CORE GROUP POLIO PARTNERS (CGPP) PROJECT

FY05 Narrative Report

October to March 2005

Nomad in Liben Zone, Somali Region, area covered by Ethiopia Pastoralist Concern Association Ethiopia (PCAE)

CA# HRN-A-00-98-00053-00

USAID
FROM THE AMERICAN PEOPLE

ACRONYMS

ADRA	Adventist Development and Relief Agency
AFP	Acute Flaccid Paralysis
ANM	Auxiliary Nurse Midwife
CBO	Community Based Organization
CCF	Christian Children's Fund
CDC	US Centers for Disease Control and Prevention
CGPP	CORE Group Polio Partners
CHW	Community Health Worker
CMC	Community Mobilization Coordinators
CRDA	Christian Relief and Development Association
CRS	Catholic Relief Services
DHO	District Health Officer
EPI	Expanded Programme on Immunisation
ESHE	Ethiopia Child Survival and Systems Strengthening Project
FBO	Faith-based organization
HAPCO	HIV/AIDs Prevention & Control Organization of Ethiopia
HCS	Hararghe Catholic Secretariat of Ethiopia
HFMC	Health Facility Management Committee
HMIS	Health Management Information System
ICC	Inter-Agency Coordinating Committee
IEAG	India Expert Advisory Group
IEC	Information, Education, Communication
IMC	International Medical Corps
IMCI	Integrated Management of Childhood Illness
KI	Key Informant (for AFP case detection)
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHP	Nutritional Health Promoters of Nepal
NID	National Immunization Day
NPSP	National Polio Surveillance Program
OPV	Oral Polio Vaccine
PCAE	Pastoralist Concern Association Ethiopia
PCI	Project Concern International
PEI	Polio Eradication Initiative
PEN	Polio Eradication Nepal
PET	CORE Group Polio Eradication Team
PLAN	Plan International
PVO	Private Voluntary Organization
RI	Routine Immunization
RSO	Regional Surveillance Officer (Nepal)
SA	Salvation Army
SC	Save the Children
SMO	Surveillance Medical Officer
SNID	Sub-national Immunization Day
SNNPR	Southern Nations Nationalities and Peoples Region of Ethiopia
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh State of India
USAID	United States Agency for International Development
VVAF	Vietnam Veterans of America Foundation
WHO	World Health Organization
WB	World Bank
WPV	Wild Polio Virus
WV	World Vision

SECTION 1.
BACKGROUND AND STATUS OF THE CORE GROUP POLIO PARTNERS PROJECT

In late July of 1999, the CORE Group Polio Partners Project (CGPP) was formed to fulfill the terms of a grant from the USAID Global Bureau, Office of Health and Nutrition, Child Survival Division. The project has since been awarded $25 million covering eight years for the Polio Eradication Initiative (PEI).

The **vision** of the CGPP sees the involvement of CORE PVOs and NGO partners helping accelerate the eradication of polio. At the same time, the CGPP vision sees something of value being left behind that can be used to address other health priorities.
Specifically, the three parts of the vision statement are the following:
1. Eradication of polio is accelerated by the coordinated involvement of PVOs and NGOs in national eradication efforts.
2. Collaborative networks of PVOs and NGOs are developed with the capacity to accelerate other national and regional disease control initiatives (in addition to polio eradication).
3. Relationships are strengthened between communities and international, national and regional health and development agencies.

The **strategy** to achieve this vision includes the following seven components (our mission):
Building partnerships,
Strengthening existing immunization systems,
Supporting supplemental immunization efforts
Helping improve the timeliness of AFP case detection and reporting,
Providing support to families with paralyzed children,
Improving documentation and use of information for improving the quality of the polio eradication effort, and
Participation in either a national and/or regional certification activities.

The CORE Group is uniquely positioned to serve in this capacity as it represents 38 US-based Private Voluntary Organizations (PVOs) which manage hundreds of USAID funded Child Survival projects worldwide. For this reason, PVOs are well positioned to address the challenge of global polio eradication in high-priority countries, such as those in conflict and those with extremely hard-to-reach communities.

Success with initial USAID/Washington funding has enabled critical additional support from USAID Missions, the Government of Japan, UNICEF, WHO and other Embassies to be leveraged. To date, the project beneficiaries number approximately 14 million under-five children including those in the remotest areas of Ethiopia, in the most resistant communities in India, the most dangerous areas of Angola, and in the most marginalized communities of Nepal

During this period, USAID funds supported activities in four countries: Angola, Ethiopia, India, and Nepal. In each country, the CGPP supports a coordinating secretariat with at least one full-time coordinator/director.

USAID mission funds wholly or partially supported activities in India during this period. These mission funds allow projects to shift their efforts into high-risk areas, and are supporting new partners .

India has ongoing transmission of polio, with 12 cases so far in 2005. Ethiopia and Nepal had imported cases, while Angola's last case was in 2001.

A description of key activities carried out by the CGPP during this reporting period is provided, in addition to the country-specific reports.

SECTION 2. REPORT OF ACTIVITIES BY MISSION STATEMENT

2.1. Build effective partnerships between PVOs, NGOs and international, national and regional agencies involved in polio

Figure 1 CRS and CORE Polio Team, Angola

Building partnerships is an essential ingredient of the CGPP vision and mission. We believe that including PVOs and NGOs in existing national and international eradication partnerships will accelerate the eradication of polio. We also believe that the CGPP will develop new collaborative networks of PVOs, NGOs and partner communities and health authorities that can work together on other health initiatives after polio has been eradicated.

The key CGPP strategies for building partnerships include the following:

- A functioning collaborative organization of PVO/NGO partners
- Meet regularly with polio partners (MOH, USAID, WHO, Rotary, other ICC
- members) and brief these partners on CORE activities
- Collaborate and work with local NGOs and CBOs to carry out or support project activities
- Send CGPP TCG/TFI Meetings representatives to all WHO Regional

Progress towards strategies

- All countries continue to have dynamic, committed collaborative groups, with an proactive secretariat director/coordinator and staff.
- CORE continues to be respected and valued by the partners, MOH, UNICEF, Rotary and WHO. Contributions are recognized at local, national and international levels
- CORE Secretariats partner with ten US PVOs and approximately 40 local NGOs.
- Secretariat directors Drs. Roma Solomon, Filimona Bisrat, and Antonio Dias attended regional specific WHO TFI, TCG or IEAG meetings
- Angola and Ethiopia Secretariat Directors met with representatives of Japanese Embassy and JICA regarding Grass Roots Grants

Figure 2 PCI's BMC, SMC, SRC & local partner, SSGS. Badaun, Uttar Pradesh, India

Highlights	Partnership Activities
Ethiopia	• **CORE** partners with MOH at local level to build capacity in both polio eradication and routine EPI. WHO and UNICEF continue to be active members of the Secretariat. • **CORE** Director attended an inter-country cross border c0-ordination meeting on polio eradication activities in Khartoum, Sudan in Feb 05. • In order to tackle the importation of WPV from Sudan, CORE is attempting to continue efforts made in the past in Gambella and Benshangul-Gumuz Regions. **CORE** approached the Ethiopian Evangelical Church Mekane Yesus (EECMY) to work together in Gambella. **WV** recently started development activities in four Woredas in Benishangul-Gumuz. Both have indicated an interest to work with us.
Angola	• **CORE** provided LQAS training in Bie with partners including WHO. Information on WHO EPI trainings in the region will be shared with CORE so that the immunization officer might attend. • **CARE** partners with the MoH, **Africare**, and WHO in Kuito by establishing weekly and monthly plans for joint supervision, transport of vaccines and materials, routine immunization activities and surveillance. They also agreed to be fully involved in the Municipal Days of Child Health at the municipal and community levels. • **CARE** and **Africare** standardized the training curricula and developed the "Manual for Community Volunteers." • **SA** visited the center where refugees from DRC and Zambia stay before they join their original communities or villages. In the center, **SA** worked closely with UNHCR, WFP, SC US, Lutheran Federation, Medicos Sem Fronteira and other NGOs to welcome refugees and assist them. • **CRS** Project team participated in all Health and Nutrition Provincial Sub-group monthly meetings. The team also met with the provincial EPI and the WHO to discuss the coordination of joint/ integrated activities, on job training for routine EPI, social mobilization and disease surveillance.
India	• MOU signed by **CRS, PCI, WV, ADRA**, and Secretariat regarding roles and responsibilities. • **CORE** India is an indispensable part of the SM Net.
Nepal	• WHO shared strategic plan for next year and suggested possible collaborative activities with **CORE.** • GIS officer continues to be housed at **CARE**. Jointly assesses GIS and/or training needs of all partners. Trainings conducted for **CORE** partners, MOH, WHO and UNICEF staff • **CORE** Partners work closely with HFMCs with the belief that motivated and aware community members can make a big difference in the health of their communities.

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

CGPP polio projects are strengthening the immunization systems in such a way as to support both polio eradication and other vaccine-preventable disease control programs. Strengthening routine immunization by increasing community demand and support, while enhancing the capability for quality routine immunization is the cornerstone of the activities. Strategies to strengthen the routine system include:

- Technical and/or management training
- Support social mobilization to increase demand for routine immunization services
- Capacity building
- Encourage community participation & planning
- Improve cold chain and/or vaccine logistics systems

Progress towards strategies

- **Angola** works to increase community demand and support for immunization, while enhancing the capacity for quality routine immunization, through training, supervision, improving technical and management capacity, social mapping, cold chain and other logistics, and mobilizing the private sector.
- **Ethiopia** assists partners by providing technical and financial support. Some of the activities undertaken by partners are: mobilization of communities to bring children for vaccination during outreach services, provision of health education particularly the importance of immunization, maintenance of refrigerators and motorbikes, provision of vehicles for transportation of vaccine and outreach services, participation in supervision activities.
- **India** is focusing on identifying newborns and pregnant women, and linking them with ANMs or outreach sessions to get them immunized.
- **Nepal's** strength is working at the district level on data analysis and mapping.

Figure 3 Figure 3 CRS SRC Parul Ratna, Dr Abha Jha and CMC with her village map, used both for SNIDs and identifying newborns and pregnant women

Highlights	Immunization Strengthening Activities
Nepal	• **CORE** Nepal works to strengthen HFMCs to improve immunizations. HFMC is an executive body for operation and management of health facilities; its objectives are to: identify and prioritize the existing health problems at local level, mobilize the local resources in an appropriate way, make action plan for effective and regular services, and build capacity on monitoring and evaluation of program. • **SAVE** organized a planning workshop with HFMC members in Bardia. At least 10 VDCs with the least immunization coverage and high drop-out were selected for this activity. Oobjective of the workshop was to orient the HFMC members and community members about the national health policy, services available at local health facilities, target population and program monitoring indicators and to orient them about their expected role and responsibilities. About 9-10 numbers participated in each workshop. During the workshop, discussion was held to increase the service utilization rate and also prepared a work plan for awareness raising activities for improving immunization status. • Trend analysis of routine immunization in CORE districts is routine. **SAVE** works with district MOH staff to improve skills in analyzing HMIS data. Jhapa, Bardiya and Dang districts have been analyzing the HMIS report regularly. **See Figure 4** • Mapping is done to pinpoint coverage issues. Due to shortage of DPT and OPV vaccine supply there was not universal coverage to the entire districts. BCG Coverage seems > 80 percent but DPTIII coverage is < 80 % and drop out rate was still higher than average in some districts. It was better than national coverage and coverage of adjoining districts. **See figure 5** • CARE also organized planning workshop for HFMCs for 20 VDCs in their area. A comprehensive workplan assessing the the four different pillers of service management.
Ethiopia	• **CORE**, WHO and UNICEF are examining joint strategies with communities to drive the demand for EPI. • To eradicate polio and strengthen EPI, **CORE** focuses on social mobilization, and

	training PVOs, CBOs and district level MOH staff in LQAS, ArcView/GIS for community based surveys, focusing on mapping, analyzing data, and using it for decision making. • Close to 4,500 zero dose children were found in two **CCF** woredas during the SNID. In addition to polio, sensitization of community and religious leaders, elders and women was done on routine EPI . • **HCS** is implementing various development activities in six Woredas of Shinile Zone, Somali Regional State. Currently there are 23 health facilities (2 health centres, 9 clinics and 12 health posts) in Shinile Zone, of which only 4 health facilities are providing EPI static services. All outreach activities have ceased because of lack of transportation, lack of vaccines, refrigerator maintenance and shortage of kerosene. However, the majority of the health facilities have cold chain facilities and the potential to render the service if the problems are relieved. Data concerning the EPI coverage is not available mainly due to reports which are not compiled and unsentimental catchments population. DPT3 coverage in the zone is estimated at 3.3%. Recently **CORE** Ethiopia approved funds to strengthen the EPI program in the zone, and it is hoped that this will improve the coverage in the course of the coming six months. • **CARE** communicated both to the woreda health offices for identification of damaged motorbikes and refrigerators and repaired 7 motorbikes from both Woredas. However, they were not able to find technicians who can maintain the solar refrigerators. **CARE** in collaboration with the Woreda offices has conducted joint social mobilization meetings for 79 community influentials and community health workers. As the traditional and religious leaders have already been sensitized on EPI issues and the community health workers were already trained and working on the issue, they discussed and reached a consensus easily, and agreed to strive for the improvement of EPI coverage of their respective villages by and through health education, community mobilization and advocacy works. Finally the community health workers were assigned to be focal persons for EPI activities in their respective villages • To strengthen routine immunization, training was given to community surveillance focal persons by **SAVE** so that they can orient students in their peasant associations (PAs) to detect EPI defaulters in the students' families as well as their neighbours. By doing so, they mobilize the defaulter families or care takers and assist in completing vaccination schedule and also contribute to high EPI coverage.
India	• In Badaun a plan was developed by **PCI** and CMO for urban Sahaswan block where CMO has deputed 7 special ANMs who are working closely with 25 CMCs. This has improved the immunization coverage in urban community. In Meerut and Muzaffarnagar days are fixed to visit CMCs areas for the immunization sessions. • **PCI** CMCs intensified efforts to find zero dose children. • To strengthen RI service, the **ADRA** India team tries to help ANMs increase RI coverage during the health camps, outreach immunization camps, and government fixed RI days. • **ADRA** CMCs keep track of children that receive RI service by the government vaccinators. CMCs inform ANMs about the newborns in the community and inform mothers about the fixed RI dates.
Angola	• In Mbanza Congo and Maquela do Zombo, **IMC** worked with community based groups, traditional birth attendants, village health committees, as well as health activists and MoH technical staff. The principle topics of involvement included polio surveillance, vaccination sensitization, and reporting. • All 269 community-volunteers from **CARE** participated as mobilizers during the Municipal Days of Child Health in their communities. Four vehicles supported the logistics and transport team in Kuito, Chinguar, Cunhinga and Andulo. • **CRS** staff started negotiations with the MoH to open a vaccination room in Mujombue Health Post, Chongoroi Municipality, using cold chain equipment purchased with funds from the Japanese Embassy. Part of the materials, such as three thermometers, 2000 vaccination cards, posters with quick reminders and a gas container, are already in

	place. In addition, **CRS** provided health posts with 12,000 vaccination cards and supported the transportation of vaccines and materials from the provincial cold chain to Caimbambo and Ganda and from Lobito cold chain to Egipto Praia and Canjala. • **CRS** supervisors monitored, on a monthly basis, the cold chain equipment previously installed by **CRS** in health posts in Lobito, Benguela, Chongoroi, Ganda, Balombo, Cubal, Baia-Farta and Bocoio. The team continues to collect weekly information about vaccine stock in municipalities with **CRS** administrative base in order to prevent stock rupture.

Immunization Trend of Jhapa District:

Antigen	FY 2003/04	FY 2004/05 (First 4 months)	FY 2004/05 (First 8 months) %
BCG	92.7	67.7	97.6
Polio III	95.7	56.5	82.9
DPTIII	95.7	56.5	73.3
HEP B III	93.2	57.4	91.0
Measles	94.3	65.0	91.0

Source: HMIS Report 2004/05

The immunization coverage in the first quarter of FY 2004/05 was not satisfactory even though it was improved in the next quarter. But still the coverage for Polio3 and DPT3 is below 90 % i.e. below national target. This might be due to current shortage of DPT and OPV vaccine at national level.

Figure 4 Example of trends in immunization data, in Jhapa District, Nepal, by SAVE

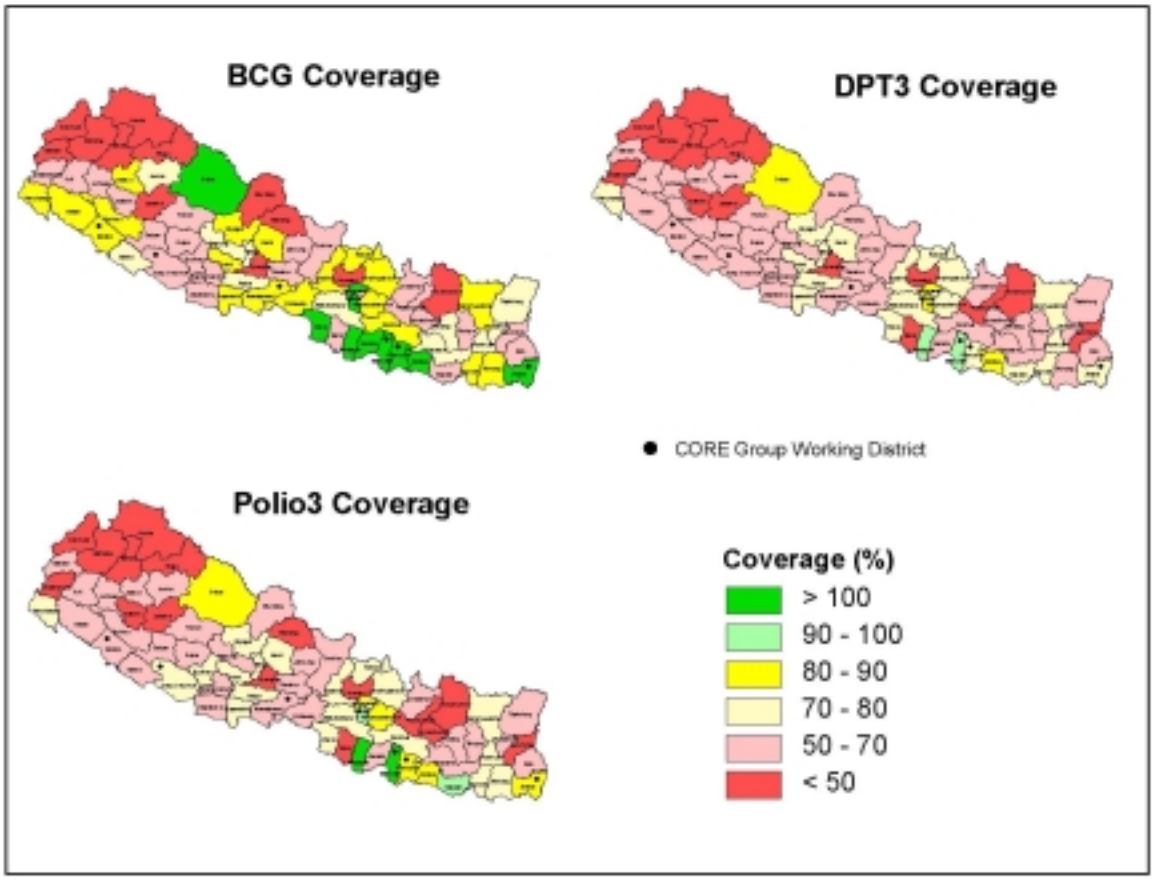


Figure 5 Sept 04-Mar 05 BCG, DPT3, & OPV3 coverage in CORE and non-CORE districts, Nepal

More return than investment!

During HFMC Training of Sunawal Sub Health Post of Nawalparasi district, discussion was ongoing on "optimum utilization of existing resources." HFMC member of Amraut VDC said, "Mostly, people spend a lot of money for building construction for their own reputation but we should initiate to deposit our one day's allowance to display HFMC members board in Health Facility." Then they decided to deposit participant's allowance in HFMC fund as a matching fund which should be used to display immunization monitoring chart board in the Health Facility. After 15 days of the training the monitoring team visited the health facility and found that the wall was filled by displaying various type of boards. Couple of board were set up were decided by HFMC meeting. They are using Immunization Monitoring Chart to review the monthly achievements in every HFMC meeting monthly.

Experience of Ran Bahadur Thapa, Health Supervisor, Nawalparasi

CORE Nepal Report, Oct 04-Mar 05

2.3 Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunizations

The CORE Group Polio Partners Project's main strength has been involvement in supplemental immunizations. This has led to many more children being vaccinated than would have without the availability of USAID funds for CORE PVOs. We believe this involvement---through planning and implementation of national immunization days, sub-national immunization days, and mop-up immunizations---is helping accelerate the eradication of polio. These efforts will inevitably strengthen routine immunization program activities also.

The following are the key CGPP strategies for supporting supplemental immunizations:

- Participate in preparation of plans and evaluations for NIDs, SNIDs or Mop-up campaigns
- Identify problematic areas and develop plans and strategies to increase coverage in those areas
- Support social mobilization to increase demand for supplemental immunizations
- Encourage community participation in or contribution to supplemental immunizations
- Participate in implementation of NIDs, SNIDs or Mop-up campaigns
- Participate in national or local-level cross-border planning, implementation and/or evaluation efforts.

Progress Towards Strategies

- In late 2004, WPV was imported into Siraha District, Nepal. SNIDs were organized, and CORE Partners responded with planning, social mobilization, logistical, and supervisory activities.
- Two polio cases have been confirmed in Ethiopia, genetically linked to virus circulating in Sudan. The cases occurred in Tigray, close to the border of Sudan and Eritrea. Ethiopia had been polio free since 2001.
- India maintains its focus on frequent SIAs, with four rounds in the past six months, and five more planned for the next six months.
- Each country is poised to act when/if more cases are found, using proven activities to improve SIAs.

Figure 5 Supervision during SNID by Dr Filimona Bisrat, Ethiopia Secretariat Director

Highlights	Supplemental Immunization Activities
India	• **ADRA's** health camps are organized only in the identified high-risk areas of the districts to support the SM activities. In order to break the resistance, SMCs in coordination with the Chief Medical Officer (CMO), Surveillance Medical Officer (SMO), and block-level coordinators organized 47 health camps addressing the needs of these high-risk areas. Specific needs on women's health issues (skilled provider for obstetric and gynecological care), and personal hygiene were addressed. • **PCI's** social mobilization activities have focused more on the high-risk areas. The health camps and sanitary drives conducted in the underserved population areas to motivate the community towards the polio campaign. The quality of the planning and review meetings has increased at district and blocks levels. Capacity of local partners such as anganwadi workers, schoolteachers, panchyat raj institutions and CBOs built to work more effectively to enhance the community participation. • **PCI** Before each the SIA rounds work plan/ district communication plans were shared with the other partners of the polio program. • In **CRS** Agra CMC area, with more clusters of hard to convince community, the focus was to organize the health camps for mobilization of underserved community before the campaign • In **CRS** Gonda CMC area, during Q1, vaccine shortage during booth day lead to poor coverage; the issue was raised by the SMC during review meeting • A three-day district-level dental camp was organized in Baghpat by the health department in March, where a special cell was built by **ADRA** to distribute the message about polio. The cell was well decorated by IEC material and was open from 10 am to 4 pm all 3 days where CMCs and BMCs provided counseling services to the parents. In all the three days, Magic Shows were also organized to attract more people. • In March 2005, 136 Milk Men in Baghpat actively attended the Social Mobilization Activities with **ADRA**. These men, early in the morning, go house to house to sell milk. The project team contacted them and asked them to join the polio message distribution activities. • An activity named "Polio Volunteer" was one of the most useful innovations conducted by the Sitapur **ADRA** SMC. Compared to other districts, the blocks in Sitapur district consist of small "backward" hamlets that are smaller than villages. In every hamlet and village the team selected a few motivated community members as Polio Volunteers who helped the vaccination team during the house-to-house activities during the November round. It was very effective in Pisawan block. From January 2005 onwards, the concept will be replicated in all areas. • The major focus of the training was (i) Tracking of newborn and newborn registration. (ii) Continuous up- grading of the CMCs field book (iii) Use of field book during the round (iv) Home visit and (v) Interpersonal Communication Skills (IPC). • **WV** involved and sensitized cane sugar societies and National Child labor project teachers and students.
Angola	• **Save** participated in the micro planning of measles and polio mop-up campaign conducted by the MoH in Luau Municipality of Moxico. They also participated in the implementation by providing cold chain and vaccination supervisors

Nepal	Both **Save** and **CARE** worked on the measles and SNID campaigns: • Facilitated District Immunization Coordination Committee meeting and micro-planning workshop • Provided support for vaccine movement and additional immunization booths • Mobilized monitors in municipalities, hard to reach, crowded areas and bordering places for monitoring and supervision support • Provided timely report collection, analysis and feedback to poor performing areas using LQAS technique • Assisted to conduct the orientation for the district supervisors. • Disseminated the messages through the public announcing and cable network. • In Jhapa district, **Save** organized convenience surveys. 832 households were visited and 929 children were observed during the survey. 69 children were found unvaccinated during the survey and provided OPV on the spot. • **CARE's** independent monitors visited 1023 household and identified 114 missed children in both Dhanusha and Mahottari district.
Ethiopia	• Involvement by **CCF** and **Alemtena Catholic Church** was based on discussions with the Woreda and Zonal Health Offices. In addition, they worked with Federal Ministry of Health (MoH) and World Health Organization (WHO) country office, focusing on filling the gaps and avoiding duplication efforts. • **CCF** and **Alemtena Catholic Church** activities included: a) Sensitization of community and religious leaders, elders and women mainly about SNIDs but also about routine EPI and AFP surveillance; b) Orientation and training of community based health agents and volunteers; c) Participation in the planning and implementation, monitoring and supervision activities; d) Engaged in house to house agitation, mounting of various communication materials including banners, posters, leaflets etc and use various other media to increase public awareness about the campaign and facilitate the full participation and support in the SNIDs, and e) Providing vehicles to transport vaccine and health professionals. • Vitamin A supplementation was also provided during the campaign

2.4 Support PVO/NGO efforts to strengthen AFP case detection and reporting (and case detection of other infectious diseases)

Figure 6 SAVE community Pastoralist (Nomads) volunteers, Oromiya Region, Ethiopia

The most important evaluation tool for the polio eradication effort is surveillance. Good surveillance is critical for both evaluating the effectiveness of polio eradication efforts in a country and for determining how the national eradication strategy should evolve over time. Good surveillance systems allow us to do two critical tasks: (1) determine where polio continues to be transmitted for purposes of mop up and increasing coverage; and (2) provide evidence that polio transmission has been interrupted.

The CGPP strategies for supporting AFP Case Detection & Reporting are the following:

- Expand efforts to support and provide training in detection and reporting of AFP (and related forms of paralysis or other selected diseases)
- Support MOH efforts to conduct active AFP surveillance
- Support poliovirus outbreak and/or AFP/polio case investigations and/or response
- Support logistics network for the transport and testing of stool samples by reference labs

Progress towards Strategies

- Given the declining numbers of supplementary immunization activities, Ethiopia, Angola, and Nepal focus on community based surveillance.
- CORE Ethiopia partners, in order to create strong linkages with communities in disease surveillance, trained 1016 community surveillance focal persons and started working on AFP, measles and neonatal tetanus surveillance. So far a total of 53 cases (19 AFP and 34 measles) were detected and reported.
- The community-based approach in AFP, measles and MNT surveillance proved to be relevant, feasible and appropriate where basic health service and infrastructure are non existent
- Community volunteers, with training on both surveillance and immunizations have been effectively utilized in hard to reach areas or hard to reach populations, such as migrants or nomads

Figure 4 CORE meeting with CARE PEI volunteers, Angola

Highlights	AFP Case Detection & Reporting Activities
Ethiopia	• **CORE** Partners have 748 community based surveillance volunteers in poor performing or silent areas in six regions. • **SCF** uses community volunteers from the Pastoralist communities in hard to reach reporting and nomadic populations. This has helped in silent reporting zones • **PCAE** trained 85 (42 male and 43 female) community surveillance volunteer workers on AFP, measles, & MNT from 38 kebeles of Dollo Woreda. The community surveillance volunteers are also trained in social mobilization needs and defaulter tracing for routine EPI. After the training, it was visible that they were highly motivated to participate in the education about and control of these diseases within their own communities. A reporting network has already been established between the trained focal persons and the near by health institutions. Reporting formats prepared in the local language were also distributed to the focal persons. The training was facilitated by health professionals from nearby health facilities, and this has helped the creation of a sense of ownership and involvement among staff. The Woreda was categorized as a silent zone in the WHO AFP surveillance report • In Shone, SNNPR, **WV** provided community based surveillance training for 125 community members, Sensitization workshop for 324 community members, 146 students, 32 high school teachers, 52 government office staff. • **CCF** has been implementing community participation in AFP and measles surveillance since 2004 in 51 Kebeles of Sodo Woreda, Guraghe Zone, SNNPRS with the active involvement of the District Health Office & the six health centers.

	Community surveillance focal persons have visited an average of 9419 homes per month and 500 community members received IEC materials (leaflets) on AFP, measles and EPI. Moreover, three monthly meetings were convened at six-health centers; reports were collected, tabulated and analyzed. • **CARE** has identified, selected and trained community volunteers from each village of the project area to serve as focal persons for community based AFP and measles surveillance activities. The focal persons are expected to survey their village for AFP and measles cases and report to their nearby clinics monthly (including zero) reports.
Angola	• **CARE** volunteers stated that the community is more sensitive now to taking sick children to the health post, due to their daily house-to-house visits. None of the volunteers have found AFP, but they have found several measles cases which they promptly walked to the nearest health center. • A **PROMAICA** volunteer, working with **Africare,** does house to house visits as part of a 40-mother volunteer group, discussing topics such as polio, meningitis, tetanus and other preventable diseases. The volunteers report any suspected case to both the **Africare** contact as well as the health center. • **IMC** provided Village Health Committees supervisors with twenty-nine bicycles to increase AFP detection, notification and timely reporting in locations where access is very difficult. • The **CRS** polio team worked with the surveillance department in data collection and sent it via HF radio from the municipal to the provincial level to expedite the flow of information. Surveillance bulletins were also sent via car. Project staff is also working with trained traditional healers in order to inform the community focal point about any suspect EPI disease case. During talks, community members are also encouraged to report cases to the community focal point and the nearest health facility. • During this period, **CRS** project volunteers notified three AFP cases (Lobito, Benguela and Ganda) and **CRS** supported the surveillance department in case investigation, stool sample collection and sample transportation from the community level to Luanda. • **CARE** volunteers conducted 21,320 house visits in an effort to strengthen integrated active surveillance in their communities and the project conducted seven refresher trainings for 135 community volunteers in Kuito and Andulo. Volunteers also received raincoats. See figure 4.
Nepal	• **CARE** participates in monthly coordination meeting with SMO of Western Region. During the meeting, Nawalparasi team shared VDC wise immunization coverage status and updated status of AFP surveillance. Coverage of routine immunization by VDC was analyzed by using GIS generated map during SNID orientation of health facilities in charges. Regular coordination meetings have been fruitful for program update, problem solving and developing planning for immunization strengthening and get support for VPD surveillance. • **CARE** advocates AFP/Measles, Neonatal Surveillance and case report messages to the people in every opportunity, such as small gatherings, teashops, community visits etc with service utilizers • **Save** organized one day VPD surveillance orientation for 28 traditional healers in Dang. Healers are the recognized people for the primary treatment in the community, especially those in bonded labor. Main objective of the orientation was to orient about the causes and prevention of vaccine preventable diseases and orient them about the importance of regular immunization. During the workshop they learned certain messages that would contribute to empower mothers for scheduled immunizations and social mobilization for early detection of VPD cases

2.5. Support PVO/NGO efforts to provide long-term assistance to families with paralyzed children

Through the CGPP effort, we expect that an increased number of polio and other types paralysis cases will be discovered. Because of this, we encourage CORE polio projects to provide assistance to families of children identified with paralysis (from any cause). If we make efforts to find paralysis cases, we believe it is our obligation to provide assistance to these persons and their families in some way that makes sense within the local context. Strategies to support families with paralyzed children include:

- Identifying paralyzed children
- Linking children to rehabilitation
- Linking families to food distribution, transportation help, school
- Family education

Progress towards strategies:

- India and Angola have been able to connect identified children to assistance. Angolan partners link families to other programs, such as agriculture and food distribution as well as securing private funding for mobility aid devices. Indian partners work to assist families with referrals for such things as calipers, reconstructive surgeries, railway concessions, and to provide families with counseling.
- Further momentum is needed in Ethiopia and Nepal

Highlights	Assistance to Families Activities
Angola	• **Africare** and **CARE** distributed agricultural tools to families with paralyzed children in Bie. These tools will help to increase family output and the value of the paralyzed children within the household. • **SC** project staff identified six new paralyzed children during this period and collaborated with the VVAF in supporting them with a pair of crutches, a tricycle and a wheelchair. This kind of collaboration will continue as both **SC** and VVAF are interested in helping paralyzed children. • During talks and house-to-house visits**, CRS** project volunteers encouraged the community to report to the focal points if they know about under-15 paralyzed children. During this period, they reported 16 children. To these children, **CRS** donated five wheel chairs, and five pairs of crutches • In collaboration with Irmãs da Caridade de São Vicente de Paulo, **CRS** is also identifying adults with disabilities who will benefit with wheelchairs from this religious group. Project team facilitated the donation of one wheelchair to an adult in Bocoio.
India	• **PCI** partners have made efforts from the match funds to organize camps at the village level where all the district officials have visited and provided disability certificates on the spot. 941polio-affected children were identified apart from other services. • During Q1, 2906 polio-affected children were identified by **ADRA**. An intensified survey is being conducted to identify the children below 15 years of age who are affected by polio as well as having received certificates from the government authorities previously. Many of the identified children already have the disability certificates issued by the government. But the children with a grading below 30% disability are trying to get another certificate with the hope to get a higher grading for obtaining more facilities. It is expected that at the end of the April polio round the survey will be completed. Sitapur and GB Nagar SMCs helped 161 children to issue disability certificates.

2.6 Support PVO/NGO participation in either a national and/or regional certification activities

Activities to certify that a country is polio-free vary across the CGPP countries, especially with the new importations and changing epidemiological situation. For this reason, the main interest of the CGPP at this time is for collaborative PVO organizations to begin thinking about an appropriate role for PVOs/NGOs during their countries' certification period.

We have requested that the secretariat directors notify the national certification committee of their interest in contributing or participating in committee activities if appropriate.

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

Information is necessary for maintaining and improving quality of polio eradication activities. Are the activities being done the right activities? Are they being done in the right way and at the right time? Answers to these questions can only come after appropriate information has been collected and analyzed. The CGPP strategy for the information documentation includes the following types of activities as well as others:

- Count zero-dose children following supplemental activities and use information about distribution of zero-dose kids to improve plans to prevent zero-dose children in next round;
- Document the percent of AFP cases with 2 stool samples taken within 14 days of onset of paralysis;
- Document problems in logistics and/or implementation of supplemental immunizations and use this information to improve planning of follow-up supplemental immunization rounds;
- Report to CORE partners the results of MOH or WHO clinical exams and laboratory tests of stool specimens--- related to AFP cases identified in the project area during the prior reporting periods (polio, non-polio/discarded, pending).

Progress towards strategies:

- **CORE** Ethiopia provided training in Lot Quality Assurance Sampling (LQAS) in the reporting period to enable relevant people to strengthen, expand and scale up the role of PVOs and Woreda health staff efforts in PEI and routine EPI, especially in monitoring and evaluation. In this regard, most of the health professionals at lower level lack the skill and knowledge in monitoring and evaluation of community health programs. Therefore, this training has been appropriate in enhancing the capacity of monitoring and evaluation techniques of the Woreda Health Offices and health staff of PVOs/NGOs health working in the area of immunization as well as other health activities at the community level.
- LQAS taught to all partners in Angola, and the training will be incorporated on a quarterly basis to report on progress in order to decide which places and indicators need more attention and to use our scarce resources more carefully
- India has developed a unique HMIS software package for rapid examination of data

Figure 7 Using the random table during LQAS field training, Angola

Highlights	Documentation & Data Analysis Activities
India	• HMIS software revised to make it more efficient. All partners and field staff trained and using HMIS data for analysis, decision making and for effective presentations. • The program tracks indicators specific to India by block and district level, using data from CBOs and partners, campaign, MOH & NPSP data. **See figures 8 & 9** • This data is analyzed and used for improving programs, reporting, and presentations.

Nepal	• **SAVE** organized convenience survey in 42 places during the SNID. 832 households were visited and 929 children were observed during the survey. 69 children were found unvaccinated during the survey and provided OPV on the spot**. See figure 10.** • **CORE** organized GIS Refresher training for PVO staff and counterpart both from central and district level. Main objectives of the training were to review the GIS application and how to apply GIS technology for data analysis, use of information and dissemination.
Ethiopia	• During the reporting period, two rounds of LQAS training programs were conducted by **CORE**. The trainings were mainly organized for woreda health office heads, EPI coordinators and PVO/NGO health professionals, and development workers working in the area of immunization and polio eradication.
Angola	• In order to speed up the flow of information from the community to the health facility, **CARE** distributed 100 bicycles to community volunteers and surveillance focal points. • **IMC** collected, analyzed and shared monthly vaccination data with MoH, the WHO, and other NGOs during a monthly meeting on stock control, polio surveillance update and measles. • **CRS** is supporting the MoH in reproducing and distributing surveillance and report forms to Caimbambo, Culango, Canjala, Egipto Praia e Chongoroi as well in collecting data. Weekly surveillance data is also transmitted via HF radio system from the municipal to the provincial level. • Through **Save** HF mobile radio, installed in a vehicle, project staff was able to timely transmit surveillance and vaccination data from the community and municipality to the provincial level, both in Kwanza Sul and Moxico provinces. • In Bie Province, **Africare** gives on the spot, one to one training to polio activists and assists the MOH in compiling monthly EPI data at the provincial level. In Kwanza Sul Province, Africare is supporting the MoH in compiling data in the new EPI data bank and supports data collection of these data as well through its radio communication system. In Luanda, project staff is also supporting in collection of epidemiological data, compiling and sending it to the provincial level. Three meetings were conducted with all EPI activists in Sambizanga municipality to review progress on their activities.

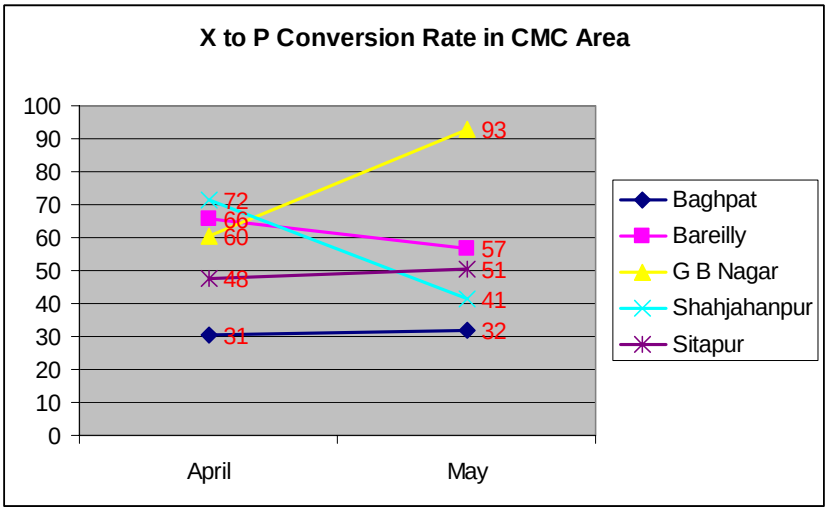


Figure 8 X to P Conversion Rate % in ADRA CMC Districts, May vs. April Rounds Uttar Pradesh, India 2005

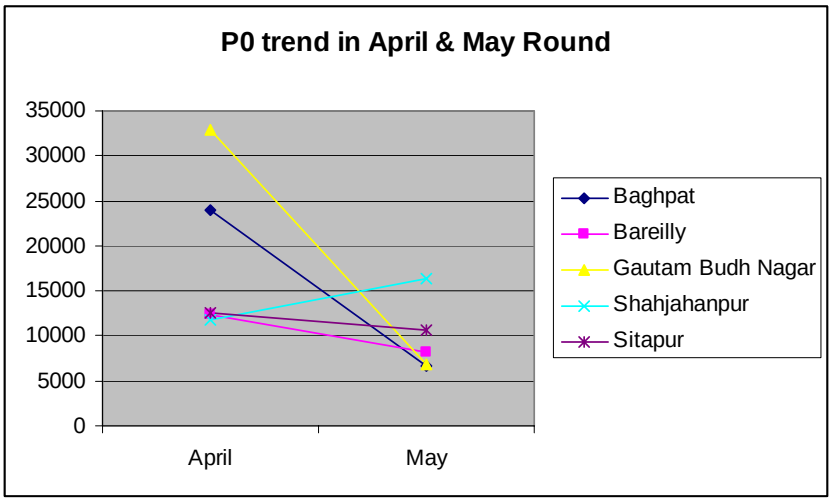


Figure 9 P '0' in ADRA CMC Districts, May vs. April Rounds, Uttar Pradesh, India 2005

Reason for not visiting immunization booths (n=69)

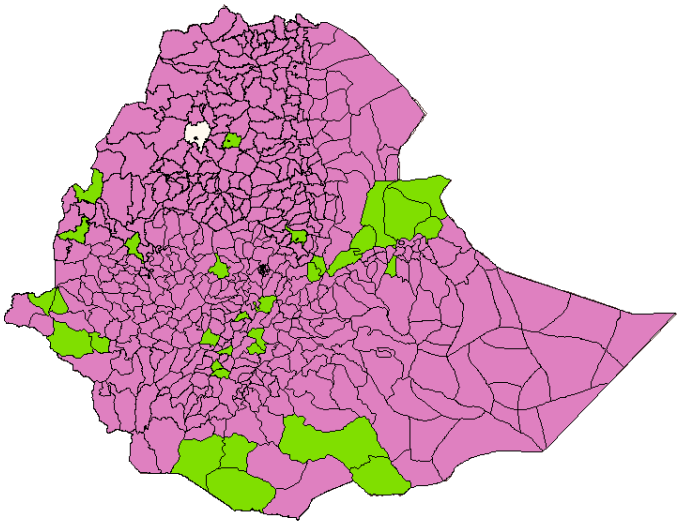
Reasons	Percent
Not informed about the campaign	71.01
Time constraints	7.24
Health Volunteer will visit the next day	17.39
Children were not at home	4.34

Figure 10 Reasons by Mothers for not visiting immunization booths, Jhapa District Convenience survey, SAVE Nepal, 2005 SNID

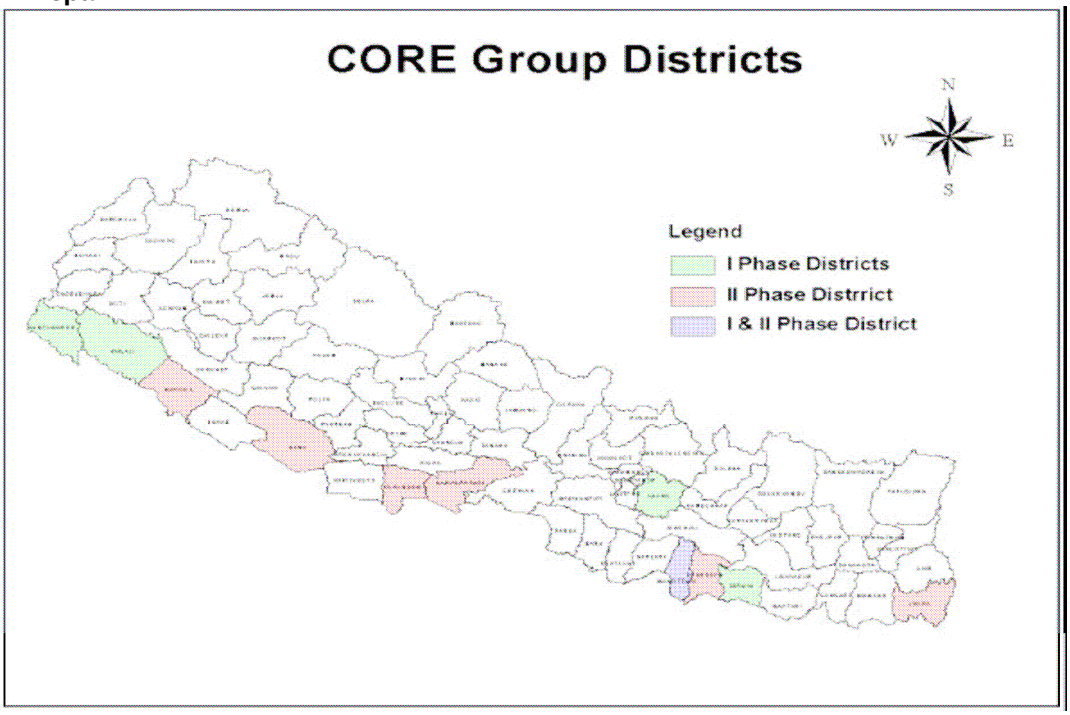
Annex X Maps of Project Areas
1. Ethiopia

CORE Ethiopia Project Area by Woreda FY2005

CORE	



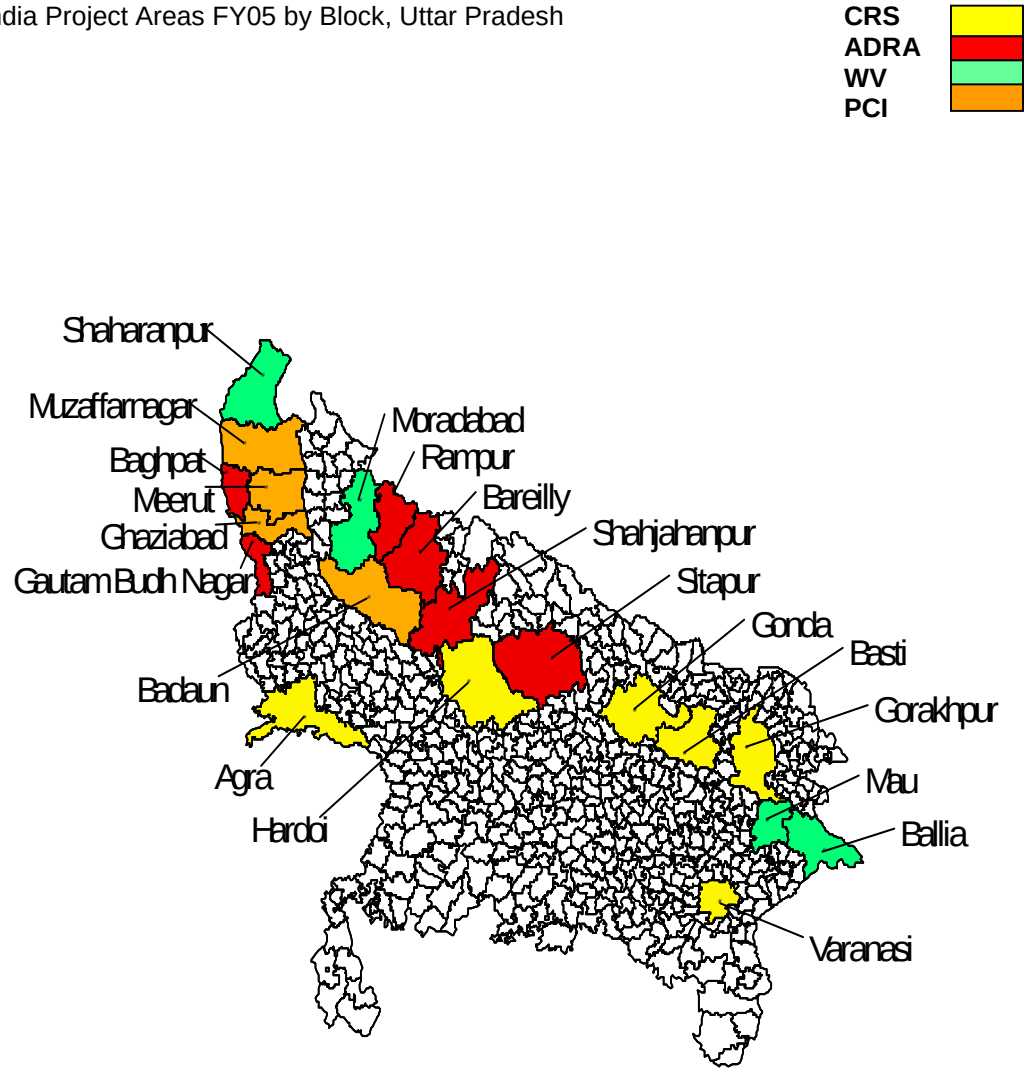
2. Nepal



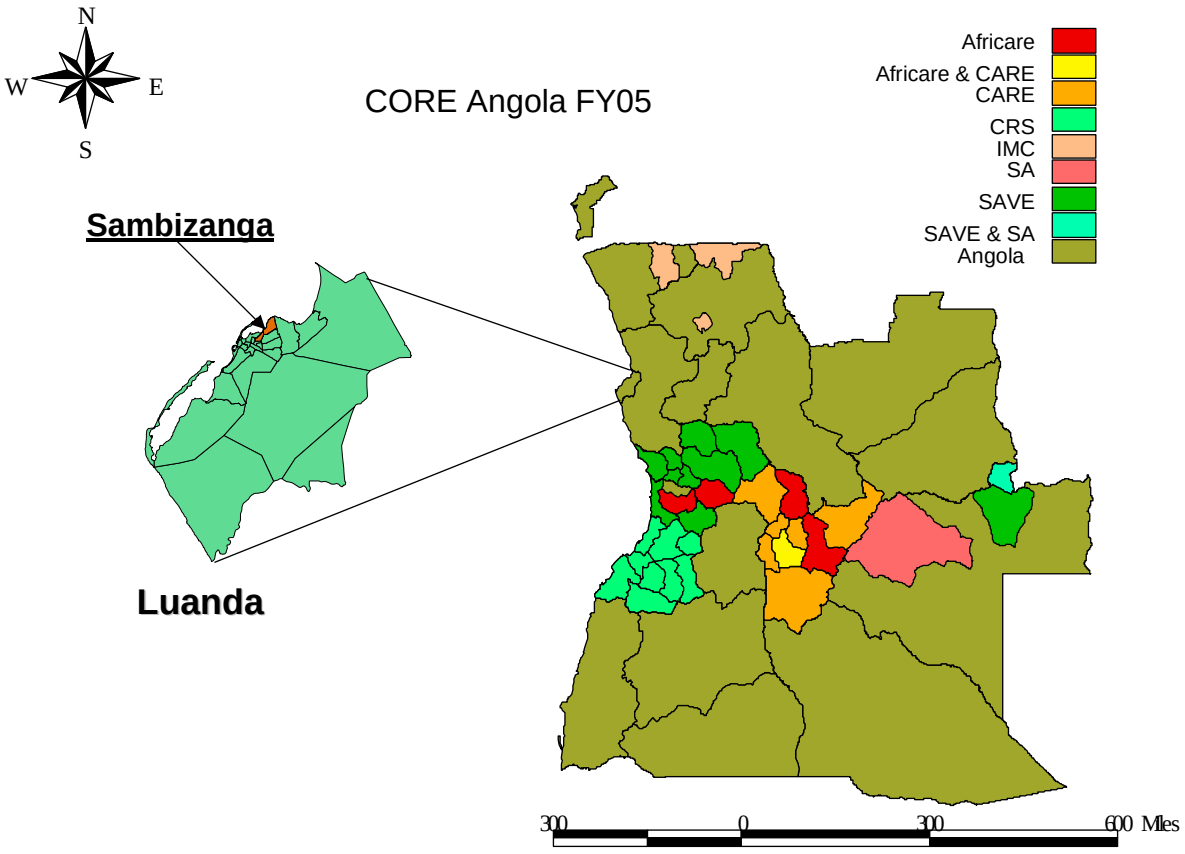
Phase I Districts	2000-03	
Phase II Districts	2003-04	
Phase I & II Districts	2004-05	

2. India

India Project Areas FY05 by Block, Uttar Pradesh



4. Angola


N
W
E
S
CORE Angola FY05
Africare
Africare & CARE
CARE
CRS
IMC
SA
SAVE
SAVE & SA
Angola
Sambizanga
Luanda
300
0
300
600 Miles