zoonotic diseases, i.e., Anthrax, Rift valley fever, brucellosis, trypanosomiasis, and rabies.”

“Community members got the opportunity to share ideas on how to address local problems. Local leaders and government officials got an opportunity to interact with community members and address concerns.”

- Geocoding of alerts using a smartphone by the community volunteers. It was now possible for the county health and veterinary departments to respond to events much faster, conduct a risk assessment, and put appropriate responses.

Conclusion

The highly trained and experienced existing polio workforce with a good understanding of their geographical project areas and host community’s infrastructure could easily assume new responsibilities on GHS implementation after undergoing basic orientation with the veterinary teams & community volunteers to form the One Health taskforce. Community-Based Surveillance was enhanced by the formation and going OH approach, the integration of community reporting structures (CDRs and CHVs), and mobile technology (Android-based ODK) for reporting on CBS.

The formidable team (OH taskforce), which works as a unit, has shown to improve early case detection (active case search), risk communication and community engagement, reporting and response of priority zoonotic as well as vaccine-preventable diseases by going deeper into the community to complement the existing facility-based surveillance system; that is particularly poignant in communities where access to formal health facilities is limited, security is problematic, and traditional leaders are the preferred choice of care.

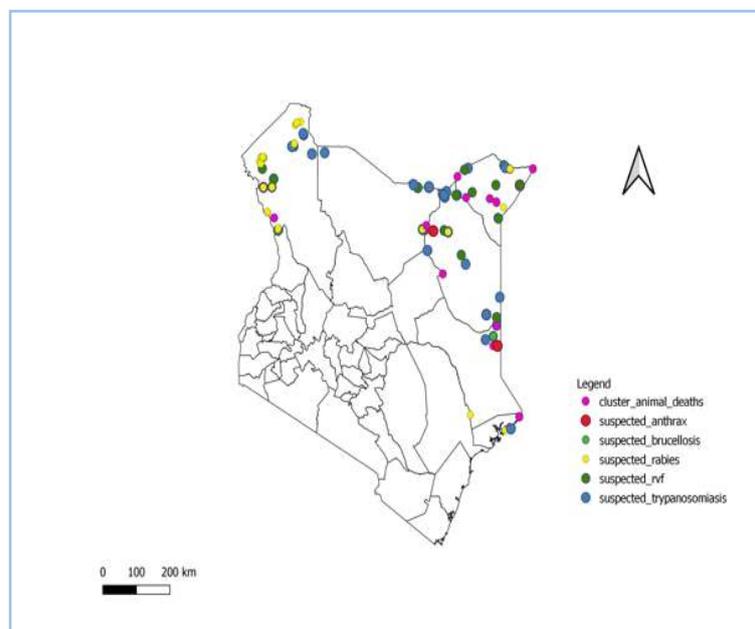
Use of Geographic Information System in enhancing Zoonotic Surveillance in the CORE Group Polio Project (CGPP) supported areas in Kenya.

Yusuf Ajack, M&E coordinator CGP-GHS

According to the Communication Commission of Kenya (CCK), mobile penetration subscriptions stand at 91% compared to Africa's 80. Meanwhile, internet access through the mobile phone use in the country recently reached 83%. The global health security secretariat in Africa's horn took advantage of the high mobile phone adoption to revolutionize data collection by visualizing the priority zoonotic disease alert collected by the community mobilizers into a geographical context, i.e., linking alerts/signals to global position system.

The community mobilizers are equipped with low-cost mobile phones to collect geocoded surveillance events to enhance community-based surveillance and risk communication. This has enabled the sharing of epidemiological data in near real-time, which is helpful not only to the program but also for decision-makers (Ministry of Health and Veterinary services) at all levels. The relevant stakeholders had access to the server, enabling them to access and download the data.

Moving forward, the program is collecting waypoints of essential variables (watering points, migration routes, vegetations, etc.) to create a base map that would then be overlaid on the surveillance data. This would provide additional information for epidemiological analysis and to enable visualization of how pastoral communities move across Ethiopia/Somalia borders and then back into Kenya.



GHS reported zoonotic alert, April-Sept. 2020



Community mobilizers sensitize nomads at watering hole in Gedo region of Somalia. Photo by Ibrahim Mohamud –CGPP/ Somali AID



A CGPP supported nurse administers OPV during outreach. Photo by Mohamed Ahmed-CGPP/ADRA



Blood sample collection from camels after alerts of cluster of animal deaths in Mandera. Photo by Mohamed Ahmed-ADRA



COVID-19 screening at Kenya-Somalia border crossing . Photo by Yussuf Abdullahi-CGPP/ARC Somalia

Meet our community health champion

"Real heroes are all around us and uncelebrated" Peter Capaldi, Irish actor & film maker



Community health volunteers (CHVs) are front-line service providers who dedicate their time and energy to their communities; they are trusted and known by everyone. They play an invaluable role in linking underserved community members to health and social services. Communities view them as a credible source of health information. In this edition, CGPP highlights the stories and contributions of one of the celebrated community health volunteers who made polio eradication a reality in Kenya and continues to help reduce health disparities in vulnerable, underserved communities.

Aisha Hamisi is a community mobilizer (CM) with CGPP in Kamukunji, Nairobi. She supervises CHVs from Amani Community Health Unit, reporting to Eastleigh Sub-County Health Center. Aisha is a single mother with four children; her two daughters are in University pursuing Education and Computer Science, respectively, while her two sons attend high school. Aisha is a trained social worker and a professional counselor. Previously, she worked full-time with NGOs and CBOs implementing social work. She joined Eastleigh Health Center in 2013 as a CHV during the wild polio outbreak in Kenya. She worked in the densely populated informal settlements in Kamukunji, delivering behavior change interventions to immigrants, the homeless, and other vulnerable host community populations. Aisha says volunteering is not easy; some people assume you are less educated and have no other work to do. On top of her part-time counseling work and household chores, she dedicates two days a week visiting households and holding group meetings to educate community members on family health practices, such as hygiene, immunization, and breastfeeding, and refers people to the health center. Aisha appreciates the training and support from CRS Kenya, the CGPP implementing partner in Kamukunji, Nairobi. "I'm passionate about helping my community, and this has given a lot of satisfaction. I feel



Asha was recognized for exemplary performance during a recognition & award ceremony for community health volunteers

about helping my community, and this has given a lot of satisfaction. I feel

A tribute to David Newberry: Father of the CORE Group Polio Project (CGPP)



FEBRUARY 9, 1934 – AUGUST 4, 2020

After making his mark on the world by contributing to the eradication of smallpox and guinea worm, David Newberry moved on to embrace the challenge of defeating polio. In 1999, David became the first director of the CORE Group Polio Project. He was the driving force behind engaging civil society, particularly the non-governmental organization community, by launching community-based polio eradication efforts through the development of secretariat teams in Angola, India, Ethiopia, Uganda, Bangladesh and Nepal. Even after officially leaving the project, David returned to continue steering the formation of project teams in South Sudan and Nigeria.

David had a wealth of more than 40 years of public health experience, having worked at the Centers for Disease Control and Prevention and CARE. David traveled to the polio-priority countries of Angola, India, Ethiopia, Uganda, Bangladesh and Nepal, assessing the need and feasibility of developing CGPP programs there. The CORE Group and USAID had earlier established guiding principles for the project to ensure that NGOs would work cooperatively in high-risk locations that would most benefit from the CGPP's engagement. "He was enthusiastic and optimistic but saw things for what they were, and he didn't hesitate to confront problems head on," said Eilyn Ogden, USAID Worldwide Polio Eradication Coordinator and the original architect of the CGPP and the Secretariat Model. "He pulled this together and got us over the initial bumps when everybody was skeptical that the project had merit."

About CORE Group Polio and Global Health Security Program:

CGP-GHS is a multi-year project funded by the United States Agency for International Development (USAID) under award No. AID-615-A-16-0011. The project contributes to polio eradication initiative through community-based AFP surveillance, routine immunization, social mobilization and outbreak response in Kamukunji, Nairobi, Turkana, Marsabit, Mandera, Wajir, Garissa, and Lamu counties in Kenya and Lower-Juba, Gedo region and Elbardhe & Rabdure districts in Bakool region of Somalia. In 2018, CGP-GHS received additional investment to support Kenya's health security programming by integrating community-based surveillance for five priority zoonotic diseases- Anthrax, Trypanosomiasis, Rabies, Brucellosis and Rift Valley Fever

Partners:

World Vision-Kenya (WVK), Catholic Relief Service (CRS), American Refugee Committee (ARC), International Rescue Committee (IRC), Adventist Development & Relief Agency (ADRA-Kenya), and Somali AID, working with the national Government of Kenya & the Federal Government of Somalia.

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