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**THE CORE GROUP POLIO PROJECT (CGPP)  
ETHIOPIA SECRETARIAT  
QUARTERLY NEWSLETTER**

**THE**

**NEWSLETTER**

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**CGPP Ethiopia conducts data quality audit training :**

*126 government EPI experts and CGPP field coordinators attended the training*



*Participants of DQA , Arbaminch, August 2022*

CGPP Secretariat organized Data Quality Self-Assessment (DQS) training for CGPP and Woreda EPI staff in five clusters. In Gambella town, it was held on July 27 to 29, 2022, in Dire Dawa and Assosa towns on August 3 – 5, 2022, and in Bahir Dar and Arbaminch towns on August 17 – 19, 2022. The training

was attended by a total of 126 participants. The training was conducted for three days for each of the clusters. At the training, it was emphasized that the trainees should cascade the training at the woreda level and implement the DQS at the health facilities to improve the data quality of the immunization system.

**CGPP organizes its partners annual review and planning meetings in its program implementation areas**



The CGP-GHS secretariat conducted the CGPP partners annual review and planning meetings in four clusters; in Gambella town on July 25 & 26, 2022; in Dire Dawa and Assosa towns on August 1 to 2, 2022; and, August 15 and 16, 2022 in Arba Minch and Bahir Dar towns. A total of 216 participants

from CGPP partners and government's Woreda EPI, zonal human and animal health staff were attended. The secretariat presented the nine month plan versus achievement reports of fiscal year 2022. CGPP program implementation partners also presented the fiscal year 2022 nine month summary of achievements and their best experiences. Moreover, the fiscal year 2023 planning exercise were conducted by each partner and final plan was submitted to the CGPP



## EDITORIAL —

# MALARIA VACCINE: *Accelerator of Malaria Eradication*

*By Filimona Bisrat (MD, MPH), CGPP Ethiopia Secretariat Director and Senior Regional Technical Advisor*

We hope that the malaria vaccine will be an important tool that will accelerate the efforts of malaria control and eradication programs. Consequently, they bring added value in facilitating the government's efforts to avert the current morbidity and mortality due to malaria.

In Africa, malaria remains a primary cause of illness and death among children. It is a serious and sometimes fatal disease caused by a parasite that commonly infects a certain type of mosquito that feeds on humans. Plasmodium falciparum is the type of malaria that results in severe infections and, if not promptly treated, may lead to death.

Globally, the World Health Organization estimates that in 2020 there were 241 million clinical cases and 627,000 deaths due to malaria, most of them children in Africa. An estimated 90% of deaths due to malaria occur in Africa, south of the Sahara; most of these deaths occur in children under 5 years of age.

According to the Federal Ministry of Health of Ethiopia HMIS reports (2016–2019), the number of all-cause admissions over the years showed an upward trend. However, malaria-related admissions have significantly decreased over the same period. The drop has been especially dramatic in 2019, with 15,307 admissions, compared to over 30,000 admissions in 2018. Similarly, all causes of inpatient death have been increasing every year, while malaria-related deaths have declined annually. Accordingly, deaths due to malaria have decreased by 58%, from 510 to 213 between 2016 and 2019.

The malaria vaccine trial study was introduced in many countries, which took more than 40 years. However, the final country-led and WHO-coordinated pilots, known as the Malaria Vaccine Implementation Program (MVIP), began in 2019 when Ghana, Kenya, and Malawi introduced the vaccine in selected areas through routine immunization programs, and the result fulfilled the criteria of WHO.

The first malaria vaccine is RTS,S/AS01 (RTS. S), trade name Mosquirix, and was endorsed by the WHO on October 6, 2021, for use in children at risk in sub-Saharan Africa and Asia regions. These regions have moderate to high transmission of malaria caused by Plasmodium falciparum. The vaccine is proposed to be given to children aged 6 weeks to 17 months.

The board of Gavi also approved a malaria vaccination program to support the broader rollout of the vaccine in Gavi-eligible countries. In this connection, Ethiopia applied an expression of interest to get support from Gavi for the malaria vaccine introduction in the country.

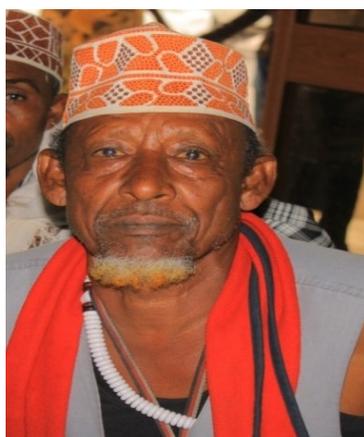
Mosquirix vaccines will be essential tools in stopping malaria. It will be coordinated with the current fight against the disease, which is being waged on a variety of fronts, including the distribution of bed nets, the promotion of indoor spraying, and the development of new medicines and insecticides. I hope it will bring a lot of change to avert the current morbidity and mortality due to malaria. All governments and partners need to work together to make the malaria vaccine available to all, most importantly to children and pregnant mothers, who are most affected by the disease.

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## “A stitch in time, saves nine”

### *Using local tales for immunization*



*Sheik Mohammed Hakim*

**Sheik Mohammed Hakim**, a religious leader in Afar region shared a famous tale that was once told by wise people of Afar. He said the story can be used to teach individuals who differ immunization in fear of adverse effects:-

*“...Once upon a time, there was a woman in a village who had a toddler son. The*

*toddler was so naughty and very noisy if his mother or anybody else deny what he want. Someday, the kid was playing with an awl and the mother couldn't even try to*

*take it from him. Later that day, the toddler fell and injured his eye, and became blind. The mother cried so hard. When her neighbors gathered they asked why she couldn't take the awl from him, she responded “I thought he would cry”. The villagers then said, “he better cry than blinded...”*

*“... The lesson here is if we differ vaccination in fear of its adverse effects which last only for one or two days our children will end up ill from vaccine-preventable diseases and develop severe complications even death as we have learned today.”*

**Contribution:** Bayush Gezachew (CGPP-GAVI/FSA) and Bethelehem Asegedew (CGPP Sec.)

## CGPP holds its annual staff retreat program

The CGP-GHS Secretariat staff retreat program was held at Hawassa town from August 28 to September 3, 2022. All Secretariat staff participated in the retreat program and the CGP-GHS project's nine month report for the fiscal year 2022 was presented and discussed on the achievements, challenges, and future directions. Topics for the upcoming operational research were also selected during the retreat. Ideas were also brainstormed on the upcoming preparations and production of IEC/BCC materials and, it was decided to pilot and implement the new initiative to support the “zero dose” project i.e. the production of a referral slip using the additional \$500,000 fund obtained from our donor USAID which was aimed at facilitating and improving the newborn, pregnant women and defaulters tracking and reporting by the CGPP



*Group photo of CGPP Secretariat Staff at the retreat program*

## *Thank you for your contribution*

*Your contribution to this newsletter is highly appreciated. Without your valuable contribution, it is hard to reach our audiences with messages that are worth reading. We need to collaborate and exert more efforts together.*



# POLIO CORNER

*The latest on the battle to eradicate polio*

Summary of AFP Surveillance indicators by Region , Ethiopia  
Jan 01 – Oct 07, 2022

Region	Expected Cases (2022)	Reported (this period 2022)	Reported (same period 2021)	Reported this Week	NP-AFP Rate (annualized) 2022	NP-AFP Rate (annualized) 2021	Stool Adequacy (%)	Stool Cond. (%)	NPENT (%)	Compatibles	VDPV Cases	WPV Cases
A ABABA	20	23	20	1	3	3.1	96	100	10.0	0	0	0
AFAR	21	9	22	0	1.1	2.7	89	100	0	0	0	0
AMHARA	205	254	221	9	3.2	2.9	96	99	5.2	0	0	0
B/GUMUZ	11	22	22	0	5.2	4.1	95	100	9.3	0	0	0
D/DAWA	4	6	10	0	3.9	6.5	83	100	0	0	0	0
GAMBELLA	7	7	11	0	2.6	4.1	100	100	4.3	0	0	0
HARERI	2	3	5	0	3.9	6.5	100	100	0	0	0	0
OROMIA	418	436	474	4	2.7	3	89	99	7.0	0	0	0
Sidama	56	61	64	1	2.8	3.3	93	100	6.2	0	0	0
SNNPR	141	215	200	2	4	3.1	95	98	6.7	0	0	0
SOMALI	68	89	109	4	3.4	4.4	99	99	10.5	0	0	0
South West	36	66	NA	2	4.8	NA	95	100	0	0	0	0
TIGRAY	53	2	11	0	0.1	0.5	100	100	50.0	0	0	0
<b>NATIONAL</b>	<b>1042</b>	<b>1193</b>	<b>1169</b>	<b>23</b>	<b>3.0</b>	<b>3.0</b>	<b>93</b>	<b>99</b>	<b>6.8</b>	<b>0</b>	<b>0</b>	<b>0</b>

Week 40, 2022



## The CGPP Global Chief of Party visits Ethiopian program

Dr. Hibret Tilahun, the CGPP's Global Chief of Party, has made his first official visit to the CGPP program in Ethiopia from July 4 – 6, 2022. During his visits, Hibret attended the CGPP Ethiopia Secretariat weekly staff meeting and discussed the implementation status of CGPP programs in Ethiopia. Moreover, in his introductory meeting with the USAID Mission staff in Ethiopia, he made a discussion on the successful implementation of the community-level



*Dr. Hibret Tilahun at the meeting with CGPP Ethiopia Secretariat*

surveillance and awareness creation activities implemented by CGPP Ethiopia, and about USAID's commitment to continue its support to the project. Dr. Hibret has also attended the CGPP partners' monthly meeting organized

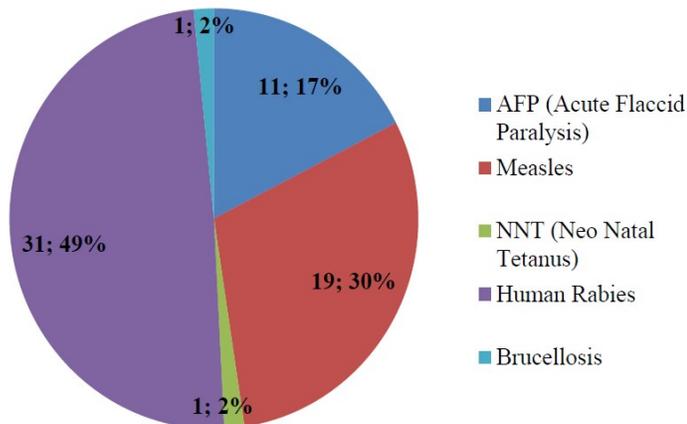
by the Ethiopia secretariat. In the meeting, the quarterly progress reports of each partner were presented and discussed. Hibret appreciated the efforts of CGPP Secretariat and its partners and encouraged them to keep their commitments.



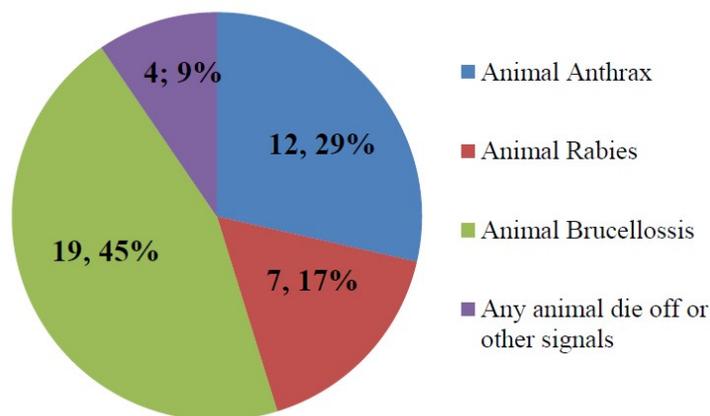
# SURVEILLANCE AND SUPERVISION UPDATES

## Human and Animal Disease Cases Reported through ODK from CGPP implementation Areas (July 1 to September 30, 2022)

**Human Disease Cases Reported.**  
Total number of cases= 63



**Animal Disease Cases Reported**  
Total number of cases = 42



### Ethiopia COVID – 19 Updates

Total Number of Reported Cases in Ethiopia

Updated on September 30, 2022

Laboratory test → 5,260,699

Total cases → 493,579

Total deaths → 7,572

Total recovery → 471,922

Total Vaccinated → 43,135,298

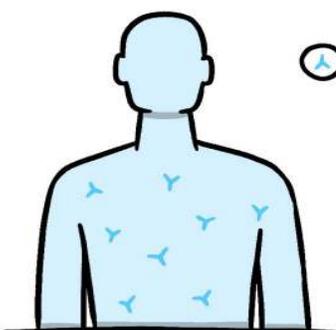
Source: FMOH Ethiopia

### Facility level supportive supervision field visits conducted by CGPP Secretariat and implementing partners

(July1/2022 to September 30/2022)

Facility Visited	Number of Visit	Percent
Hospitals	4	0.9
Health Center	74	17.4
Health Post	269	63.3
Animal Health Clinics	78	18.4
<b>Total</b>	<b>425</b>	<b>100</b>

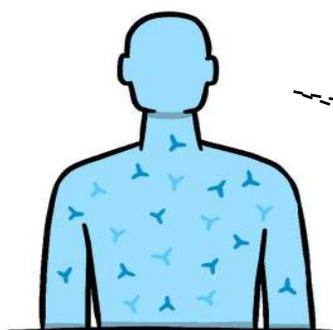
Do people who've already had the virus still need to be vaccinated?



Natural Immunity

Immunity can weaken over time and be strengthened with vaccinations.

Even if a person has contracted and recovered from COVID-19, their immunity can be boosted by a vaccine.



Natural Immunity + Vaccine

Source: <https://twitter.com/WHO/status/1380088430550515714/photo/1>



## Second dose of Inactivated polio vaccine

### SECOND DOSE OF INACTIVATED POLIO VACCINE (IPV2) IN ROUTINE IMMUNIZATION PROGRAMS (PART 1)

Contributed by: Asrat Asress and Dr. Muluken Asress, CORE Group Polio Project

#### INTRODUCTION:



Under the current Polio Endgame Strategy 2019-2023, oral polio vaccine (OPV) withdrawal remains one of the goals necessary for the complete eradication of all polioviruses, wild

as well as vaccine-derived polioviruses. To prepare for complete OPV withdrawal, WHO recommended in 2013 that all countries should introduce at least 1 dose of IPV in their routine immunization schedule to provide an immunity base against paralysis caused by circulating vaccine-derived poliovirus type 2 (cVDPV2) and boost immunity against poliovirus types 1 and 3. By April 2019, this milestone was achieved by all 194 Member States. The introduction of the second dose of IPV (IPV2) is recommended as the next step towards complete OPV withdrawal while providing higher protection against cVDPV2 which is currently circulating and represents a risk in many areas of the world.

#### WHY SHOULD COUNTRIES INTRODUCE A SECOND DOSE OF IPV?

The addition of a second dose of IPV will increase protection against all polioviruses, including protection against paralysis caused by VDPV2. Once bOPV is removed after certification of eradication, two doses of IPV will ensure adequate protection against all poliovirus. The initial introduction of one dose of IPV provided an immunity base against polio virus types 1, 2 and 3. In the context of the eradication of type 2 wild poliovirus and the subsequent withdrawal of type 2 oral polio vaccine, that

immunity base produced by the first IPV dose could be rapidly boosted by a second dose of IPV, manifested by high antibody titers that would be expected to mitigate the consequences of cVDPV2 outbreak. The WHO recommendation in 2013 for the introduction of a single IPV dose was mainly driven by supply availability. Now that IPV supply availability has improved and all countries have introduced the first IPV dose in vaccination schedules and considering the WHO recommendation of two IPV doses for the post-certification era schedules, countries are strongly encouraged to introduce a second dose of IPV. This recommendation concerns the period before bOPV withdrawal. During this period, we do not anticipate the need for additional IPV doses in routine immunization.

#### WHAT ARE THE CURRENT SCHEDULE OPTIONS FOR PLANNING THE INTRODUCTION OF THE SECOND DOSE OF IPV?

As a principle, the best final immunogenicity is achieved when the first IPV dose is administered at 14 weeks (with DTP3) or later, and the second IPV dose is administered at least four months after the first IPV dose; in most countries, this coincides with measles-containing vaccine given at nine months of age. This schedule achieves the best immunogenicity with 2 doses of IPV, however, does not provide for early-in-life protection. As an alternative to the preferred option described above, countries may also select an early protection IPV schedule starting with the first dose at 6 weeks of age and the second dose at 14 weeks of age. While this schedule does not follow the four-month interval between doses described previously, it has the advantage of providing early protection as well as preventing vaccine-associated paralytic polio (VAPP) with the tradeoff being a decrease in final immunogenicity. This could be an option in countries with programmatic challenges of implementing IPV at the visit at 9 months of age.



## SECOND DOSE OF INACTIVATED POLIO VACCINE (IPV2)

**Table 1:** Summary of available studies on seroconversion against poliovirus types 1, 2, 3, after receiving 2 IPV doses according to different schedules.

2 IPV Dose Schedule			Final Seroconversion		
Study	Location	Schedule	Type 1	Type 2	Type 3
Unpublished (2020)	China	4m, ≥4 months after first dose (2 <sup>nd</sup> dose between 8-12 months) (Sabin)	100%	99%	98%
Resik (2019)	Cuba	4, 8 months	100%	100%	100%
Resik (2013)	Cuba	4, 8 months	100%	100%	99%
Cynthia (2019)	Bangladesh	14, 22 weeks	100%	99%	99%
Mohammed, A. J. (2010)	Oman	2, 4 months	88%	86%	92%
Cuba IPV group (2007)	Cuba	2, 4 months	90%	89%	90%
Anand, A (2015)	Bangladesh	6, 14 weeks	95%	91%	97%
Unpublished (2020)	Nigeria	6, 10 weeks	65%	67%	92%
Unpublished (2019)	India	6, 10 weeks	85%	70%	94%
WHO Collaborative Study (1996)	Oman	6, 10 weeks	71%	99%	91%
WHO Collaborative Study (1996)	Thailand	6, 10 weeks	94%	99%	93%

### CAN COUNTRIES CHOOSE TO PROVIDE THE TWO DOSES OF IPV AS TWO FRACTIONAL DOSES?

**Yes.** Countries can also achieve high levels of immunity against poliovirus types 1, 2, and 3 by providing two fractional intradermal IPV doses. A fractional intradermal IPV dose is 0.1 ml as opposed to 0.5 ml. This option should be considered after a careful review of the programmatic feasibility, cost-effectiveness, and regulatory implications.

**Table 2.** Summary of available studies on seroconversion against poliovirus types 1, 2, 3 after receiving 2 fractional IPV doses according to different schedules

2 fIPV dose schedule			Final Seroconversion		
Study	Location	Schedule	Type 1	Type 2	Type 3
Resik (2019)	Cuba	4, 8 months (ID)	89%	93%	82%
		4, 8 months (IM)	97%	99%	91%
Resik (2013)	Cuba	4, 8 months	94%	98%	93%
Mohammed, A. J. (2010)	Oman	2, 4 months	67%	67%	69%
Unpublished (2020)	India	10, 14 weeks	96%	77%	99%
Unpublished (2020)	India	6, 14 weeks	96%	87%	97%
Anand, A (2015)	Bangladesh	6, 14 weeks	88%	81%	89%
Cynthia (2019)	Bangladesh	6, 14 weeks	79%	64%	73%

### References

R.Sutter, L. e. (2014). The new polio eradication end game: Rationale and supporting evidence: Considerations for the introduction of a second dose of Inactivated polio vaccine (IPV2) in routine immunization programs from 2021. *Journal of Infectious Diseases*.



## Photo updates from the Field



Mr. Abuna Mohammed, CGPP/EOC-DICAC Zonal Coordinator receiving award and recognition from the Borena Zone Health Office on behalf of The Ethiopian Orthodox Church Development and Inter-Church Commission (EOC/DICAC) for their tremendous contribution and support to the community on immunization and health. (photo credit—Abuna Mohammed)



EPI and PZDs Mainstreaming with Religious Leaders in Warder District, July 2022. (Photo credit Mohammed Sheik, CGPP/OWDA)



Vaccination at the place called “Leg Sera” crossing vaccination point at the Ethiopian-Kenyan Moyale, July 2022. (photo credit—Haji Rashid IRC Ibrahim, CGPP/SC)



Conversing with the community. Menge District of Benishangul Gumuz Region, July 2022. (Photo Credit: Yasin Ahmed, CGPP/2022. (photo credit—Haji Rashid IRC)



Animals vaccination campaign at the Kadhim and Arbale Kebeles of Dilo District in Borena Zone, July 2022. (photo credit—Abuna Mohammed)



Outreach vaccination in Hudet District of Dawa Zone. July 2022. (photo credit—Abuna Mohammed)

