



CORE GROUP POLIO PARTNERS (CGPP) PROJECT

FY04 Narrative Report (2nd Half)

April to September 2004



Bulava Toll Formation - "Children as change agent" Shahjahanpur

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



ACRONYMS

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

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

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

The **vision** of the CGPP sees the involvement of CORE PVOs and NGO partners helping accelerate the eradication of polio. At the same time, the CGPP vision sees something of value being left behind that can be used to address other health priorities.

Specifically, the three parts of the vision statement are the following:

1. Eradication of polio is accelerated by the coordinated involvement of PVOs and NGOs in national eradication efforts.
2. Collaborative networks of PVOs and NGOs are developed with the capacity to accelerate other national and regional disease control initiatives (in addition to polio eradication).
3. Relationships are strengthened between communities and international, national and regional health and development agencies.

The **strategy** to achieve this vision includes the following seven components (our mission):

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,
6. Improving documentation and use of information for improving the quality of the polio eradication effort, and

7. Participation in either a national and/or regional certification activities.

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

During this period, USAID funds supported activities in four countries: Angola, Ethiopia, India, and Nepal. Also, in each country, the CGPP supports a coordinating secretariat with at least one full-time coordinator/director. Note that only one of the CGPP countries---India---has ongoing transmission of polio; the other three countries last had transmission in 2001 or 2000. USAID mission funds wholly or partially supported activities in Angola and India during this period. In India, mission funds have included "non-polio" health funding that allows the partners to address other interventions in the same communities. These "non-polio" funds allow the partners to include "add-on" activities that build trust between the community and the partners and therefore help break down resistance to polio eradication activities. In Angola and India, mission funds allow continuing projects to shift their efforts into high-risk areas, and are supporting new partners.

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

SECTION 2. REPORT OF ACTIVITIES BY MISSION STATEMENT

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

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

The key CGPP strategies for building partnerships include the following:

- A functioning collaborative organization of PVO/NGO partners
 - Meet regularly with polio partners (MOH, USAID, WHO, Rotary, other ICC members) and brief these partners on CORE activities
 - Collaborate and work with local NGOs and CBOs to carry out or support project activities
 - Send CGPP representatives to all WHO Regional TCG/TFI Meetings
 - **Progress towards strategies**
 - All countries have robust, active collaborative groups, with an effective secretariat director/coordinator and staff.
- CORE is recognized and valued by the partners, MOH, UNICEF, and WHO
 - Each director/coordinator consistently is in close contact with other major partners on a weekly or more frequent basis
 - Partnerships with local NGOs and CBOs are solid and functioning. Technical assistance is provided from the secretariat level to all levels and partners
 - Secretariat directors Drs. Roma Solomon, Filimona Bisrat, and Antonio Dias attended regional specific WHO TFI or IEAG meetings
 - Dr Antonio Dias and Mr. Bal Ram Bhui attended "Role of NGOs in Increasing Access to Immunization," sponsored by GAVI and American Red Cross in Washington DC.
 - All secretariat directors attended The CORE Group Annual meeting in Baltimore, MD
 - Angola uses funds obtained from Japanese Grassroots Grants

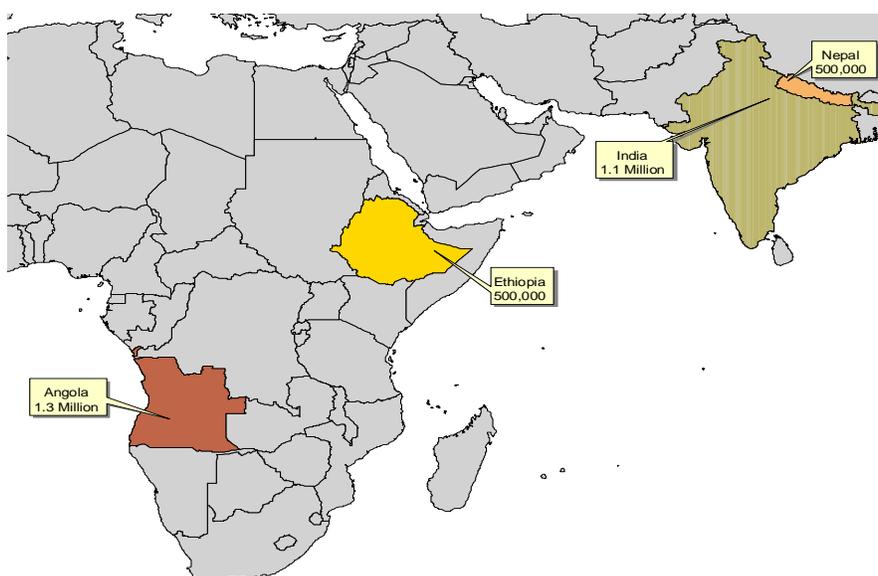


Figure 1 CORE Polio Partners Project: Countries and Estimated >5 Beneficiaries

Country Highlights	Partnership Activities
Ethiopia	Participation in ESHE/SNNPR regional & project planning. Cross visit of Angola team to Ethiopia. Explored World Bank/HAPCO M&E partnership options. Secretariat and Haraghe Catholic Secretariat in collaboration with Zonal Health office organized the 'Communication and Social Mobilization Workshop on AFP Surveillance and EPI.' CORE Ethiopia is housed at CRDA
Angola	Secretariat attended Technical Advisory Group (TAG) on Polio Eradication in Angola in May. Participates in all ICC and EPI National Technical Commission meetings. In Moxico, the UNHCR has offered use of their e-mail account to help Save the Children, The Salvation Army and the MoH communicate from Luau
India	PVOs participated in joint planning session for FY05 and beyond. Secretariat attended India Expert Advisory Group (IEAG). CORE India is an active member of the Social Mobilization Network of Uttar Pradesh.
Nepal	CORE Nepal secretariat member staff made field visits to the implementing districts as per need and held meetings with district health office, NGOs, SMOs, and multilateral development agencies in the districts in terms of strengthening of the immunization services. CORE Nepal remains housed in WHO offices.



Figure 2 PCI Partners Meeting in Uttar Pradesh, India

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

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

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

Progress towards strategies

- All PVO partners provide TA to their local partners, District or lower level MOH staff, CBOs, and volunteers
- Innovative, country specific social mobilization activities are undertaken in all countries that include routine immunization messages
- Trainings conducted on issues such as supportive supervision, LQAS, data collection, monitoring and analysis, & communication that support all antigens
- Community mobilizers, influencers, activists or leaders effectively utilized
- Significant contribution to increasing vaccination coverage in project areas for all antigens (see Figure 2)

Country Highlights	Immunization Strengthening Activities
India	<ul style="list-style-type: none"> • ADRA CMCs and BMCs directed to maintain record book for RI coverage. RI included in all social mobilization activities (mothers, community and influencer meetings). (See Figure 3) In Sitapur district, all 48 CMCs deployed in the two targeted blocks accompanied and provided assistance to their respective area ANMs. They all maintained a registration of newborn infants and pregnant women. One day before the routine immunization day (every Wednesday and Saturday of the week), CMCs asked the local mosques and temples to make public announcements through loudspeakers regarding the routine immunization day. The CMCs also visited those families with newborn infants and pregnant women to inform and remind them of the routine immunization day. • PCI CMCs help ANMs register pregnant women and newborns. Child mapping done. Coordination between ANMs and CMCs improved; they jointly work to organize out reach sessions. Health camps combined with out-reach immunization sessions
Nepal	<ul style="list-style-type: none"> • SAVE staff participated in quarterly and annual EPI reviews. Assisted in compiling and analyzing VDC monthly EPI report. Supported in PDQ Follow-up orientation. • CARE continues to use joint supervision and LQAS to assess EPI coverage and quality, reviewing routine immunization target verses achievement and drop outs, follows up health facilities that have been introduced tickler file system to track the defaulters and identify the dropout children. Also has provided support for vaccine and logistic transportation from regional medical store for effective running of routine immunization. • CARE, SAVE, and ADRA contributed to improving EPI coverage (see Figure 4).

Ethiopia	<ul style="list-style-type: none"> • SC conducted training for health facilities staff & CHWs, stressing the defaulter follow-up system. Maintenance of refrigerators, motorbikes, provision of supply and training, logistic support for static and outreach activities and social mobilization • 15,309 community members received health education on EPI through CCF project support. Community surveillance focal persons were highly involved in doing community mobilization activities at local level during outreach and static service of EPI, contributing to increases in RI coverage. In Buee area project, Woreda measles coverage went from 34% to 80%, DPT3 from 49% to 84%, & TT2+ Pregnant from 21.1% to 72% with help of CCF. (See Figure 5 for Silte Woreda, SNNPR coverage)
Angola	<ul style="list-style-type: none"> • CRS polio team visited the cold chain of all nine municipalities in Benguela to provided support to their activities, monitored vaccine stocks, & sent information to the provincial level • Africare will involve 400 community malaria volunteers in EPI activities • In Cunhinga Municipality, CARE conducted a small study in collaboration with the MoH to assess the immunization service and design strategies to improve coverage. The project team made an intensive effort to mobilize communities, identify children with uncompleted vaccination schedule and transport vaccination teams to hard to reach and far away areas, resulting, within a quarter, in: increase of service access from 28% to 57%, increase vaccination coverage from 10% to 29% and decrease dropout rate from 57% to 45%. • All staff is taking advantage of meetings carried out by municipal administrators with <i>Sobas</i> (traditional leaders) to increase awareness about general health issues, with an emphasis on polio and routine immunization.



Figure 3 ADRA community women and mother's meeting held in Dabhora village, Tilhar block, Shahjahanpur district, Uttar Pradesh, India

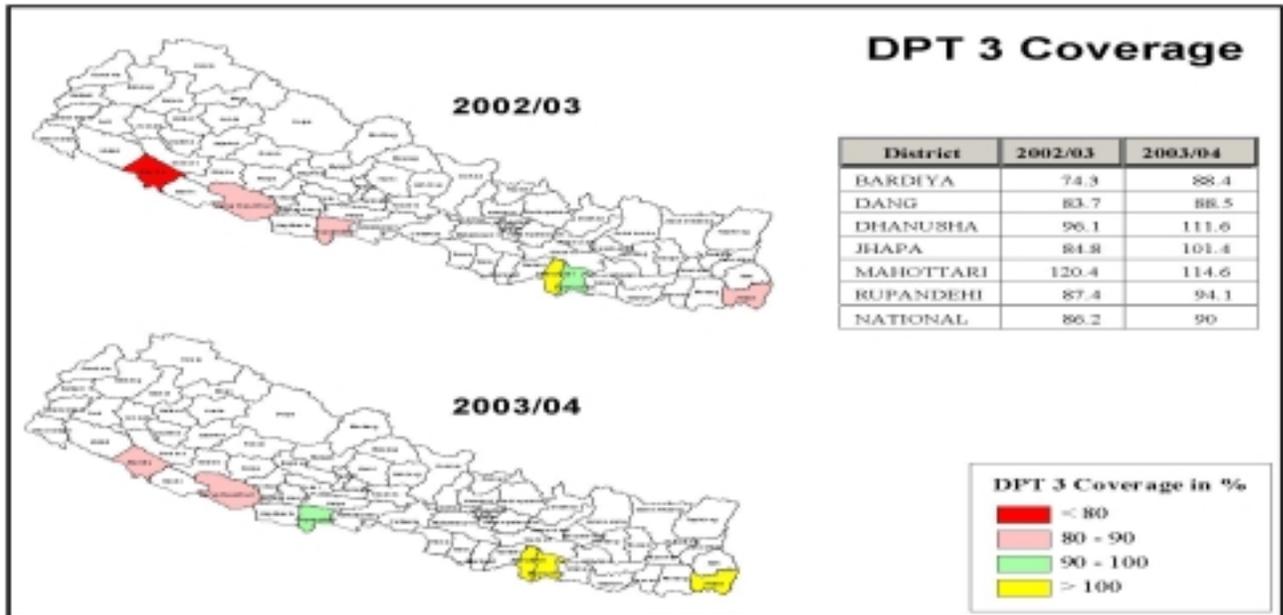


Figure 4 Changes in DPT3 Coverage in CORE Partners Districts, Nepal

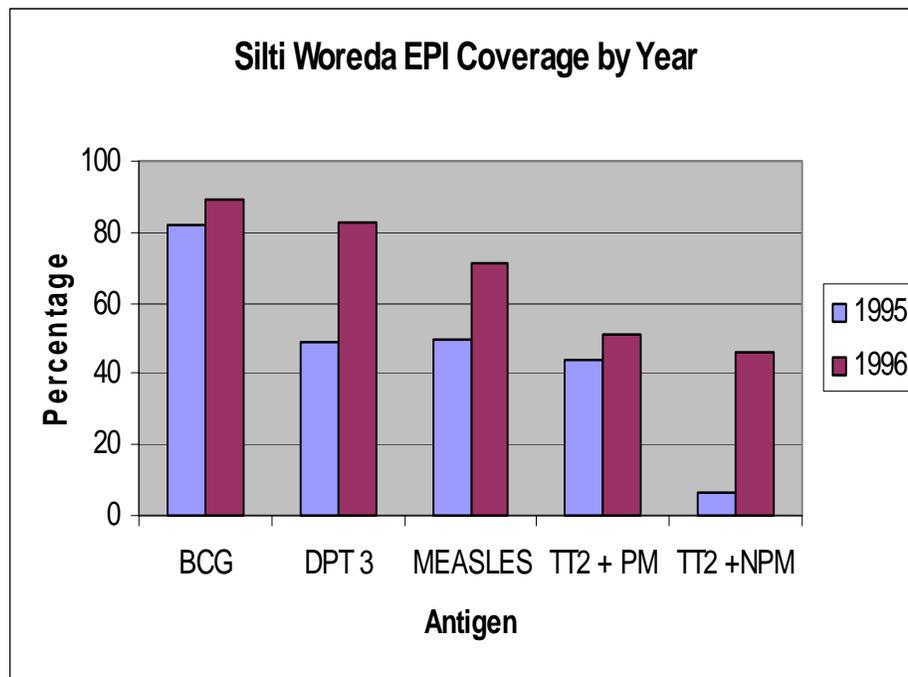


Figure 5 Change in EPI Coverage Silte Woreda, SNNPR by Antigen, and in Pregnant (PM) and Non-pregnant women (NPM) in 1995 (2003) and 1996 (2004)

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

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

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

- Participate in preparation of plans and evaluations for NIDs, SNIDs or Mop-up campaigns
- Identify problematic areas and develop plans and strategies to increase coverage in those areas
- Support social mobilization to increase demand for supplemental immunizations
- Encourage community participation in or contribution to supplemental immunizations

- Participate in implementation of NIDs, SNIDs or Mop-up campaigns
- Participate in national or local-level cross-border planning, implementation and/or evaluation efforts.

Progress Towards Strategies

- India maintains its focus on frequent SIAs, which present challenges in retention of trained workers, quality of campaigns, worker fatigue, etc. Despite this, WPV continues its steep and rapid decline
- Add on activities in India such as health camps and sanitary drives enhance community participation and help to break down resistance
- In each country, a variety of village and community members participate in campaigns (teachers, students, religious leaders, influencers) with innovative social mobilization methods



Figure 6 CORE NID Monitoring Team with community guide, Lobito, Angola

Country Highlights	Supplemental Immunization Activities
India	<ul style="list-style-type: none"> • The SNID data collected by our partners reflects an improved performance of the field partners in achieving the desired outcome. As compared to the non-CMC areas, the booth coverage of CMC covered areas is 10-15% higher than those of the non-CMC areas in Ghaziabad. The SNID data also shows decreased incidences of false marking of houses by our CMCs. • The ADRA SMC Bareilly (Dr. David John) contacted in person, a world-renowned Muslim spiritual leader, Maulana Shahabudheen Razvi, and asked him to write an appeal to Muslim people in Bareilly to take oral polio drops. The SMC took the appeal with the signature, and showed it to decision makers of the resistant houses. After this exercise, many resistant families accepted the polio vaccinations. • In Badaun the PCI partnership with the Tata chemical farmers groups and with ward members in Sahaswan urban has brought remarkable changes in these villages/areas. Influencers meeting in high risk areas before the SIA rounds helped increase the percentage of X to P conversion. In UP, more close interaction with the community enabled understanding to skillfully tackle the challenges and barriers to related to the resistance.
	<ul style="list-style-type: none"> • IMC staff supervised vaccination activities in Kaala Municipality and transported vaccination materials from central cold chain to the vaccination teams. 200 Village health committee (VHCs) members were involved in polio campaign awareness conducting education sessions at churches, schools, and markets in municipalities of Bailundo, Kaala, Longonjo and Ukuma. • In Bie Province, Africare participated in the NIDs in Kuito and Nharea municipalities. In Nharea, together with the MoH, Africare trained 10 supervisors, 108 vaccinators and 20 mobilizers, apart of providing three vehicles to assist in Logistics. In Kuito Municipality, Africare trained 43 supervisors, 434 vaccinators and 40 mobilizers and provided two vehicles for transport during the NIDS. Africare also distributed materials on social mobilization provided by the MoH to community activists and monitored quality indicators during the NIDs. • After the first round in Kwanza Sul, the MoH called for a meeting with all partners involved in PEI and EPI to analyze the performance during the NIDs. The outcome was that NGOs should take the responsibility of NIDs in the municipalities where they are based. Save was then responsible for Amboim, Porto Amboim, Ebo and Kilenda. Project team re-organized the cold chain, transported materials and vaccines, trained supervisors and vaccinators by communes, followed up the implementation and sent data to the municipal and provincial EPI
Ethiopia	<ul style="list-style-type: none"> • No NIDs or SNIDs during this reporting period. Due to the changing epidemiological situation in the Horn of Africa, CORE Ethiopia plans on participating in any FY05 activities pending availability of funding
Nepal	<ul style="list-style-type: none"> • No NIDs or SNIDs during this reporting period, however the next planned SNID will talk place in October 04. The CORE partners support will be focused in high risk areas, facilitation of district immunization coordination committee meeting, micro planning workshop, orientation to vaccinators, publicity of NID, mobilization of independent monitors, funding additional vaccinator teams and transportation for vaccine supply and supervision. Support will also extend to DHO in documentation of vaccination report,

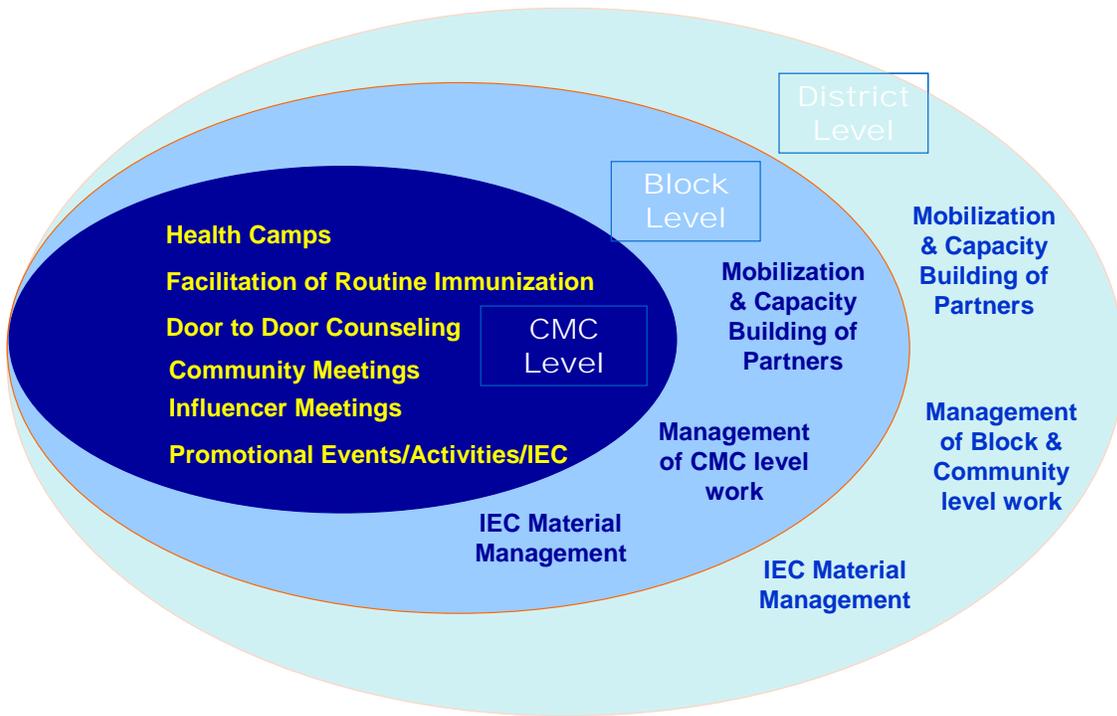


Figure 7 Social Mobilization Network Structure, India



Figure 8 "The Virus Man"- a joint exhibition of ADRA and UNICEF SM Network Team Baghpat District, Uttar Pradesh, India

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



Figure 9 Community Based Surveillance Volunteer Meeting, CCF Ethiopia

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

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

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

Progress towards Strategies

- Given the declining numbers of supplementary immunization activities, Ethiopia, Angola, and Nepal increasingly focus on community based surveillance.
- The community-based approach in AFP, measles and MNT surveillance proved to be relevant, feasible and appropriate where basic health service and infrastructure are non-existent
- Community volunteers, with training on both surveillance and immunizations have been effectively utilized in hard to reach areas or hard to reach populations, such as migrants or nomads

Country Highlights	AFP Case Detection & Reporting Activities
Ethiopia	<ul style="list-style-type: none"> • PCAE, an indigenous NGO implementing community based AFP and measles surveillance since July 2004 in Filtu Woreda, Libon Zone of Somali Region. A total of 100 (77 males and 23 females) volunteers surveillance focal persons were trained in collaboration with the Zonal Health Department and PCAE staff. Selection of the trainees focused on the previously trained CHWs who are members of a health action committee (HAC), a bridge to health team (BHT), TBAs or pastoralist health extension workers (PHEWs). All are functional in 42 localities. During the reporting period seven suspected AFP cases were reported to the nearest health institution. A total of 14,700 people received health education regarding AFP and the importance of immunization • HCS is a church based agency that began implementing community based surveillance activities during this reporting period in six woredas of Shinile Zone, Somali Region. A total of 37 community surveillance focal persons were trained on AFP and measles surveillance and deployed in six woredas of their respective localities

	<ul style="list-style-type: none"> • CCF Buee Project Area, reports that due to the intervention of community focal persons in the community, AFP case detection and reporting increased from zero to four and measles cases from 3 to 21. Access to health education on EPI & AFP was also increased by 80%.
Angola	<ul style="list-style-type: none"> • In Moxico, during one quarter, Save project staff and community volunteers visited 231 villages. During these activities, volunteers and project staff detected 12 measles cases in Luau and 2 cases in Luacano. All those children are returnees from Democratic Republic of Congo and Zambia. No AFP cases were detected • During one quarter, CARE project volunteers and supervisors visited 14,913 households seeking AFP (and other EPI targeted diseases) cases, resulting in detection of one AFP case in Cutato and collection of the corresponding stool sample. Eight cases of measles have been notified as well. • In Kuito Municipality of Bie Province, Africare trained 40 women from PROMIACA, a Catholic women's association, as community polio activists. Africare organizes biweekly meetings with its polio activists and attends weekly surveillance and health meetings with health partners.
Nepal	<ul style="list-style-type: none"> • CARE followed upon seven Zero reporting units and ensured the timely Zero report to SMO. Advocated AFP/Measles and Neonatal Surveillance and case report messages to the people in every opportunities viz-small gathering, teashop, community visit mother group meetings etc. • AFP, neonatal tetanus and measles are part of the Nutritional Health Promoters (NHP) training and monthly meetings conducted by ADRA and SAVE. Mothers are informed about these three diseases while receiving nutrition education.
India	<ul style="list-style-type: none"> • India is focusing on supplemental campaigns



Figure 10 Angola CARE Activists

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

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

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

Progress towards strategies:

- India and Angola have been able to link identified children to assistance
- Further momentum is needed in Ethiopia and Nepal



Figure 11 Kanhika, a polio victim young girl in Barragem da Açucareira, Lobito Municipality, is always there to welcome the CRS polio team and help to mobilize children for vaccination. She is scheduled for a wheelchair when it becomes available.

Country Highlights	Assistance to Families Activities
Angola	<ul style="list-style-type: none"> • During lectures and trainings, the CRS team is advising the community to report disabled children cases to the focal point. During this period, they reported five cases. CRS is planning a group discussion with them to know about their needs and constraints. CRS Polio Team made a special agreement with Irmãs da Caridade de São Vicente de Paulo (a religious group) in Balombo and Benguela that they will provide wheelchairs to disabled children identified by the Project. • Up to the present moment IMC has identified 352 children who have been paralyzed by polio and/or war injuries. IMC is soliciting help from other agencies in an attempt to provide assistance in the form of wheelchairs and crutches to these children. It is the hope of IMC that with this assistance, these children will be better equipped to attend school • CARE supported families with paralyzed children by distributing 25,000 Kg of manioc in the leprosy center of São José and IDP camps in Bie.
India	<ul style="list-style-type: none"> • Polio affected children have been identified from the CRS program area. Focus is on those who have not been issued disability certificate by Government, with an effort has been made to persuade district official to issue the disability certificate • In the last quarter, the ADRA's SMCs, BMCs and CMCs of Bareilly, Shahjahanpur, Sitapur, and Rampur organized and conducted community meetings with mothers and caretakers to provide information on government programs for the disabled. The meetings helped improve our working relationship with the parents of the paralyzed children. These meetings also provided opportunities for the local leaders to know about the needs and situation of the families with paralyzed children. The meetings also enhanced the formal application processes to obtain the disable certificates for the paralyzed children from the local government authority. • During the last quarter, PCI partners have listed 55 polio-affected children from the CMC villages. Partners made efforts in issuance of disability certificates, railway and bus concessions, and assisted 300 parents through counseling. In Bihar 5 children got the scholarships from the school. In UP 18 polio affected children received disability certificates; one child got the railway concession. The 35 families of polio-affected children have counseled by the professional counselors.
Ethiopia and Nepal	<ul style="list-style-type: none"> • No reported activities

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

Activities to certify that a country is polio-free vary across the CGPP countries as some countries continue to have polio transmission in 2002. For this reason, the main interest of the CGPP at this time is for collaborative PVO organizations to begin thinking about an

appropriate role for PVOs/NGOs during their countries' certification period.

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



Figure 12 PCI Bullawa Tolly or Children's Brigade from Madrassa in Uttar Pradesh, India

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

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

- Count zero-dose children following supplemental activities and use information about distribution of zero-dose kids to improve plans to prevent zero-dose children in next round;
- Document the percent of AFP cases with 2 stool samples taken within 14 days of onset of paralysis;
- Document problems in logistics and/or implementation of supplemental immunizations and use this information to improve planning of follow-up supplemental immunization rounds;
- Report to CORE partners the results of MOH or WHO clinical exams and laboratory tests of stool specimens---

related to AFP cases identified in the project area during the prior reporting periods (polio, non-polio/discarded, pending).

Progress towards strategies:

- India has developed a unique HMIS software package for rapid examination of data
- To scale up the efforts of NGO involvement in PEI and routine EPI, it is crucial that the capacity of NGO staff and District Health Offices be built to effectively implement immunization programs in particular and health program in general. With the exception of India, LQAS has been implemented in project areas
- Analyzing data is key effective monitoring and evaluation

Country Highlights	Documentation & Data Analysis Activities
India	<ul style="list-style-type: none"> • The CORE Secretariat has developed an HMIS which has facilitated using data for analysis and decision making • In Shahjahanpur district, ADRA CMCs formed a Polio Panch (a village-level committee consisting of a Pradhan [village head], a Kotedar [a dealer who works with government and private companies, and distribute company products at a reasonable price], a teacher, a Moulvi [priest] or a Pandit [religious leader], and any other influential people in a community) in every village targeted under the PEI project. They collectively worked on the polio eradication program and attained success in increasing the booth coverage in their respective villages. This was made possible through counseling services provided to the XR-marked families, and by visiting the remote villages before the rounds took place. The conversion rates of X marked houses to P houses in CMC areas are 10-15% lower in CMC covered areas than that of non-CMC covered areas. • PCI includes analysis of SIA data and monitoring tools during BMC training sessions
Nepal	<ul style="list-style-type: none"> • Use of GIS to help district health teams better analyze existing data, CORE continued to assist the district public health office in documentation, analysis, and use of information of immunization data as the EPI section, Child Health Division has devised a classification scheme of monitoring the performance of immunization coverage. These classifications are mapped by subdistrict (VDCs) so that district health teams can set priorities for special attention within districts.

	<ul style="list-style-type: none"> • CORE projects share the information with DHOs, supervisors and health facilities to develop a work plan for following quarter to improve the immunization status. Priority VDCs receive investigation and are given increased supervision, social mobilization, and community meetings. Every quarter and/or year comparisons are made as to transition of VDCs from high priority to low or no priority. (See figures 13 & 14)
Ethiopia	<ul style="list-style-type: none"> • CORE Ethiopia found problems observed in relation to the Partners information management services: poor registration, poor recording of daily health activities, lack of capacity for collection and compilation of data, and lack of skills for processing and presenting data. Due to these limitations, the management information collected from all levels was incomplete and activities were usually under reported. • CORE Ethiopia provided training in Lot Quality Assurance Sampling (LQAS) in the reporting period to enable relevant people to strengthen, expand and scaling up the role of PVOs and Woreda health staff efforts in PEI and routine EPI especially in monitoring and evaluation. • CORE Ethiopia, in collaboration with WHO, organized a data management training in EpiInfo, EpiMap and HealthMapper. The objective was to build data management capacity and to equip them with data analysis and mapping techniques.
Angola	<ul style="list-style-type: none"> • Save the Children is also supporting the MoH with their HF radios and mail service to improve the flow of information between the municipal and provincial levels. • Africare continues to photocopy and distribute surveillance bulletins for all vaccine preventable diseases due to delay by the MOH in supplying these materials to health facilities • CRS is collecting weekly surveillance and vaccination data from the municipalities to allow coverage analysis and decision making in order to improve service delivery. CRS vehicles and HF radios are used to collect and transmit data.



Figure 13 LQAS Field Training, Ethiopia

Priority 1	Priority 2	Priority 3	Priority 4
(Problem)	(Problem)	(Problem)	(No Problem)
High Drop-out (>10%)	Low Drop-out (<10%)	High Drop-out (>10%)	Low Drop-Out (<10%)
Low Coverage (<80%)	Low Coverage (<80%)	High, Coverage (>80%)	High Coverage (>80%)

Figure 13 Nepal Child Health Division VDC Classification System for Immunizations

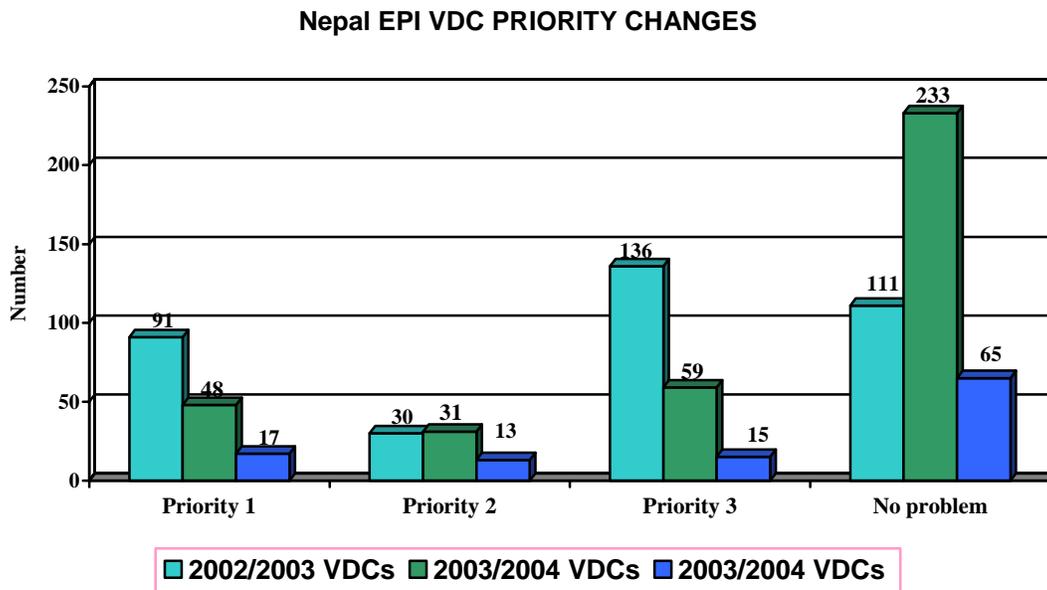
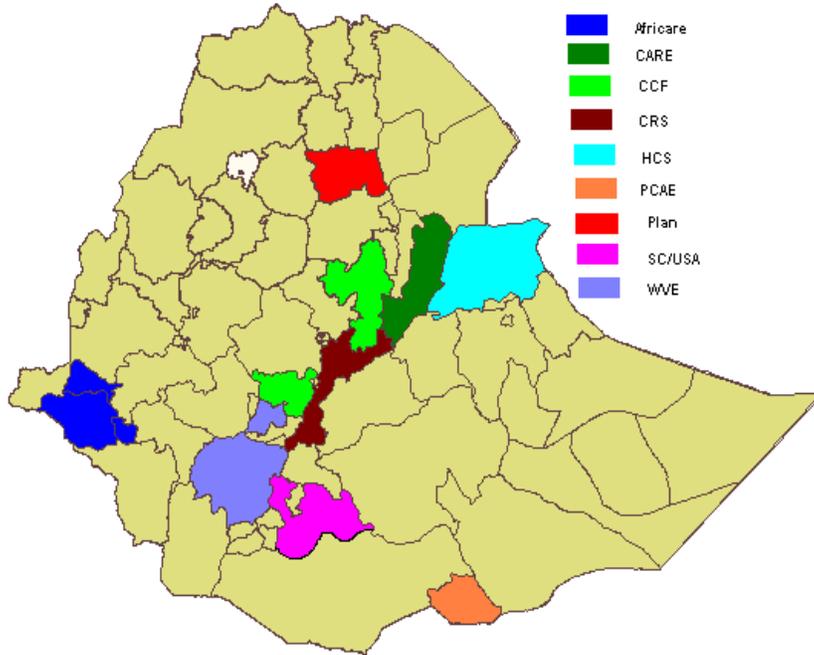


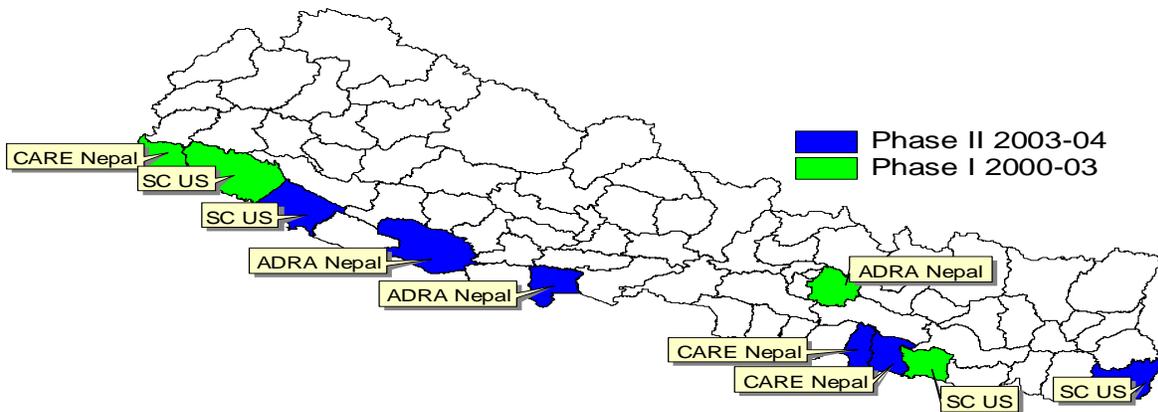
Figure 14 EPI priority changes from 2002/2003 to 2003/2004 in CORE Nepal Districts & their VDCs

Maps of Project Areas
1. Ethiopia

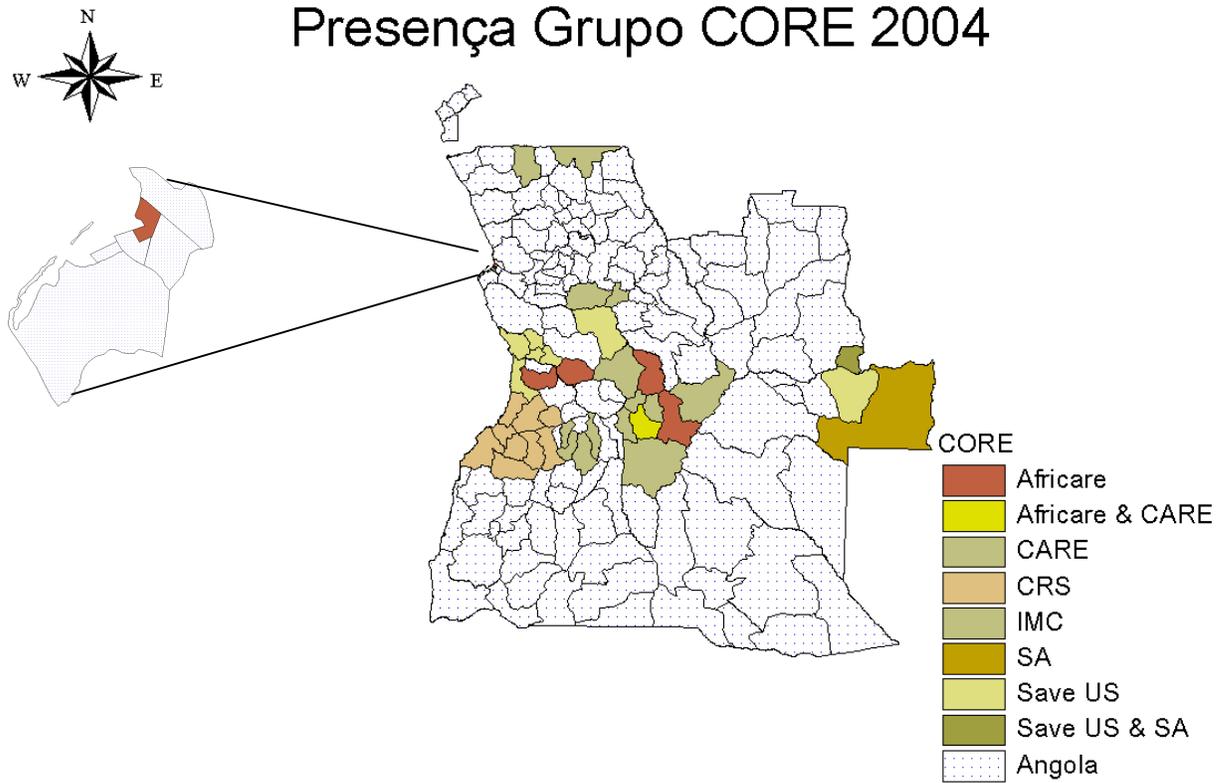


2. Nepal

CORE Group Nepal Partners Project



3. Angola



4. India, Uttar Pradesh

