



**CORE GROUP POLIO PARTNERS (CGPP) PROJECT**

**Quarterly Narrative Report**

**1 January through 31 March 2001**



**Child as poliovirus: PLAN Bangladesh**

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



# CORE GROUP POLIO PARTNERS (CGPP) PROJECT

## Quarterly Narrative Report

1 January through 31 March 2001

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## ACRONYMS

|        |  |
|--------|--|
| ADRA   | Adventist Development and Relief Agency            |
| AFP    | Acute Flaccid Paralysis                            |
| AMREF  | African Medical Research Foundation                |
| CBO    | Community Based Organization                       |
| CDC    | US Centers for Disease Control and Prevention      |
| CCF    | Christian Children's Fund                          |
| CGPP   | CORE Group Polio Partners                          |
| CRS    | Catholic Relief Services                           |
| EPI    | Expanded Programme on Immunisation                 |
| ICC    | Inter-Agency Coordinating Committee                |
| IEC    | Information, Education, Communication              |
| IMC    | International Medical Corps                        |
| IMCI   | Integrated Management of Childhood Illness         |
| KI     | Key Informant (for AFP case detection)             |
| MIHV   | Minnesota International Health Volunteers          |
| MOH    | Ministry of Health                                 |
| NGO    | Non-Governmental Organization                      |
| NID    | National Immunization Day                          |
| OPV    | Oral Polio Vaccine                                 |
| PCI    | Project Concern International                      |
| PEI    | Polio Eradication Initiative                       |
| PET    | CORE Group Polio Eradication Team                  |
| PLAN   | Plan International                                 |
| PVO    | Private Voluntary Organization                     |
| SC     | Save the Children                                  |
| SMO    | Surveillance Medical Officer                       |
| SNID   | Sub-national Immunization Day                      |
| UNICEF | United Nations Children's Fund                     |
| UP     | Uttar Pradesh State of India                       |
| USAID  | United States Agency for International Development |
| WHO    | World Health Organization                          |
| WIF    | Women's InterLink Foundation                       |
| WV     | World Vision                                       |

# **CORE GROUP POLIO PARTNERS (CGPP) PROJECT**

## **Quarterly Narrative Report, 1 January through 31 March 2001**

### **SECTION 1. EXECUTIVE SUMMARY**

In late July of 1999, the Polio Eradication Team (PET) of the CORE Group 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 was awarded \$8 million over five years for the Polio Eradication Initiative (PEI). The CGPP coordinates and mobilizes community involvement in mass oral polio vaccine (OPV) immunization campaigns in high-risk areas and the hardest-to-reach populations of polio-endemic countries. The CGPP also supports PVO involvement in AFP case detection and reporting. This quarter, 19 CORE polio projects were active in the following five countries: Angola, Bangladesh, India, Nepal and Uganda.

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. The strategy to achieve the CGPP vision includes the following six components (our mission): (1) building partnerships, (2) strengthening existing immunization systems, (3) supporting supplemental immunization efforts, (4) helping improve the timeliness of AFP case detection and reporting, (5) providing support to families with paralyzed children, and (6) improving documentation and use of information for improving the quality of the polio eradication effort.

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 CGPP funds a secretariat in a country with the purpose of building a collaborative network among PVOs funded by the CGPP in that country. Currently, four of the five CGPP countries have a secretariat. In addition, the CGPP is represented on the national ICC in each of the five CGPP countries. This is an accomplishment of an objective of the CGPP. Also, of the 19 current polio projects, 17 (89%) report participating in polio eradication coordination meetings with representatives of stakeholder organizations this quarter. Sixteen of the 19 projects (84%) also report collaborating with national NGOs or CBOs this quarter.

To achieve the CGPP vision of leaving something of value behind once polio has been eliminated from the CGPP countries, polio projects are strengthening the immunization systems in such a way as to support both polio eradication and other vaccine-preventable disease control programs. USAID polio funds are being used by CORE PVOs for the following activities that we believe will leave behind strengthened immunization systems: (1) improving technical and management capacity of health workers to provide immunizations; (2) improving quality of the immunization logistics system; (3) encouraging private sector (e.g., business sector, private physicians) involvement in immunization efforts; (4) increasing community demand for immunizations; and (5) encouraging community participation in and/or contribution to immunization efforts. All projects have carried out at least one of these activities since the beginning of the project, which is an accomplishment of an objective of the CGPP. More projects are carrying out this kind of activity this quarter than was reported before. This quarter, the most frequently reported system-strengthening activities include social mobilization to increase demand for immunization services (89%), and encouraging community contribution to and participation in immunization activities (74%).

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. All 19 projects to date have reported helping with supplementary immunizations using USAID funds for CGPP. In helping implement NIDs and SNIDs, projects report participating in the following ways: (1) preparation of plans; (2) social mobilization; (3) taking part in implementation; (4) covering gaps in operations (planning and/or implementation); (5)

encouraging community participation and contribution in the conduct of supplementary immunizations; and, (6) participating in some form of process evaluation of supplementary immunizations. Social mobilization to increase community demand for supplementary immunizations is probably the greatest value-added by CORE PVOs to national polio eradication efforts.

This quarter, 16 of 19 projects (84%) report carrying out an AFP case detection/reporting activity; 17 project since the beginning of the CGPP. The most frequently mentioned AFP detection/reporting activity was training and education. Fifteen of 19 projects (79%) reported carrying out this activity this quarter (16 since the beginning of the CGPP project). Least common was project support for stool sample collection. To date, only three CORE polio projects (16%) have reported supporting the network for transport and testing of AFP stool samples. Non-timeliness of stool sample collection is a critical barrier to achieving high quality surveillance for polio and AFP in polio endemic countries. ***It seems clear that CGPP projects should now begin to give more emphasis to supporting timely stool sample collection where allowed by local government authorities.***

Through the CGPP effort, we expect to discover an increased number of polio and other types paralysis cases. 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. However, only two projects reported providing assistance to families with paralyzed children this quarter. ***We strongly encourage projects to look for ways to support families with paralyzed children, especially those families that are identified through our efforts to detect and report AFP cases.*** The CGPP objective is for 50% of projects to include support to families with paralyzed children on their workplans by the end of September 2001. We believe this objective is achievable and we are encouraged by new efforts underway to support this activity.

Information about zero-dose children is used to identify specific areas with pockets of under-immunized children that can be better targeted in future NIDs. The number of zero-dose children found during NID rounds was provided by five projects, although ten projects reported documenting zero-dose children. Three projects reported documenting "zero-dose" children for the first time this quarter. ***Few projects, however, document using this information to identify pockets of under-immunized children and improve planning/targeting for future NIDs/SNIDs as we recommend.***

Eleven projects (58%) reported on the timeliness of AFP stool sample collection this quarter; this is eight more than the last quarter. Two projects reported documenting problems in NIDs logistics or implementation for the first time this quarter. In sum, sixteen projects (84%) have reported carrying out at least one of the above three documentation activities this quarter; 17 projects (89%) since the beginning of the program. This number approaches (by mid-year) the FY01 CGPP objective of 100% of projects reporting at least one these three documentation activities.

A key management challenge for the CGPP is to continue working in areas with high-risk for polio transmission. As current project areas become less than high-risk, the specific challenge for projects is to shift activities to high-risk areas, perhaps in areas a PVO has little experience working in. Funds from donors other than CORE (including USAID missions) look promising as ways to help projects shift to high-risk areas without leaving lower risk areas without any coverage. For example, India is involved in intensive eradication efforts and the government surveillance unit, NPSP, has identified very high-risk areas. The India Secretariat is requesting that the organizations consider shifting to locales that considered high-risk, especially in UP and Bihar, and to increase coverage in urban slums. The USAID Mission in India is considering the possibility of providing funds to CORE PVOs to make these shifts.

## SECTION 2. BACKGROUND AND STATUS OF THE CORE GROUP POLIO PARTNERS PROJECT

In late July of 1999, the Polio Eradication Team (PET) of the CORE Group 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 was awarded \$8 million over five years for the Polio Eradication Initiative (PEI). The CGPP coordinates and mobilizes community involvement in mass oral polio vaccine (OPV) immunization campaigns in high-risk areas and the hardest-to-reach populations of polio-endemic countries. The CGPP also supports PVO involvement in AFP case detection and reporting, and documents the participation and contribution of the PVOs toward the global eradication of polio. The CORE Group is uniquely positioned to serve in this capacity as it represents 35 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. The PET objectives and workplan for fiscal year 2001 are provided in Annex 1, along with the PET vision and mission statements.

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:

- Eradication of polio is accelerated by the coordinated involvement of PVOs and NGOs in national eradication efforts.
- 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).
- Relationships are strengthened between communities and international, national and regional health and development agencies.

The strategy to achieve this vision includes the following six components (our mission): (1) building partnerships, (2) strengthening existing immunization systems, (3) supporting supplemental immunization efforts, (4) helping improve the timeliness of AFP case detection and reporting, (5) providing support to families with paralyzed children, and (6) improving documentation and use of information for improving the quality of the polio eradication effort.

This quarter, 19 CORE polio projects were active in the following five countries: Angola, Bangladesh, India, Nepal and Uganda. [One project of these 19 was active in polio eradication even though the sub-agreement had not been finalized and the project had not received funds]. The distribution of these projects by country, potential beneficiary population (under five years) and anticipated USAID funding is provided in Table 1 below. The distribution of projects by country and PVO is in Annex 2.

**Table 1. Current distribution of 19 CORE Polio projects:**

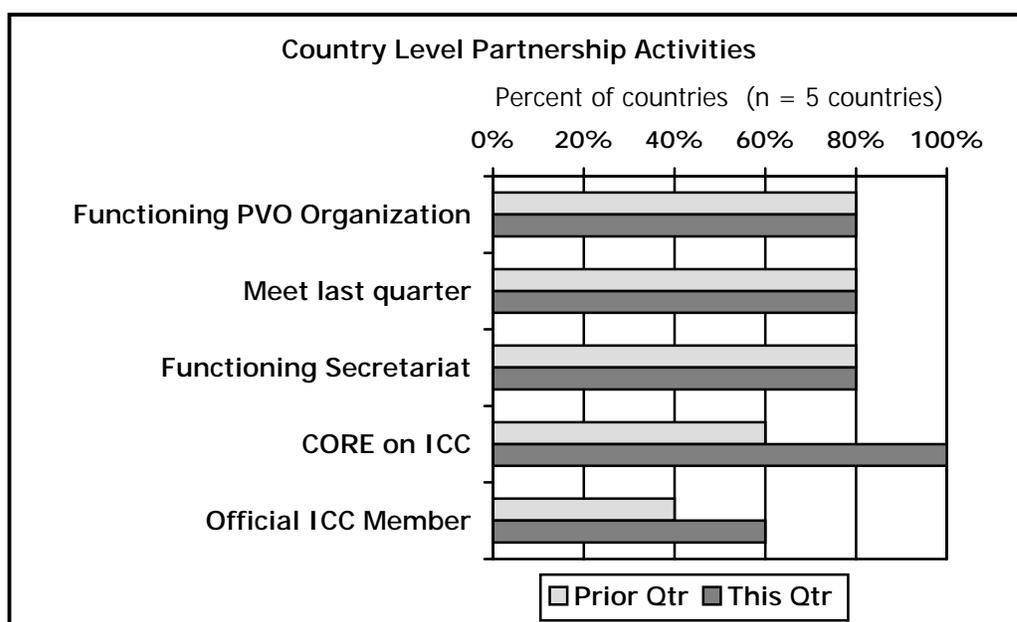
| <b>Country</b> | <b>No. of Projects</b> | <b>Potential Beneficiarie</b> | <b>USAID Funding</b> |
|----------------|------------------------|-------------------------------|----------------------|
| Angola         | 5                      | 1,087,467                     | 1,065,064            |
| Ugand          | 2                      | 128,000                       | 346,067              |
| Banglades      | 4                      | 1,160,798                     | 592,083              |
| India          | 5                      | 2,434,375                     | 1,388,916            |
| Nepal          | 3                      | 333,054                       | 293,557              |
| <b>TOTAL</b>   | <b>19</b>              | <b>5,143,694</b>              | <b>3,685,687</b>     |

## SECTION 3. REPORT OF ACTIVITIES BY MISSION STATEMENT

### 3.1. Mission - Build effective partnerships between PVOs, NGOs and international, national and regional agencies involved in polio

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.

USAID funds are being used by CORE PVOs for the following types of activities that we believe will lead to effective long-lasting partnerships: (1) participation in collaborative PVO organizations; (2) CORE participation on national and regional/local inter-agency coordinating committees (ICCs); and (3) collaborative efforts with national NGOs or community-based organizations (CBOs). These partnership efforts result in increased effectiveness and efficiency of national polio eradication efforts. Examples of partnership activities funded under the CGPP project are described provided below.



#### ***Collaborative PVO organizations***

To facilitate the building of collaborative PVO organizations, the CGPP has pursued a “secretariat” strategy. The CGPP funds a secretariat in a country with the purpose of building a collaborative network among PVOs funded by the CGPP in that country. A director, who organizes collaborative meetings, training, and cross-visits, leads the secretariat. The secretariat director also helps define a common monitoring and reporting system in each country. The secretariat director acts as a liaison between PVOs funded by the CGPP in the country and CORE HQ, and the director represents the CORE PVOs on the national inter-agency coordinating committee (ICC) that is responsible for organizing the national polio eradication effort.

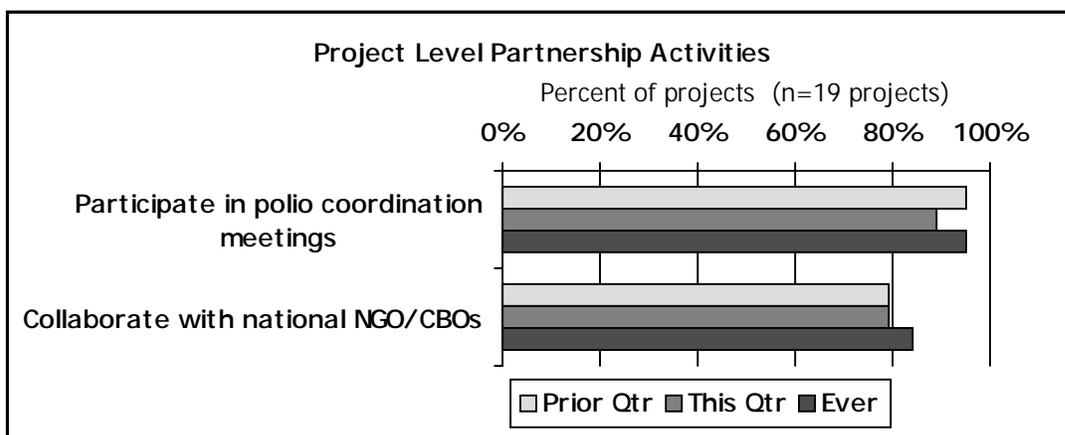
Currently, four of the five CGPP countries have a secretariat. The Secretariat Directors in these countries are Lee Losey, Dr. Shamim Imam, Harshni Raghav and Bal Ram Bhui, respectively. Dr. Roma Solomon is the Asia Regional Technical Advisor and Lee Losey will act as the Africa Regional Technical Advisor. Only Uganda (two projects) currently does not have a secretariat but this may change with the proposed establishment of an IMCI secretariat that could also be used to coordinate immunization and surveillance activities of CORE PVOs in Uganda. There has been no change in the number of countries with a secretariat since the last quarter.

In the four countries with a secretariat, a collaborative PVO organization has been established. Each of these four collaborative PVO organizations met together this quarter. This is the same as the prior quarter. For example, our newest secretariat in Nepal has met twice this quarter with the participating PVOs. At the meetings, participants explored program intervention options for developing implementation plans, discussed polio orientation and social mobilization, identification of high and/or hard to reach populations, reviewed NID and discussed mop-up plans. In Bangladesh, the secretariat held a workshop to develop a logical framework common to all CORE PVOs and other partners. The logical framework was finalized along with the monitoring system.

There were no activities this quarter in Ethiopia or DR Congo as per the workplan (See Annex 1). Moving forward in Ethiopia and DR Congo awaits an amendment to the CORE PEI Cooperative Agreement (ceiling increase and time extension) that will allow USAID missions to use this mechanism to fund CORE PVOs in these countries. Therefore the objective to establish a collaborative PVO organization in each "new" country supported by the CGPP is not yet applicable.

**CORE participation on national ICCs**

The CGPP is represented on the national ICC in each of the five CGPP countries. This is an accomplishment of an objective of the CGPP. In three countries (Angola, Bangladesh and Uganda) the CGPP representative is an officio member of the ICC. In India and Nepal, a CGPP representative is an ex-officio member of the ICC. This is a great improvement over the prior quarter when the CGPP was represented on the national ICC of only three countries. For example, in India for the first time, USAID and WHO facilitated participation of Dr Roma Solomon in a key India national ICC meeting.



**CORE participation on regional or local level ICCs**

Collaboration on polio eradication efforts at the project level helps develop collaborative networks that can be used in the future to address other PVO health initiatives. These networks are being established through the CGPP project. Of the 19 current polio projects, 17 (89%) report participating in polio eradication coordination meetings with representatives of other stakeholder organizations this quarter. [This is a lower number than last quarter probably due to the fact that fewer projects had NIDs or SNIDs this quarter than last quarter].

As an example, all CORE PVOs in Nepal participated in the District ICC meetings for NIDs and Mop-ups. In India, a meeting of PVO partners working in Ghaziabad District of U.P. was held to discuss the upcoming mop-ups, and was chaired by the SMO and CMO. Strategies for mop-up were explained with suggestions to improve IEC activities, coverage of areas left out by the health department, involvement of ICDS staff and training by the health department. Representatives from CORE and partner NGOs attended.

**Collaboration with national NGOs and CBOs**

Sixteen of the 19 projects (84%) also report collaborating with national NGOs or CBOs this quarter; one project reported this activity for the first time this quarter. For example, in Uganda, AMREF provided training workshops on IEC materials and graphic posters on AFP for health workers and community members; district health team members, community leaders and NGO representatives also attended the

workshops. MIHV/Uganda works closely with community based leadership organizations. In Angola, Africare participated with the CORE Secretariat and CARE, and in collaboration with Concern, Angolan Red Cross and the MOH in coverage surveys done immediately after the SNID.

In Bangladesh, CARE collaborated with national NGOs like BRAC, the Grameen Bank and other local CBOs in order to plan for the ninth NID. PLAN Bangladesh shared cross border experiences on organizing NIDs, SNIDs, and social mobilization with NGOs involved in polio eradication in West Bengal, India. World Vision Bangladesh held NGO coordination meetings at the sub-district level to ensure NGO staff and volunteers' participation in the ninth NID as volunteers and supervisors. Save the Children (US) Bangladesh, in collaboration with 16 local NGOs, formed a "trainer's pool" to conduct volunteers' training on polio eradication activities with an emphasis on routine EPI and AFP surveillance. These NGO staff members also worked as Independent Observers during NIDs, while also agreeing to use their non-health channels/forums to communicate polio-related messages.

An excerpt from CCF/India's report is also illustrative of these kinds of partnership activities: *"All our 19 polio partner NGOs working in the state of Bihar, Jharkhand, Uttar Pradesh and West Bengal participated in the 4<sup>th</sup> round of SNID held in the month of January 2001. Our volunteers visited 3,468 villages in 29 developmental blocks covering 368,749 households. As many as 181,084 children were administered OPV doses, out of which 3,524 zero-dose babies were detected."*

An objective of the CGPP is for all 19 projects to collaborate with a national NGO or CBO. This appears a feasible objective to accomplish by the end of FY01 given that 16 projects have already done so. ***We therefore strongly encourage projects that have not yet reported collaboration with national NGOs or CBOs to explore ways to do so within the next six months.***

### **3.2. Mission - Support PVO/NGO efforts to strengthen national and regional immunization systems to achieve polio eradication**

To achieve the CGPP vision of leaving something of value behind once polio has been eliminated from the CGPP countries, polio projects are strengthening the immunization systems in such a way as to support both polio eradication and other vaccine-preventable disease control programs. USAID polio funds are being used by CORE PVOs for the following activities that we believe will leave behind strengthened immunization systems: (1) improving technical and management capacity of health workers to provide immunizations; (2) improving quality of the immunization logistics system; (3) encouraging private sector (e.g., business sector, private physicians) involvement in immunization efforts; (4) increasing community demand for immunizations; and (5) encouraging community participation in and/or contribution to immunization efforts.

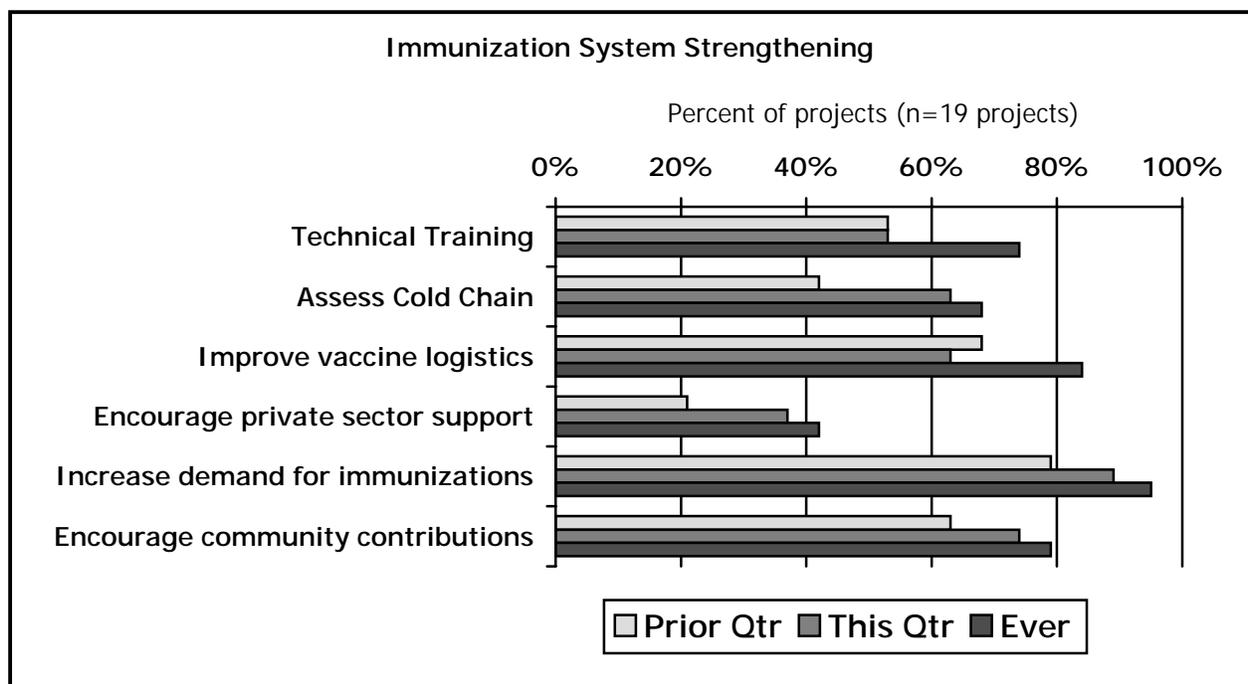
All projects have carried out at least one of these activities since the beginning of the project, which is an accomplishment of an objective of the CGPP. More projects are carrying out this kind of activity this quarter than was reported before. This quarter, the most frequently reported system-strengthening activities include social mobilization to increase demand for immunization services (89%), and encouraging community contribution to and participation in immunization activities (74%). A description of each of these activities is provided below.

#### ***Improving technical and management capacity of health workers to provide immunizations***

This quarter, ten of the 19 polio projects (53%) report carrying out technical or management training related to immunizations. An improved capacity to provide immunizations is expected to last beyond polio eradication and be able benefit other immunization efforts. While this number is the same as last quarter, the number this quarter now includes four projects that had not reported this activity at all prior to this quarter. The same number this quarter in spite of new projects reporting this activity may reflect a decreasing need for training (in project areas that have already carried out training).

As an example of this kind of activity, CARE/Nepal developed community maps that help female community health volunteers (FCHVs) to monitor childhood immunization status. To raise the motivation of each FCHV and facilitate their community visits and education sessions, each FCHV was given a bag. Save the Children (US) Bangladesh participated in EPI progress meetings of Health and FP staff at the sub-district level. On the job training on EPI activities, including child registers, tally sheets and field visit findings was given. Through these meetings, antigen-wise EPI reported coverage was reviewed to assess inconsistencies, develop action steps and recommend future improvements. A compiled status of routine EPI was presented at District Health coordination meeting that reflected very low performance in routine

EPI. Accordingly, a decision was taken in the district meeting to take a local level special initiative in low coverage areas to improve routine EPI. The initiative included selection of community based volunteers (from among the best NID volunteers) - 2 per EPI session to join in IPC and session management with EPI team for the time being to strengthen routine EPI.



### **Assess the cold chain**

Understanding better the current cold chain situation is the first key step to quality improvement of the cold chain; this will benefit the entire immunization program (not just the polio eradication effort) and is a true systems strengthening activity. Thirteen projects (68%) have reported this activity since the beginning of the project. This quarter, 12 projects (63%) report having participated in a formal assessment of the cold chain. This represents five projects that had not reported this activity previously. **While we are encouraged that significantly more projects are reporting this activity than in prior quarter, we encourage the remaining projects to see if a cold chain assessment is feasible to do within the next six months.**

As an example of this activity this quarter, WV/India reports carrying out a cold chain assessment in Ballia district in Uttar Pradesh. The cold chain was found to be poorly equipped and maintained. The project installed a transformer in Beruarberi PHC so now there is electricity to run the cold chain. WV/Angola, in collaboration with UNICEF, IMC, Caritas de Angola and the Angolan Red Cross all worked hand in hand in the maintenance of the cold chain in the project area, showing that as a result of combined efforts, smooth functioning of the cold chain is possible.

### **Improving quality of the immunization logistics system**

Apart from assessing the cold chain, 12 of the 19 projects (63%) report working to improve the cold chain and/or vaccine logistics system this quarter; 16 projects (84%) since the beginning of the project. For example, SC/Nepal provided bicycles to vaccinator couriers in the Terai areas in order to maintain the efficiency and effectiveness of the cold chain.

### **Encouraging private sector involvement in immunization efforts**

Having private-sector support is another way of strengthening the immunization system. This indicates that more resources of a sustainable nature are being used to prevent vaccine-preventable diseases. Seven projects (37%) reported an instance of such support this quarter, eight projects (42%) since the beginning of the program. This is a significant improvement since the last quarter when only 21% of projects reported such an activity. **We are greatly encouraged by the upward trend in reports of this**

**activity. However, the reports we received provide few concrete descriptions of private sector involvement in immunization efforts. We encourage projects reporting this kind of involvement to provide examples in the next reporting period.**

### ***Increasing community demand for routine immunizations***

Increased community demand for and contribution to health services is another indicator of strengthened health systems and community ownership of efforts to provide for their own health. This is another indicator of additional sustainable resources being used to prevent vaccine-preventable diseases. Seventeen of 19 projects (89%) report activities to increase community demand for routine immunizations this quarter. This number includes three new projects that did not report these activities last quarter. ***In sum, 18 projects (95%) have reported this activity since the beginning of the program, for which we are encouraged.***

Many of the activities under this heading are done in conjunction with social mobilization activities to increase participation in NIDs and SNIDs. A tremendous variety of social mobilization activities have been reported by CORE PVOs. For example, MIHV in Uganda conducted many community sensitization meetings in order to increase participation at community immunization outreach sessions. Three groups were specifically targeted: TBAs, community leaders and clergy. CRS/Angola worked with church leaders in Cubal municipality, where they committed to disseminating immunization messages to the public.

Kwadar is a remote village in the Pipalwara Panchayat of Jhadol Block, Udaipur District of Rajasthan, India. Kwadar is a hilly terrain with very poor communication facilities. The inhabitants of this village hail from Bheel tribe. The immunization rate is almost nil in this village. World Vision working through the NavPrabhat ADP appointed Anandilal Gamar as the polio volunteer in this village. The advantage of his appointment was he hails from the same tribe and is educated than others. He knows the culture and would be able to communicate to the people. ANM failed in her efforts to motivate the residents of this village for immunization. The understanding of the tribal people was that if they get their children immunized, the tribal god will get angry and their children will die. Anandilal, even being scolded and chased away by the community, patiently continued to educate them to remove their superstition. The hard work and the patience bore some results, for the first time ever, parents brought their children for routine immunization in the month of March. Hats off to Anandilal Gamar.

Submitted by World Vision India

### ***Encouraging community participation in and/or contribution to immunization efforts***

By encouraging community participation in and/or contribution to immunization efforts, we mean that members of the community invested their own resources (human or other). This is meant to be a more substantial contribution than bringing a child for vaccination. For example, this quarter CARE/Bangladesh oriented Union Council Chairmen and Members to involve them in motivating the community to increase utilization of services.

Overall, 14 of 19 projects (74%) report some kind of community contribution to immunization efforts this quarter, 15 projects (79%) since the beginning of the program. ***These figures are very encouraging and represent a value-added of USAID funds to CORE PVOs. We encourage the remaining projects to support community efforts to take responsibility and ownership for their own health.***

The story below illustrates how polio eradication activities by PVOs can in fact leave something of value behind in addition to the elimination of polio. This story describes the first contacts made by the CARE polio volunteer, Frederico Souza in Cambandua IPD camp in Angola. The camp has about 5000 children under five years of age.

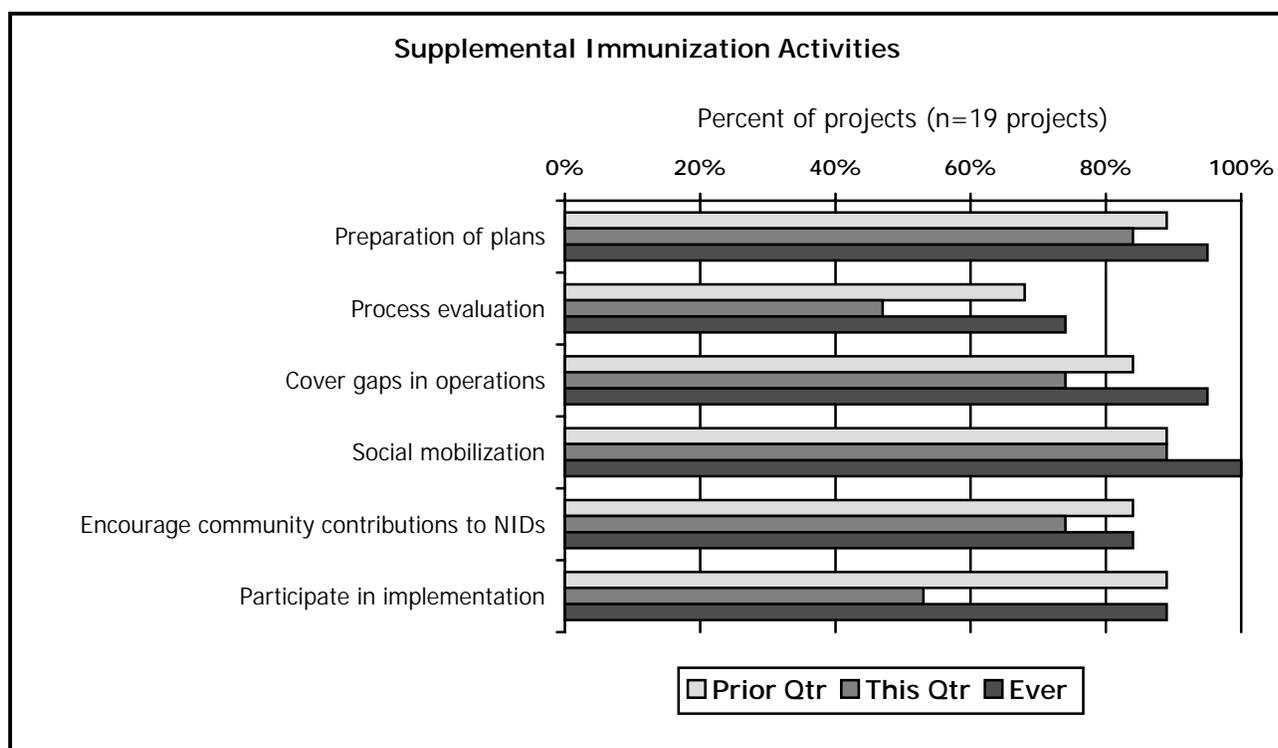
*During one of my first home visits in Cambandua camp I came to a house which belonged to Mrs. Domingas, mother of four children, the youngest one being 3 years old. I tried to find out if Mrs. Domingas knew anything about polio and if she had taken her children to get vaccinated. After a lot of questioning, I concluded that she knew nothing about polio, but took her children to get vaccinated because her neighbors also took their children, so she thought it was a good idea to do the same thing. She informed that her youngest child, Ana had not been vaccinated and I noticed a lot of dirt and garbage around her house. She was getting a bit suspicious because I was asking her a lot of questions. I explained to her that I am a volunteer of CARE's polio project and that we are working towards eradication of polio. I explained to her what polio is, how it is transmitted and how she can prevent her children from getting the disease. After awhile she seemed very interested in what I had to say and promised that she would take her youngest child to Catemo health post which is about 1 Km away from where she lived. She assured me that she would keep her house cleaner and practice better hygiene using examples that I gave her about hand washing and keeping food and water covered. I proceeded to do the rest of my rounds during the following days. About 10 days after my initial visit to Mrs Domingas' house I returned and found the house very clean and she received me with a smile on her face. She was very eager to talk to me and explained to me that she had gone to the health post and got her child vaccinated. Proudly she showed me the vaccination card for Ana and full of enthusiasm she explained to me that she is telling other mothers to go and get their children vaccinated. I left feeling very satisfied because I had helped one child get vaccinated. With our continuous work we can get many more children vaccinated, so that no child will get sick and not be able to walk anymore. I am very glad that I am a volunteer because I can help my community and at the same time I am learning a lot.*

### **3.3 Mission - 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.

Polio NIDs or SNIDs or Mop-ups were carried out this quarter in ten project areas. This is in great contrast to last quarter when all project areas had an NID, SNID or Mop-up. In spite of this drop in the number of projects with NIDs/SNIDs however, 17 projects report some kind of participation in the supplementary polio immunization activities this quarter, even if this is limited to planning. All 19 projects to date have reported helping with supplementary immunizations using USAID funds for CGPP. Therefore, CGPP has achieved to date the objective that each project "funded by" CGPP in FY01 will support supplementary immunization efforts in their project areas.

In helping implement NIDs and SNIDs, projects report participating in the following ways: (1) preparation of plans at the macro- and micro-level; (2) social mobilization; (3) taking part in implementation; (4) covering gaps in operations (planning and/or implementation); (5) encouraging community participation and contribution in the conduct of supplementary immunizations; and, (6) participating in some form of process evaluation of supplementary immunizations. The chart below shows the distribution of activities that CGPP projects carry out to support supplemental immunizations.



### **Preparation of plans**

Participating in the preparation of NID/SNID plans is the type of collaboration activity that is key for avoiding duplication of effort and for covering gaps in operations, and is a good partnership building activity. Sixteen projects (84%) report collaborating with national and local health authorities in preparation of plans this quarter. For several projects, the plans are for NIDs or SNIDs that will take place next quarter. Eighteen projects (95%) have reported this activity since the beginning of the program. For example, SC/Nepal in Kailali district (a Terai district bordering the state of Uttar Pradesh, India) attended a cross border meeting held in India with its counterpart Regional Surveillance Officer for coordinated mobilization of vaccination at the border.

### **Social mobilization**

Social mobilization to increase community demand for supplementary immunizations is probably the greatest value-added by CORE PVOs to national polio eradication efforts. CORE PVOs have been instrumental in creating within communities the shared goal of polio eradication. This has helped to overcome social barriers to mass vaccinations, reach under-served populations and to encourage community contribution to mass vaccination efforts (discussed below). Seventeen projects (89%) report carrying out social mobilization activities this quarter. For several projects, social mobilization activities this quarter are in support of NIDs/SNIDs that will take place next quarter. Since the beginning of CGPP program, all 19 projects have reported carrying social mobilization activities. The biggest achievement the CORE Bangladesh PVOs had this quarter came from WHO/SEARO funding. This enabled imams and head teachers of primary schools throughout all unions in the country to be oriented about NIDs and polio. Another example of this activity provided by ADRA/India is shown below.

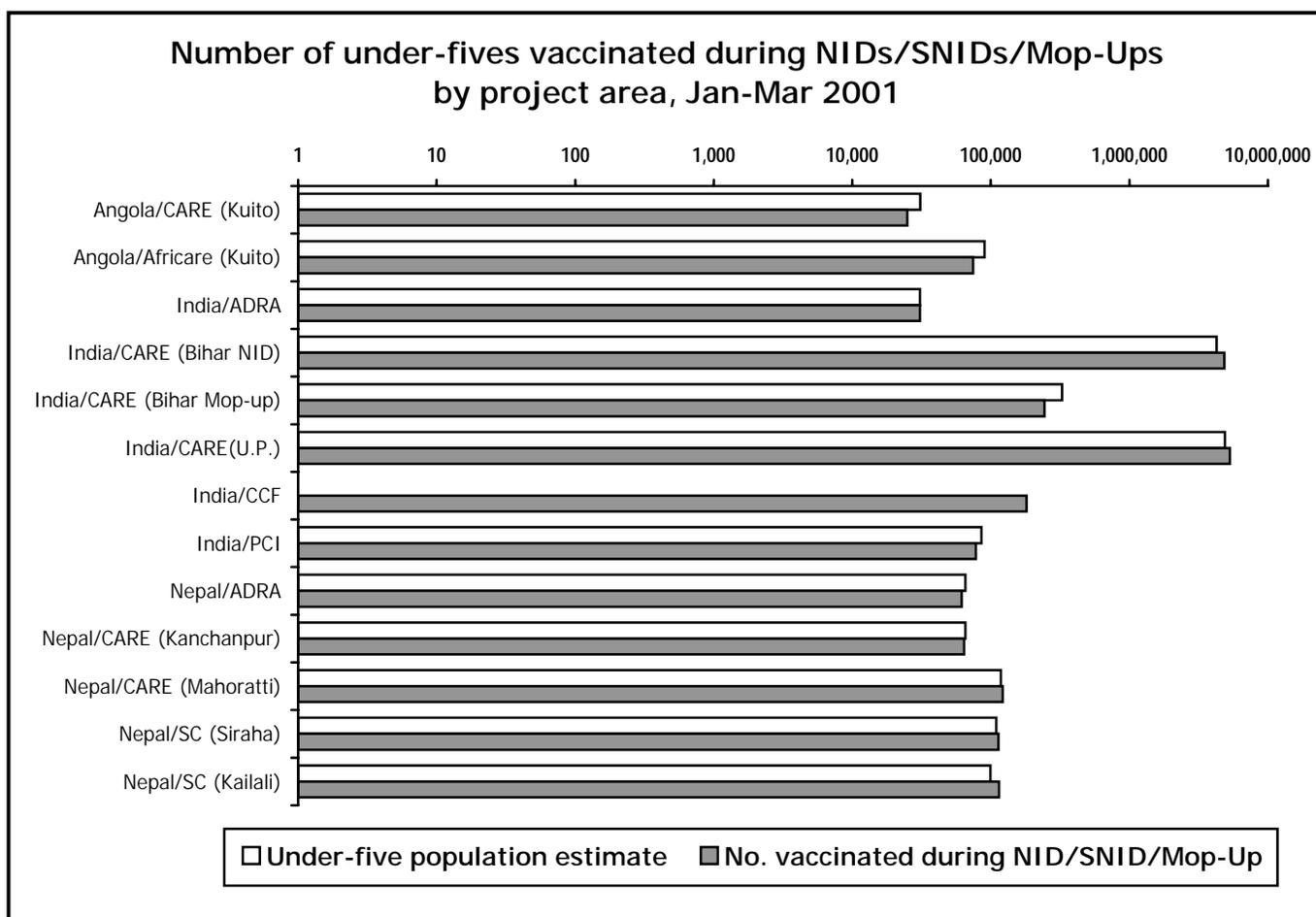
### **Implementation of supplemental vaccinations**

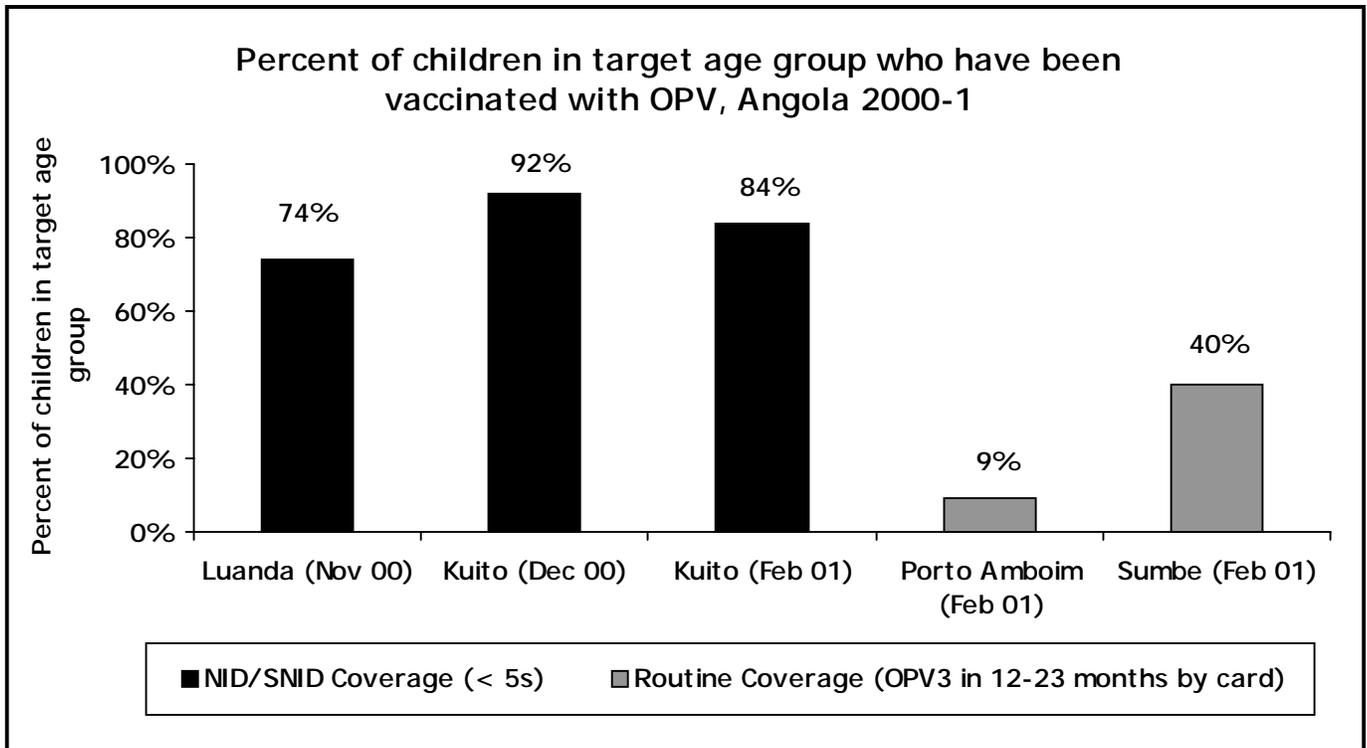
In addition to supporting NIDs and SNIDs, the CGPP is also helping accelerate eradication of polio by participating in implementation. Ten projects report participating in the implementation of supplementary vaccination campaigns this quarter. [NIDs or SNIDs were carried out in ten of the project areas that reported this quarter]. Common features of CORE PVO involvement in actual implementation of NIDs/SNIDs are the following: (1) transportation of volunteers, vaccine and ice to the booths; (2) replenishment of vaccines and ice; and (3) providing human resources for supervision, and for mobile, house-to-house and fixed-booth vaccination teams. For example, PCI/India's NGO partner, WIF,

organized mobile teams that went house-to-house in resistant areas of Calcutta where the government was concentrating its efforts on vaccinating from fixed booths.

The chart below compares the number of under-five year old children vaccinated in eight CGPP project areas during NIDs/SNIDs/Mop-ups this quarter and the estimated under-five population in these project areas. A log scale is used to help compare projects with large differences in under-five populations. We can make several observations about the data in this chart:

- In most projects, the number vaccinated is at, above or near the estimated under-five population. This is expected when NID coverage is high.
- In several projects, the number vaccinated is more than the estimated under-five population. This can happen when the population estimate is an under-estimate, and/or if children five years and older are being vaccinated.
- In two Angola projects in Kuito Municipality in Bie Province, the number vaccinated was less than the estimated under-five population. This was attributed to an under supply of vaccine, a lack of incentives for volunteer vaccinators, and an inability for vaccinators to verify their official status of vaccinators. Performance was higher in an earlier NID in December with better vaccine supply and incentives for vaccinators, and T-shirts for identification of vaccinators.
- In CARE/India the NIDs in Bihar and U.P. appear to have much better coverage than the Mop-up in Bihar (243,281 vaccinated out of an estimated 327,863 under five population in Mop-up areas). This may indicate that denominator estimates are more difficult to make or plan for during Mop-up operations, or that Mop-up operations are not as well planned as NIDs as they are a newer type of activity.





Angola is the only CGPP country where population-based coverage estimates of NIDs and routine services have been reported. In general, WHO does not recommend coverage surveys for evaluation of NIDs, but where the data are available analysis should be done and the data used to improve quality of NIDs. The chart above shows coverage estimates of individual NIDs and of routine immunization services in various municipalities over a several month period. Several interesting observations can be made from the chart below:

- Routine immunization services are failing to provide a sufficient number of OPV doses in two municipalities of Cuanza Sul Province (Porto Amboim and Sumbe) that are considered relatively safe and conflict free. We may assume that routine coverage in conflict areas is unlikely to be at or above these low levels. This reinforces the strategy that frequent, high-quality NIDs and SNIDs are essential for interrupting transmission in Angola. The involvement of CORE PVOs in this effort is important. ***It is important to remember that the status of polio transmission and polio eradication efforts in conflict and remote areas is unknown. For this reason, we encourage CORE PVOs to assist each provincial EPI team to develop a status report for each municipality: rates of polio transmission, AFP detection and reporting systems, indicators of quality NID/Mop-up planning and implementation, etc.***
- Coverage of NIDs and SNIDs varies between location and over time. For example, NID coverage in Kuito was lower in February 2001 than in December 2000. This lower coverage is also reflected on the chart above and was discussed above. This suggests that efforts at planning and implementation of NIDs must remain high during each and every NID and SNID. In Angola, success of NIDs is very sensitive to disruptions in what is a complicated logistics system that depends on UN flights to population centers because of insecurity. PEI experience in Latin America showed that campaign coverage levels of 90% were instrumental in interrupting transmission and eliminating polio from the region.

***Community participation in and contribution to the conduct of NIDs/SNIDs***

Communities served by CORE PVO polio projects have participated in and have contributed to the conduct of NIDs and SNIDs. Communities in almost all program areas in all countries of CORE PVO polio projects have provided volunteer vaccinators and/or promoters of polio eradication. Fourteen projects (74%) report some such community contribution this quarter alone; 16 projects since the beginning of the program. For example, CARE India facilitated meetings with private practitioners and community leaders to brief them on the polio situation in their areas and the upcoming mop-up. In

addition, small clusters of local people were invited to the meetings to sensitize them to the dangers of polio and what they could contribute to the eradication efforts. During these meetings, people openly discussed their apprehensions and fears related to the administration of the vaccine. Officials invited to attend the meetings answered their concerns and questions. It was observed that the community actively participated in such events and felt inspired to contribute towards the cause and take ownership.

#### THE ACHILLES HEEL

**Bharaich, in the State of Uttar Pradesh is the point of intervention chosen by ADRA for a special Mop-up Round of Polio drop administration. Unfortunately this State has the reputation of having the largest number of Polio cases in the country, and a detailed meeting with Dr S H Subba confirms that the cultural constraints being faced by the vaccinating teams continues to be an enormous challenge.**

"Together we examine the Micro Plan Dr Subba has made. A team representing ADRA, the SDA School Bharaich, Drs Subba and Sandeep Kalra (SMO's of the two blocks) and Shaheena Begum (UNICEF representative) discuss intervention approaches as the unspoken question looms large, "Will we be able to achieve success?"

"The next evening Dr Subba and I conduct a training and mobilization programme for a combination of 50 senior school students and teachers. By 6:30 am on Sunday morning the team is "raring to go". The Task – "Go as fore runners to the vaccinating team and undertake Social Mobilization of families in the villages to ensure they will permit their children to take the polio drops".

"After pausing for prayer for Divine help and with breakfast packages in hand, we board the bus and jeep. Fifty kilometers away, close to the Nepal border we stop at Babaganj, abandon the vehicles because no more motorable road exists, and walk two kilometers to the first village. The students parade in, beating drums – a certain way of attracting attention. Villagers gather to see what the ruckus is all about – exactly what we wanted! Yet there are reluctant mothers peeping out of huts. Cultural constraints prevent them from stepping out of their homes. Lady teachers from the SDA school – some of them of Muslim faith themselves – go door to door and convince these reluctant mothers of the necessity for inoculating their children. Slowly, more men, women and children gather at the village center.

"The students stop beating the drums and break out into song about Polio being not only an unwelcome guest, but also an enemy. They follow this with a skit, and now that we have everyone's attention, the lady teachers and Shaheena reinforce the message. Eaves dropping on a conversation I hear one village woman say to another, "If these children and women say they have taken the drops with no ill effect, then what harm can befall us?" I smile inwardly, "Thank you Lord, we are making an impact". Five villages and six kilometers of walking in 38C heat later, we head back for Bharaich with the satisfaction of a job well done. During the return drive, Principal S Marjee and I speak with team leaders to discuss the following day's logistics. Shaheena tells us of a group of villages which for the past two years has been under the control of an Imam, who has been completely obstructive about letting any Polio drop administering team even enter the villages. The villagers cannot go against his wishes. "Tomorrow the vaccinating team is due to go there, would you - could you consider going there? This is our most difficult area, even the filing of reports with the District Collector has proven an effort in futility", she explains. Back at Bharaich, with a hot lunch tucked under our belts (at 4:00 PM!) we discuss the prospects and accept the challenge.

"At 6:30 the next morning the vehicles wind their way to the villages located in the Mahsi area. Lady teachers, and students smartly dressed in school uniforms walk toward the first village, drums - to say nothing of hearts - beating hard with apprehension of what the Muslim Imam might say or do.

*Sure enough, as a Goliath to his Philistines, he emerges, startled by the sight of women and 50, uniformed children. "We are here with a very important message for you and the people of these villages" a student shouts at top volume. Heads pop out from every hut. The lady teachers walk up bravely, in full sight of the Imam and encourage the inmates to "come out and listen." One of the students first begins with a "lecture". He sounds like a scientist and speaks with the confidence of a politician!*

"Polio is a killer disease" he states, "look at all these children around you – they could be crippled for life. Look at me, look at my classmates! We are healthy – our parents made sure we took the Polio drops. WHO SAYS POLIO DROPS ARE DANGEROUS AND CAN CAUSE DISEASE OR INFERTILITY. IF THE DROPS ARE SUPPOSED TO CAUSE INFERTILITY, THEN IT IS THE ADULTS THAT SHOULD BE GIVEN THE DROPS – NOT THE CHILDREN! "

"There is pin drop silence and the Imam seems to shrink in size. A skit follows a song and absolutely on time, the vaccination team arrives. With no resistance, and only soft mumbling of assent, all the children are vaccinated in all five villages. Back in the transport vehicles, there is jubilant "slapping of high fives". The battle has been won.

"What was it that finally caused the Imam of this Muslim dominated group of villages to "Give In". Was it the presence of so many children? Was it the awe of seeing so many lady teachers? Was it that some of the teachers were of the Muslim faith themselves? Was it just Divine intervention?

What ever the definition of cause might be, what matters is the final result. The Imam left his Achilles Heel open at some point – and the Arrow made its impact. How gratifying to know that the resistance has broken down, and children in these five villages have a chance of leading Polio free lives.

Submitted by Dr G R Bazliel, ADRA India PEI Coordinator

### ***Covering gaps in operation of NIDs/SNIDs***

When participating in implementation of NIDs/SNIDs, a unique value-added of funds provided to CORE PVOs is the covering of gaps in current operations led by health authorities. Fourteen projects reported that they had covered a gap in operation of NIDs/SNIDs this quarter. ***We are encouraged that 18 projects have reported this activity since the beginning of the program.*** Some of the gaps that Nepal projects reported they covered include the following:

- Problems with transportation of vaccines
- Compensation to volunteers
- Inadequate supervisors
- Not enough teams for strategic points
- Mass communication

For example, ADRA/Nepal reports that during the January 2001 NID, the project provided its vehicle to transport vaccine and supplies to Nala, Panchkhal, Dapcha and Khopasi health post areas. ADRA also provided its vehicle for monitoring and supervision of the NID and house-to-house visits. CARE/Nepal supported the District Health Office by transporting vaccine and icepacks to Ilaka Primary Health Centers and Health Posts one day before the NID. CARE also provided supervision checklists and covered gaps in supervising health workers and social mobilization efforts in remote and high risk Village Development Committees.

### ***Process evaluation of NIDs/SNIDs***

The ability to provide independent feedback on the conduct of NIDs/SNIDs is a significant opportunity and potential value-added of USAID funds to CORE. The information should be used to improve quality of future NIDs leading to an accelerated interruption of poliovirus transmission. Typical ways in which CORE PVOs are involved in process evaluation of NIDs/SNIDs include the following: (1) counting zero dose children; (2) use of checklists to supervise activities at fixed-booths and of house-to-house teams; (3) conduct of surveys after NIDs to assess coverage on a population basis; and (4) participation in NID review meetings to process findings of NID monitoring and evaluation activities, and develop action plans for improvement.

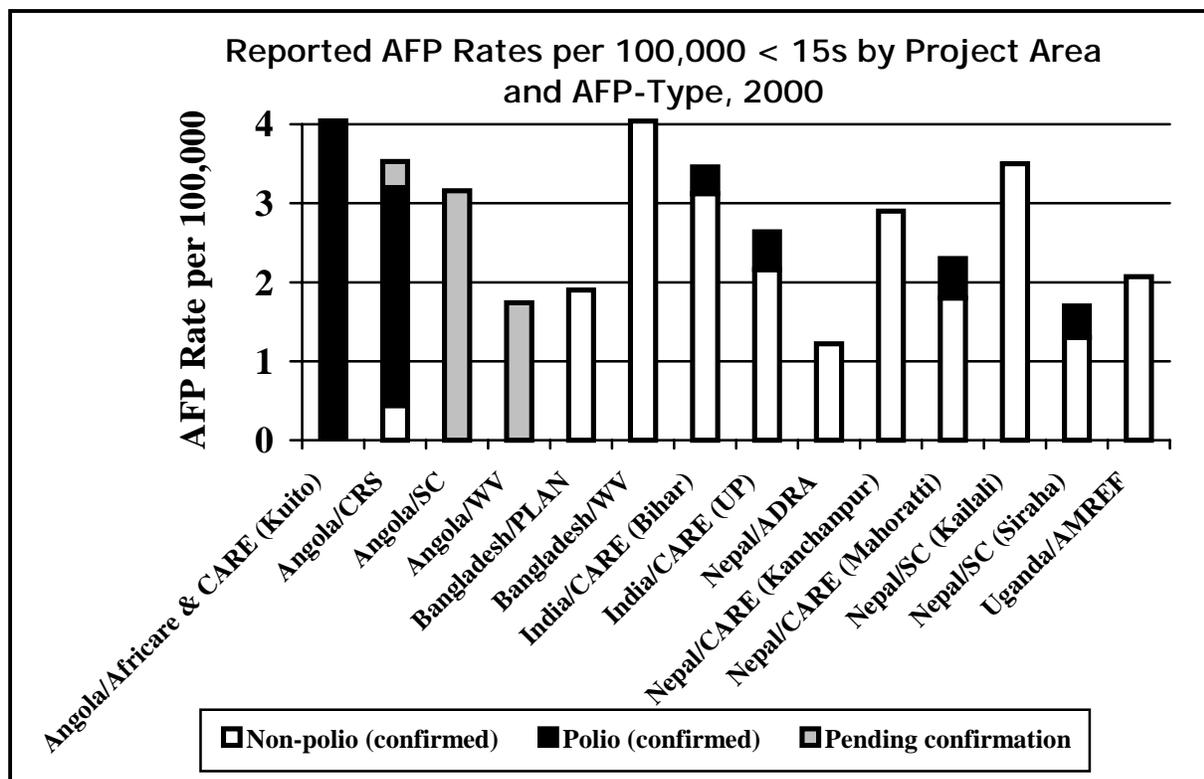
This quarter, nine projects (47%) report carrying out form of process evaluation of these activities. The lower number than last quarter (13) reflects the fact that fewer project areas had NID this quarter. ***Increasing the percent of projects that report involvement in process evaluations of NIDs and SNIDs remains a priority for the CGPP project.*** This quarter, ADRA/Nepal developed a checklist for supervisors and independent monitors. Use of this checklist resulted in improvement and spot corrections regarding recording of tally sheets, corrections in counting the age of children, more appropriate location of the session (i.e., not in the sun), application of gentian violet, and encouragement to the volunteers to return for the next days sessions. PLAN/Bangladesh participated in a national coverage evaluation survey of the 8<sup>th</sup> NID that was organized by MOHFW and WHO.

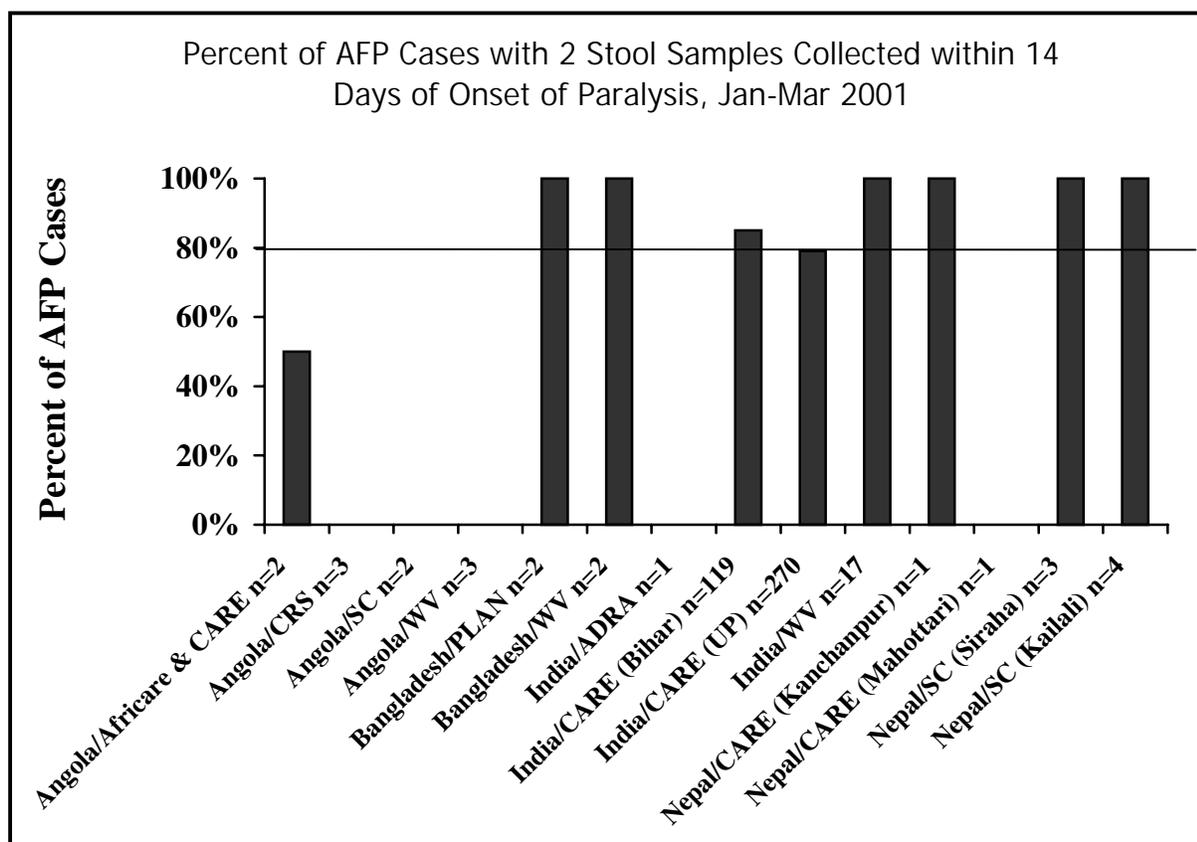
### **3.4 Mission - Support PVO/NGO efforts to strengthen AFP case detection and reporting (and case detection of other infectious diseases)**

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. Certification that a country is polio free requires a fairly sophisticated surveillance system that can provide evidence against existence of polio transmission. There are two indicators that are of primary importance for evaluating how good a surveillance system is. First is the acute flaccid paralysis (AFP) rate per 100,000 children less than 15 years of age. The non-polio AFP rate should be at least one per 100,000 because there are causes of AFP other than polio that occur at this rate (at minimum) in all populations. The second key indicator is the percent of AFP cases for which at least 2 stool samples were taken (between 24 and 48 hours apart) within 14 days of onset of paralysis. The timeliness of stool sample collection is important for being able to identify the existence/non-existence of poliovirus in the stool of an AFP case. Over time (if stool samples are collected and analyzed in a timely manner), the polio AFP rate should approach zero and the non-polio AFP rate should approach the value of at least one, as the polio eradication strategies are carried out.

The two charts below show reported AFP rates for the Year 2000 and the timeliness of stool sample collection this quarter in CGPP project areas. We can make several observations from the available data shown in the charts below:

- Surveillance systems in the Bangladesh projects reporting appear sufficient enough to document a non-polio AFP rate of at least one. The collection of stool samples was timely in these Bangladesh project areas this quarter.
- The surveillance system in the AMREF/Uganda project site also appears of sufficient quality. Note that none of the AFP cases in this project area in the Year 2000 has timely stool sample collection. It is possible, therefore, that the non-polio rate may actually include polio cases for which the stool sample was not timely enough to identify the virus; this is unlikely however as no polio cases were reported in all of Uganda in 2000. There were no AFP cases this quarter in the AMREF Uganda site to judge current timeliness of stool sample collection.
- Surveillance systems in the India appear adequate in some areas but not in all. In one project area, non-polio AFP rates are greater than one. In two projects, stool samples are collected in a timely manner. However, in another project area, the one AFP case identified this quarter did not have a stool sample taken in a timely manner.
- The Nepal projects show a good overall picture of AFP detection and reporting. Three of the four project areas that had an AFP case this quarter had both timely stool collection for these cases and a 2000 non-polio AFP rate of at least one. All five project areas (covered by three PVOs) had 2000 non-polio AFP rates of at least one. Note that polio was still being transmitted in two project areas in 2000.
- The surveillance systems in Angola project areas document a fairly high level of polio transmission. This in spite of the fact that the surveillance systems are not collecting stool samples in a timely manner and in no project is the non-polio AFP rate at least one. It may be that many polio cases are being missed by the surveillance system altogether and that transmission is even higher than reported.



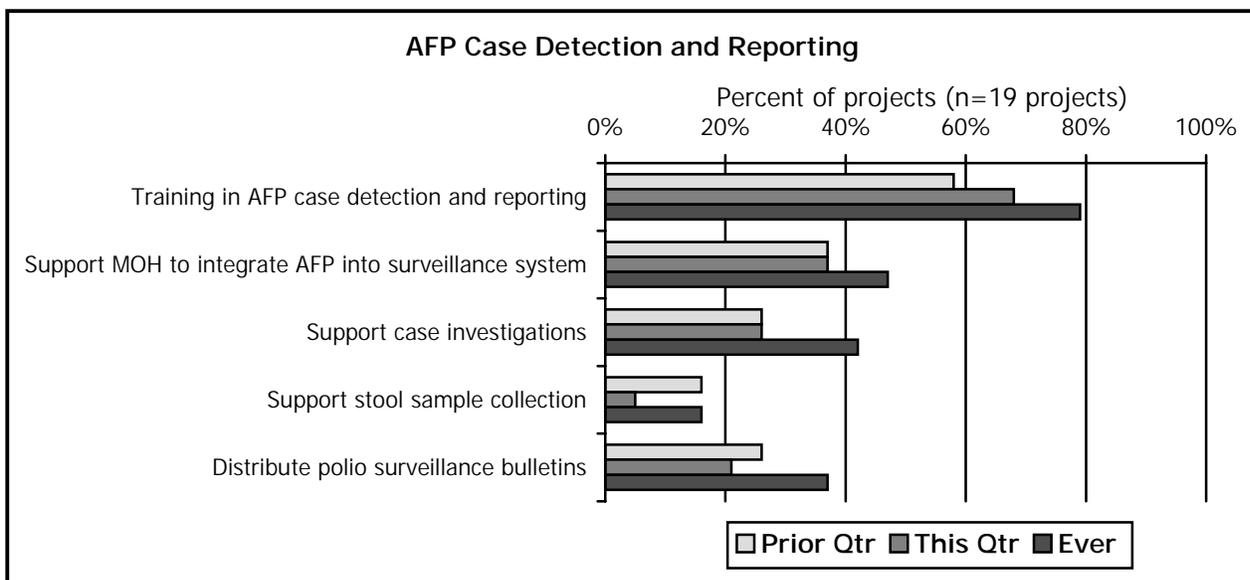


***A key priority for the CGPP in the quarters ahead is to facilitate timelier stool sample collection where this falls below the standard of at least 80%.*** Identification of poliovirus within the stool is difficult or impossible without timely stool collection, impeding our ability to identify polio cases and to provide evidence that polio is no longer being transmitted. Knowing the current epidemiological situation is critical for deciding the correct strategy and making needed adjustments, and good surveillance is the key to this.

The graphic below shows the ways that the CGPP is improving AFP case detection and reporting. This quarter, 16 of 19 projects (84%) report carrying out at least one of these AFP case detection/reporting activities; 17 since the beginning of the project. This number of projects surpasses the CGPP objective of at least 50% of projects helping to improve AFP case detection and reporting in FY01. Most common activities this quarter include training in AFP case detection and reporting. Least common was project support for stool sample collection. ***It seems clear that CGPP projects should now begin to give more emphasis to timely stool sample collection where allowed by local government authorities.*** This is a critical barrier in polio endemic countries to achieving high quality surveillance for polio and AFP. Descriptions of example CORE PVO activities on this topic are provided below:

***Training on detecting and reporting cases of AFP (and other diseases)***

The most frequently mentioned AFP detection/reporting activity was training. Fifteen of 19 projects (79%) reported carrying out this activity this quarter (16 since the beginning of the CGPP project). This number is four more than last quarter, but also represents five projects reporting this activity for the first time. ***We are encouraged that more projects have begun training in AFP case detection and reporting as this is the first step in improving the number of AFP cases detected in a population and in improving the number of AFP cases with adequate stool samples.***



The following are a few examples of these AFP training activities. As mentioned above, AMREF/Uganda participated in a workshop on AFP for health workers, district health team members, and community leaders and NGO representatives. Facilitators were from MOH-UNEPI and WHO. SC/Angola trained 52 community activists in AFP surveillance. PLAN/Bangladesh trained 243 individuals from local NGOs and communities to be key informants. World Vision Bangladesh trained village healers and community based volunteers as key informants in collaboration with district and sub-district MOHFP managers. WV also organized a session on AFP case detection and reporting for head teachers and imams in preparation for the 9<sup>th</sup> NID. This was done in collaboration with WHO that provided books on AFP surveillance. An excerpt from CCF/India's report is also illustrative: *All the staff engaged in polio immunization are trained adequately for Mop-up and AFP surveillance activities. With a network of volunteers, our project partners are constantly making efforts for reporting AFP cases. However, barring one AFP case reported in the Banka/Bounsi Block in the district of Bhagalpur, Bihar, no AFP cases are reported from anywhere.* [Editor's note: one AFP case for a project covering more than 350,000 households appears quite a low number and suggests AFP cases are being missed].

**Support MOH efforts to incorporate case detection and reporting of AFP and investigate poliovirus outbreaks and AFP cases**

To date, nine projects (47%) have reported supporting MOH efforts to incorporate case detection and reporting of AFP along with existing efforts to detect and report cases of other diseases. Seven projects reported this activity this quarter, and this is the next most frequently reporting AFP detection/reporting activity. Approximately one-half of CORE polio projects (eight projects) have reported supporting poliovirus outbreak investigations and/or AFP case investigations. Five projects reported this activity this quarter. Note, however, that these five represent three projects reporting this activity for the first time. [This may be an infrequent activity, or a variable activity, as AFP cases tend to be rare events in most project sites]. ***We are encouraged that more projects have begun reporting investigation of AFP cases, and hope to see this number increase as more and more AFP cases are detected as surveillance systems improve.***

As an example of this growth, Africare/Angola reports that active AFP surveillance has become stronger due to the CORE Project. During the year 2000, due to a lack of experience, most of the stool samples were collected later than 14 days. Now the project spends efforts weekly to visit all accessible health posts, health centers, villages and communities in Kuito municipality in order to reduce the time between onset of paralysis and stool sample collection. WV/India's community surveillance system detects cases of AFP and outbreaks of other diseases such as measles. For example, a measles outbreak was detected through this system and the response was to give a dose of Vitamin A to all the children above 6 months and an extra measles vaccination to children above 9 months who did not have measles.

### **Support the communications or logistics network for the transport to and testing of stool samples by reference labs**

To date, only three CORE polio projects (16%) have reported supporting the network for transport and testing of AFP stool samples. These three projects are all in Angola where polio surveillance systems are heavily dependent on external support. The necessity of CORE PVO involvement in this activity depends on the quality of the network in the project area. An excerpt from CARE/Angola's report is illustrative of this type of activity:

*“Polio volunteers in that camp identified the three-year old child in Katabola internally displaced camp in Kuito. Before the Provincial Ministry of Health could collect the two stool samples, the mother and child fled to Chipeta, 18 km east of Kuito. Neighbors informed us that they went to seek the traditional healer in Chipeta. The ministry of health found them a few days later in a village and arranged to meet in Chipeta the following day to collect the stool samples. The next day, on the road to Chipeta an attack occurred and the Ministry of Health car was forced to return to Kuito without ever reaching Chipeta...”*

This quarter, 11 projects reported on the percent of AFP cases that had at least two stool samples taken within 14 days of onset of AFP (see charts above). Several projects had no AFP cases detected this quarter and therefore nothing to report. However, some projects with AFP cases failed to report this indicator. ***It is expected that each project will be able to find out (from local surveillance officers or from WHO) the number of AFP cases detected in the project area each quarter and also find out the number of these that had adequate stool samples. This is a key indicator of the quality of the polio eradication program in a local area and knowing the status of this indicator can motivate local action and support for quality improvement if indicated.***

### **Support distribution of polio surveillance bulletins or newsletters**

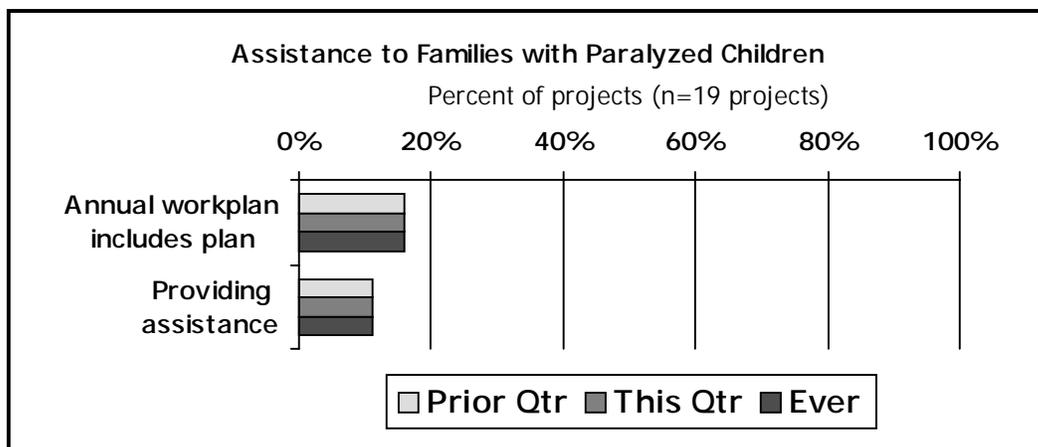
Providing feedback to persons and groups that help detect and report cases of AFP is important for communicating the value of this work. One way of providing feedback is to share bulletins or newsletters that provide information about the current epidemiological picture of polio and AFP. Only seven projects (37%) have reported supporting distribution of such information to date; only four projects reported this activity this quarter. ***There are many surveillance bulletins and newsletters at both the national and international level. As more projects increase their involvement in AFP case detection and reporting, we expect increased distribution of polio surveillance information to those workers and volunteers that projects have involved in this effort.***

As a few examples of this activity, the Nepal secretariat director regularly shares information with its field partners. CORE HQ passes on the latest bulletins from WHO and other information to all the secretariats at least on a monthly basis. The Bangladesh secretariat director distributes polio surveillance bulletins and newsletters on a weekly basis to all PVO partners.

### **3.5. Mission - 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.

Three projects (two in India, one in Nepal) reported this quarter that the project's workplan includes providing assistance to families with paralyzed children. This number represents one project reporting this activity for the first time. Two of these three projects (through partners of PCI/India and WV/India) reported providing assistance to families with paralyzed children this quarter.



PCI/India partners have found children with paralysis and is assisting the families with transportation, obtaining braces and other support. For example, WIF (a partner of PCI) has assisted the family of Sadiq Alam (a five year old with polio) to obtain referral services at a local government hospital and is in the process of obtaining a “disability certificate” from the government for Sadiq that will provide access to certain benefits reserved for disabled persons.

A CBO partner of WV India provided a boy with a tricycle. He was unable to attend school due to the difficulty of mobility, but now he is regularly attending school. WV North Delhi worked with the All India Institute of Medical Sciences to provide disability certificates to those polio victims identified by the project.

The following story from Nepal demonstrates situations CORE PVOs will face as they participate in the polio eradication effort. The story also illustrates the desire of families to help their children with paralysis---we should support their efforts as best we can: *“CORE Nepal Secretariat Director and Rabi Bhandari of Save the Children/Siraha visited Mr. Shamim Mohamad, father of Ajamat Khantun-Saima, an 11 months old girl child paralyzed with polio in November 2000. Mr. Mohamad runs a Pharmacy for several years. Mr. Mohamad showed us the child and explained about the incidence. As he said, at the onset she was unable to move all arms and legs and the head. He took her to hospital in Nepal, and in Darbhanga - India. Gradually the child moved head, arms and left leg. Now she is able to move both arms and legs to some extent, but not fully. Her right leg is not recovering well. We saw she try to move right leg as well. The child seemed recovering well at that moment. They were not sure of how many doses of polio the child had. As the mother said, the child had one or two polio vaccine. The father said that he had used a mosquito coil that night and doubt if that has any effect on child's paralysis. He asked if there is any manual for physiotherapy for it so that he could do it at home. He also asked if the child should take measles vaccine at this moment. He repents that being in medical profession, he was careless of immunization of his children. We told him that we are not aware of any evidence or literature that mosquito coil causes paralysis. We explained him about three types of poliovirus and informed that his child had P3. We promised him that we would send a manual for exercise to minimize the deformities.*

***We strongly encourage projects to look for ways to support families with paralyzed children, especially those families that are identified through our efforts to detect and report AFP cases.***

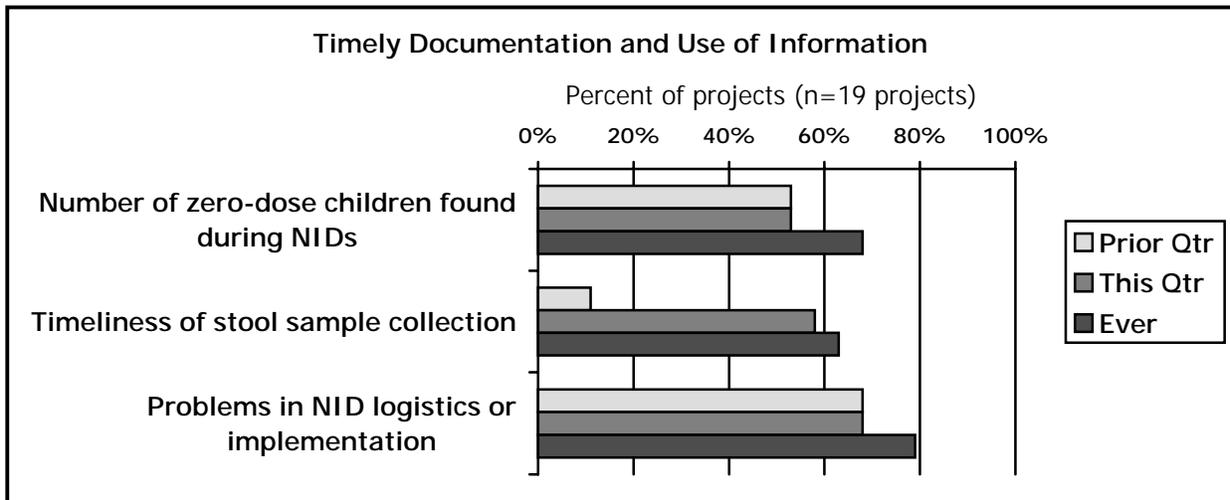
The CGPP objective is for 50% of projects to include support to families with paralyzed children on their workplans by the end of September 2001. We believe this objective is achievable and we are encouraged by new efforts underway to support this activity. The Bangladesh CORE group will conduct a workshop on supporting families with paralyzed children. The Angola Secretariat Director, Lee Losey, has been exploring ways to involve the five Angola projects in this activity. An excerpt from a meeting report of Lee Losey with Handicap International provided below is illustrative of these efforts.

“On Tuesday 20 March Lee Losey met with Mr. Laurent Gobert, Technical Coordinator and Ms. Sophie Periquet, Program Director, Handicap International, to discuss collaboration between CORE and Handicap International to support polio victims. Lee gave them a copy of the proposal he had submitted to the British Embassy and explained his ideas for using British and German funds to support assistance to polio victims in collaboration with Handicap International. Lee explained the idea of using German funds to build transit rooms at the Benguela Orthopaedic Centre for polio victims to stay in while receiving treatment. Lee also said that he thought CORE

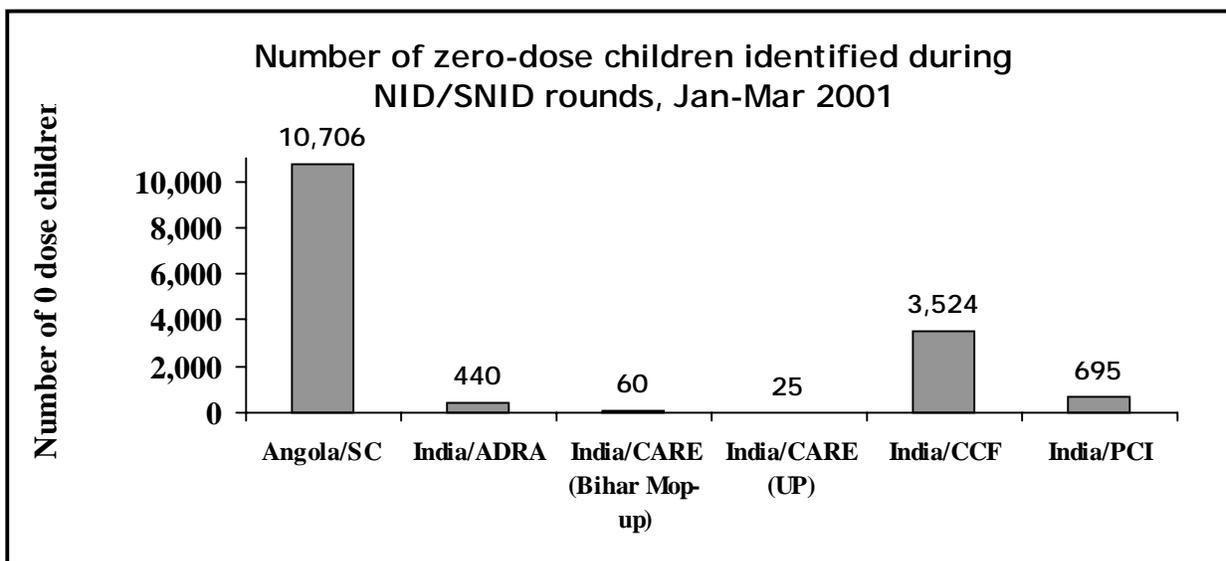
could find funds to assist victims with transport... Handicap thought the best form of support would be to purchase wheelchairs and adjustable crutches and to send nurses working for CORE member organizations to Benguela for training in basic physical therapy for polio victims. Funding for this training has been included in the proposal to the British Embassy. HI will produce the crutches and CORE will purchase them at cost with funds from the German embassy if the German proposal is accepted. The wheelchairs will need to be purchased outside of Angola and are approximately \$500 each. A pair of crutches will cost \$10. Handicap will produce a training plan for the nurses. They thought they could train two to three persons at a time.”

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

Eleven projects (58%) reported on the timeliness of AFP stool sample collection this quarter; this is eight more than the last quarter. There were fewer NIDs and SNIDs this quarter than last and therefore data directly related to NIDs were less frequently collected this quarter than last. However, three projects reported documenting “zero-dose” children for the first time this quarter. And two projects reported documenting problems in NIDs logistics or implementation for the first time this quarter. Sixteen projects (84%) have reported carrying out at least one of the above three documentation activities this quarter; 17 projects (89%) since the beginning of the program. This number approaches (by mid-year) the FY01 CGPP objective of 100% of projects reporting at least one these three documentation activities. *We are greatly encouraged about the improvement in documentation and use of information over just one quarter and expect improvement to continue and the FY01 objective to be achieved.*



Information about zero-dose children is used to identify specific areas with pockets of under-immunized children that can be better targeted in future NIDs. The number of zero-dose children found during NID rounds was provided by five projects, although ten projects reported documenting zero-dose children. This magnitude of this number varies by the estimated number of children under five in each project area and/or how this is counted. *Few projects, however, document using this information to identify pockets of under-immunized children and improve planning/targeting for future NIDs/SNIDs as we recommend.*



### 3.7 CORE Polio Project Management Activities

#### **Staffing:**

The CORE Polio Eradication Team (PET) members based in the US are David Newberry, William Weiss, Sara Smith, and Miriam del Pliego. [William Weiss replaced Richard Scott as the Deputy Director of the project this quarter]. Overseas PET members are Lee Losey, Dr. Roma Solomon, Dr. Shamim Iman, Harshni Raghav and Bal Ram Bhui. Lee Losey continues as Secretariat Director for Angola this quarter and will be the Africa Region Technical Advisor. Dr. Roma Solomon continues as the Asia Regional Technical Advisor for projects in Bangladesh, India and Nepal. Dr. Shamim Imam is the Secretariat Director for Bangladesh. Harshni Raghav is the India Secretariat Director. Bal Ram Bhui began work this quarter as the Nepal Secretariat Director.

#### **Monitoring visits:**

In January, Sara Smith visited projects in India and Nepal. Some observations from her report are provided. The Nepal secretariat is off to a strong start under the capable leadership of Bal Ram Bhui. He is currently sitting at the PLAN offices, but at the request of PEN/WHO he will be moving to their new offices within the next few months. PEN has agreed to furnish him with a motorbike and the use of a computer until such time that one can be rented. PEN and USAID agreed to facilitate his attendance at ICC meetings. Bal Ram is to develop his work plan to include:

- PVO/NGO actions plans and budgets finalized
- Meetings with Rotary, UNICEF, Handicapped International
- Work with PLAN to develop their plan
- PVO district training
- Monitoring and reporting
- Meetings with higher level PVO staff
- Management by exception

Other issues include:

- Past participation of NGOs in S/NIDs has been meager or non-existent
- Zero dose reporting is not part of national plan
- Acute shortage of IEC materials
- Accountability and management of routine and supplementary immunizations weak

Since India is involved in intensive eradication efforts and very high risk areas have been identified by NPSP, the India Secretariat is requesting that the organizations consider shifting to locales that are in line

with these areas, especially in UP, Bihar and to increase coverage in urban slums. The USAID Mission in India is considering the possibility of providing funds to CORE PVOs to make these shifts. In addition, weaker programs have been identified and Harshni Raghav will develop specific action items to bring them up to speed. Some recurrent issues have been identified:

- Networking
  - Lack of understanding by the PVOs of the concept of working together with *all* of CORE members, non-CORE members, NGOs, CBOs in the project area
  - PVOs remain insular in their areas and do not reach out to other organizations
- Communications with field and HQ staff.
  - Some PVOs only want communications going through their HQ staff, which causes delays or missed opportunities for communication and networking
- Lack of perception of PVO staff that intensive work is needed in this end game of polio.
  - Many PVO staff have multiple duties that cause conflicts with polio activities
  - PVO staff have been ill or on vacation for month long periods, often not notifying the Secretariat of their planned or unplanned absences. In addition, there is often no one covering the duties while the PVO staff is absent.
- Differing capabilities of the PVOs/NGOs/CBOs
  - Despite the fact that many organizations work for the health of mothers and children, their staff lacks basic knowledge regarding immunizations and polio.
  - Stronger organizations will work with the weaker ones to improve their capabilities.

In March, Miriam del Pliego visited projects in Calcutta to document polio eradication approaches in urban slum environments. CARE HQ USA supported the travel and per diem. The key findings include the following observations. Local NGOs play a major role as key partners in the polio eradication effort. Often they have more experience working with resistant and marginalized groups thus enabling them to apply lessons learned to new projects and initiatives, particularly polio eradication. As local NGOs partner with community based organizations (CBOs) such as youth groups, clubs and mothers' groups, a tighter bond is created between the local NGO and the community.

The local NGO with which Miriam spent most of her time was Women's Interlink Foundation (WIF) a local partner of the CORE Group member, PCI India. WIF's strategy in working in the polio eradication initiative has been to stimulate demand for routine immunizations and participation in NIDs. The strategy of focussing on routine EPI first and supplemental immunization second has made acceptance of NIDs and SNIDs much easier. By acknowledging that children must be fully protected from all childhood diseases, the community feels that WIF has a personal interest in their children and their community. WIF explains that supplemental immunizations for polio are necessary because not everyone immunizes their child, so all children—their children—are vulnerable.

The demand for routine immunization does not go unanswered however. Immunization camps held by WIF on a quarterly basis in each project area add to the effectiveness of bringing services into the community. At the mothers' meetings and youth club meetings where routine immunization is stressed, immunization camps are advertised as an opportunity to save time (and money) while keeping up with the child's immunization schedule. Government health workers are consulted and an appropriate date is agreed upon. On this particular day the government health workers come to the communities with syringes, vaccines and cold boxes to immunize all children in that particular community. Children receive all vaccines for which they are due and it is recorded on their immunization card. If a mother fails to bring the card, or it is lost, a new one is issued on the spot. Additionally, WIF staff also keeps a duplicate log of what vaccine each child has received and when it is due for the next round. During the proceeding mothers' meetings, staff reminds each mother about when their child should receive the next immunization. This mechanism integrates several strategies of accessing (if not demanding) government services while allowing the resistant community and the government health workers to begin forming a bond.

Working in coordination with local government officials and CBOs enables local NGOs to play a role in the community in which they live. Collaborating with international PVOs gives them the global perspective and training opportunities they need to effectively participate in the global eradication effort. Reports of these monitoring visits are available upon request.

**Project quarterly narrative reporting (self-assessment):**

This quarter marks the second quarter that projects have been using a standardized quarterly narrative reporting format. This format lends itself to self-assessment of programs through analysis of performance indicators (that may include use of secondary data collection) and analysis of lessons learned and how these lessons will be applied in the future. **Areas for improvement include improved analysis by approximately half of projects of completed activities and of indicators; some projects have not provided any analysis, but only a description of activities.**

**Database of project information:**

The CORE PET is maintaining a project database that provides background information and a description of completed activities for each polio project. Next steps include development of reporting formats and printing and distribution of reports by topic area.

**Meetings:**

There were no CORE meetings this quarter nor USAID Polio Partner's meetings. There were no TCG meetings attended by CORE staff this quarter.

**Staff training:**

William Weiss and Miriam del Pliego attended the January STOP Team training provided by CDC in Atlanta.

## SECTION 4. PROJECT AND COUNTRY INDEX

|  |   |
|--|---|
| ADRA   | India, 1, 2, 3, 5, 6, 7, 10, 11, 12, 15, 17, 18, 19, 21, 22, 24, 25 |
| India, 10  |   |
| Nepal, 14  |   |
| Africare   | MIHV  |
| Angola, 6, 17  | Uganda, 6, 8  |
| AMREF  | Nepal, 1, 3, 5, 6, 7, 10, 14, 15, 18, 19, 21, 24                    |
| Uganda, 5, 15, 17  | PLAN International  |
| Angola, 1, 3, 5, 6, 7, 8, 11, 12, 15, 17, 18, 19, 20, 21, 24, 26 | Bangladesh, 6, 14, 17   |
| Bangladesh, 1, 3, 5, 6, 8, 10, 14, 15, 17, 18, 21, 24            | Project Concern International                                       |
| CARE   | India, 10, 18, 19, 22   |
| Angola, 6, 18  | Save the Children   |
| Bangladesh, 6, 8   | Angola, 17  |
| India, 11, 12  | Bangladesh, 6   |
| Nepal, 6, 14   | Nepal, 7, 10, 19  |
| Christian Children's Fund (CCF)                                  | Uganda, 1, 3, 4, 5, 8, 15, 17, 24                                   |
| India, 6, 17   | Women's Inter-Link Foundation (WIF)                                 |
| CRS  | India, 10, 19, 22   |
| Angola, 8  | World Vision  |
|  | Angola, 7   |
|  | Bangladesh, 6, 17   |
|  | India, 7, 17, 18, 19  |
|  | WV. See World Vision  |

## ANNEX 1: CORE POLIO FY01 WORKPLAN BY VISION, MISSION STATEMENTS AND OBJECTIVES

**MOTTO** - We are partners, united as a team to achieve a Polio-Free World.

### VISION - THROUGH OUR EFFORTS:

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.

### MISSION - TO ACHIEVE OUR VISION WE WILL:

#### 1. Build effective partnerships between PVOs, NGOs and international, national and regional agencies involved in polio eradication initiatives

##### Objectives:

- A collaborative PVO organization is established in each new country supported by CORE Polio Partners Project in FY 01. (3 new countries anticipated: Mozambique, Congo, and Ethiopia). Indicator: MOI signed between funded PVOs.
- A collaborative PVO organization is represented on the national ICC in each country supported by the CORE Polio Partners Project by the end of FY01 (Countries with ICC: Uganda, Angola, Mozambique, Congo, Ethiopia, Bangladesh, India, Nepal). Indicator: Activity reports document that the PVO attended at least one meeting in FY01.
- Each PVO funded by CORE Polio Partners Project will collaborate on polio eradication activities with at least one national NGO/CBO during FY01. Indicator: Activity report documents PVO working together with an NGO or CBO.

| <b>Unfinished Workplan Activities from last Quarter</b>  | <b>Accomplished?</b> |
|--|----------------------|
| Assist with development of MOU between Ethiopia CORE polio partners  | No                   |
| Meeting with Ethiopia ICC members to request CORE representation on ICC and/or request approval of the CORE polio workplan | No                   |

| <b>Proposed Workplan Activities for this Quarter</b>   | <b>Accomplished?</b> |
|--|----------------------|
| -Host collaborative workshop in Congo (workplans, MOI, encourage NGO/CBO partnerships)                                   | No                   |
| -Meeting with Congo ICC members to request CORE representation on ICC and/or request approval of the CORE polio workplan | No                   |

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

##### Objectives:

Each PVO funded by CORE Polio Partners Project will do at least one of the following in FY01:

- Technical and/or management training
- Cold chain assessments
- Improve cold chain and/or vaccine logistics systems
- Encourage private sector provision of immunizations
- Support social mobilization to increase demand for immunization services
- Encourage community participation/contribution in immunization activities

| <b>Proposed Workplan Activities for this Quarter</b>  | <b>Accomplished?</b> |
|---|----------------------|
| Distribute UNICEF lessons learned about social mobilization activities for supplemental immunizations | Yes                  |
| Distribute India lessons on encouraging private sector involvement                                    | No                   |

### 3. Support PVO/NGO involvement in national and regional planning and implementation of supplemental polio immunizations

#### **Objectives:**

Each PVO funded by CORE Polio Partners Project in a country carrying out supplemental immunizations in FY01 will do at least one of the following in FY01:

- Participate in preparation of plans for NIDs, SNIDs or Mop-up campaigns
- Participate in process evaluation of NIDs, SNIDs or Mop-up campaigns
- Cover gaps in operations to prepare for and/or implement supplemental immunization activities
- Participate in implementation of NIDs, SNIDs or Mop-up campaigns

| <b>Proposed Workplan Activities for this Quarter:</b>   | <b>Accomplished?</b> |
|---|----------------------|
| Review new proposals to ensure PVO/NGO involvement in national and regional planning and implementation of supplemental immunization activities                 | No                   |
| Observe CORE Polio participation in India NID and make recommendations for improvement in PVO/NGO participation in planning and implementation of future rounds | Yes                  |

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

#### **Objectives:**

At least 50% of PVO polio projects funded by CORE Polio Partners Project will do at least one of the following in FY01:

- Support or provide training for surveillance of AFP (and other diseases);
- Support MOH efforts to incorporate AFP surveillance with surveillance efforts for other communicable diseases;
- Support poliovirus outbreak and/or AFP/polio case investigations;
- Support the communications or logistics network for the transport and testing of stool samples by reference labs;
- Support distribution of polio surveillance bulletins or newsletters.

| <b>Proposed Workplan Activities for this Quarter:</b>  | <b>Accomplished?</b> |
|--|----------------------|
| Distribute WHO and CDC and local epidemiological bulletins related to polio surveillance to projects | Yes                  |
| Finalize CHANGE project support plan for CORE Polio projects and partners                            | No                   |

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

**Objectives:**

At least 50% of PVO polio projects funded by CORE Polio Partners Project will include provision of long-term assistance to families with paralyzed children within their annual workplan.

| <b><i>Proposed Workplan Activities this Quarter:</i></b>   | <b><i>Accomplished?</i></b> |
|--|-----------------------------|
| Provide language and technical assistance to CORE polio projects for inclusion of long-term assistance activities within projects' annual workplan | Yes                         |

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

**Objectives:**

Each PVO funded by CORE Polio Partners Project will do at least one of the following in FY01:

- 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 time from onset of paralysis cases to identification of cases by PVO or health system and/or document time from discovery of an AFP case by the PVO or health system to when the case report given to SMO and use this information to improve quality of the local surveillance system.
- Document problems in logistics and/or implementation of supplemental immunizations and use this information to improve planning of follow-up supplemental immunization rounds.

| <b><i>Proposed Workplan Activities this Quarter:</i></b>  | <b><i>Accomplished?</i></b> |
|---|-----------------------------|
| Share lessons of Angola field-test of different types of dye for identifying zero-dose children following supplemental immunizations. | Yes                         |

# CORE PEI Quarterly Report

Jan - Mar 2001

Annex 2: Polio Projects by Country

# Angola

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| PVO          | Location                               | Potential Beneficiaries | USAID Funding    |
|--------------|--|-------------------------|------------------|
| Africare     | Bie, Cuanza Sul Provinces              | 153,955                 | 106,195          |
| CARE         | Luanda, Bie, Huila Provinces           | 110,000                 | 180,915          |
| CRS          | Benguela Province (all municipalities) | 433,119                 | 213,224          |
| SC           | Cuanza Sul Province (5 municipalities) | 149,921                 | 161,169          |
| WV           | Malange, Cuanza Norte Provinces        | 240,472                 | 90,915           |
| Secretariat  |  |                         | 312,646          |
| <b>TOTAL</b> |  | <b>1,087,467</b>        | <b>1,065,064</b> |

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# Uganda

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| PVO   | Location            | Potential Beneficiaries | USAID Funding |
|-------|---------------------|-------------------------|---------------|
| AMREF | Luwero District     | 95,000                  | 183,132       |
| MIHV  | Ssembabule District | 33,000                  | 162,935       |
| TOTAL |                     | 128,000                 | 346,067       |

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# Bangladesh

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| PVO          | Location   | Potential Beneficiaries | USAID Funding  |
|--------------|--|-------------------------|----------------|
| CARE         | 25 thanas in 9 districts   | 786,375                 | 333,250        |
| PLAN         | Dinajpur, Nilphamari and Gazipur districts, 3 urban slums in Dhaka | 109,418                 | 70,620         |
| SC           | 3 thanas in Brahminbaria District                                  | 117,585                 | 91,213         |
| WV           | 6 thanas in Khulna District  | 147,420                 | 97,000         |
| Secret.      | (\$ included in CARE)  |                         | 0              |
| <b>TOTAL</b> |  | <b>1,160,798</b>        | <b>592,083</b> |

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# India

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| PVO          | Location   | Potential Beneficiaries | USAID Funding    |
|--------------|--|-------------------------|------------------|
| ADRA         | 4 blocks in Bihar, Gujarat, Uttar and Andhra Pradesh   | 30,000                  | 104,687          |
| CARE         | 60 high risk blocks in Bihar, Uttar Pradesh  | 786,375                 | 450,000          |
| CCF          | 29 blocks in 4 states: Bihar, Jharkhand, Uttar Pradesh, West Bengal                                    | 700,000                 | 327,930          |
| PCI          | 15 blocks in 3 states: West Bengal, Orissa and Bihar   | 69,533                  | 189,315          |
| WV           | 10 Districts in 6 states: Uttar Pradesh, W. Bengal, Delhi, Bihar, Rajasthan, Orissa and Madhya Pradesh | 800,000                 | 146,686          |
| Secret.      |  |                         | 110,299          |
| <b>TOTAL</b> |  | <b>2,385,908</b>        | <b>1,328,917</b> |

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# Nepal

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| PVO     | Location                                     | Potential Beneficiaries | USAID Funding |
|---------|--|-------------------------|---------------|
| ADRA    | Kavrepalanchowk District                     | 56,000                  | 47,674        |
| CARE    | Kanchanpur and Mahottari border districts    | 140,009                 | 91,739        |
| SC      | Terai border districts of Siraha and Kailali | 137,045                 | 85,486        |
| Secret. |  |                         | 68,658        |
| <hr/>   |  |                         |               |
| TOTAL   |  | 333,054                 | 293,557       |

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