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Final Review of the CORE Group Partners Polio Eradication Initiative

REACHING THE UNREACHED TO INTERRUPT POLIO VIRUS TRANSMISSION

India, Ethiopia, Nepal and Angola, 1999-2008

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We also wish to thank Ellyn Ogden and her colleagues at USAID headquarters in Washington and in the Missions in Angola, Bangladesh, Democratic Republic of Congo, Ethiopia, India, Nepal and Uganda for their on-going support.

Ellen A. Coates, on behalf of the CORE PEI and CGPP team.

Abbreviations and Acronyms

ADP	Area Development Program
AFP	Acute Flaccid Paralysis
ANM	Auxiliary Nurse Midwife
CBO	Community Based Organization
CDC	US Centers for Disease Control and Prevention
CGPP	CORE Group Polio Partners
CHW	Community Health Worker
CMC	Community Mobilization Coordinators
CRS	Catholic Relief Services
EPI	Expanded Programme on Immunisation
HMIS	Health Management Information System
HRA	High Risk Areas
ICC	Inter-Agency Coordinating Committee
IEC	Information, Education, Communication
MIS	Management Information System
MNT	Maternal and Neonatal Tetanus
MOH	Ministry of Health
NGO	Non-Governmental Organization
NID	National Immunization Day
NPSP	National Polio Surveillance Program
OPV	Oral Polio Vaccine
PEI	Polio Eradication Initiative
PVO	Private Voluntary Organization
RCS	Rapid Convenience Sample Surveys
RI	Routine Immunization
SIA	Supplemental Immunization Activities
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
VPD	Vaccine Preventable Disease
WHO	World Health Organization
WPV	Wild Polio Virus

Executive Summary

The CORE Group Polio Eradication Initiative (CORE PEI) has achieved country scale with its coordinated PVO/NGO efforts to interrupt transmission of the poliovirus in high-risk areas where trained local community volunteers provide essential household and community based services, such as provide culturally relevant vaccine information to mothers and caretakers; promote good child immunization practices; track unimmunized children, mobilize communities to support government immunization campaigns; follow-up defaulters, conduct active surveillance for acute flaccid paralysis (AFP) cases and trace case contacts.

In 1999 the United States Agency for International Development awarded a grant to the CORE Group Partners Project to implement polio eradication activities in selected polio endemic and polio-affected countries This endeavor draws on the advice and support of the CORE Group, a membership association of more than 50 US private voluntary organizations that work globally to strengthen local capacity to measurably improve the health and well-being of children and women in developing countries through collaborative action and learning. The partner, World Vision, has the managerial, financial, supervisory and legal responsibility for the CORE PEI project. The remaining partners, Johns Hopkins University and CARE have provided technical staff to the CORE Polio Project Team, which reviews and funds country projects, and provides administrative/technical I support to the CORE PEI national secretariats.

Over years 1999-2008, CORE PEI has supported routine immunization and special campaigns; AFP surveillances, and health sector and local NGO capacity-building in 6 countries (Angola, Bangladesh, Ethiopia, India, Nepal, Uganda), where PVOs and their implementing NGO partners have access, local presence and established trust with hard-to-reach populations.. Although CORE PEI is working at a larger scale than most PVO programs, this partnership project has been an effective, lean mechanism. There is increasing recognition of the potential of this partnership approach that goes beyond polio itself. After 8 years of focused polio eradication programming USAID initiated an extensive review of CORE PEI to look at what PVOs and their NGO partners have learned for stopping polio transmission, and to assess the value of the PEI mechanism and approach in populations living in areas that have little or no health services, border areas, migratory groups, "silent, marginalized, or resistant populations, The findings are impressive.

CORE PEI has made important technical contributions to national polio eradications programs as documented by input, output, outcome and quality process indicators; field observations of external evaluators; and responses to stakeholder and key informant structured interviews. With 25 million from USAID and 2.6 million from participating PVO/NGOs over 1999-2008, (and support of just 6FTE in national secretariats and 3.2 FTE in the USA), this partnership mechanism has reached an estimated 30 million children living in areas of high polio risk, (i.e. low levels of <5 immunization coverage; areas with reported outbreaks of the polio virus; areas with geographical barriers to service access). While outcome documentation is lacking in three countries, the review team found that in the remaining three countries, CORE PEI, working under leadership of national immunization coordinating committees has slowed transmission of polio virus, contributed to higher immunization coverage levels in underserved communities, and detected polio cases in declared "polio free" areas. CORE PEI country programs have fulfilled functions that no other group in country could do, and are regarded as "value added" to national PEI efforts. Two CORE PEI country programs have transitioned to "graduate" status, their functions now absorbed by strengthened local organizations.

The CORE PEI project has developed a collaborative network of PVO/NGOs with capacity to support other national, regional and community disease control initiatives. This project has brought new ideas to local areas, adapted and tested them under local conditions, and local NGOs have adopted those which have proved useful. Specifically, PVOs and their implementing partners have introduced in one or more counties: child tracking, registration systems, micro-planning, social mapping and geographic information systems as aids to increasing immunization coverage and conducting AFP surveillance. CORE PEI national secretariats have standardized NGOs' strategic approach to polio eradication, and have

achieved greater consistency and quality in PVO/NGO training of country staff and volunteers. Secretariat planning with partners is based on epidemiological and program data, and has promoted understanding and good use of district health data for targeting social mobilization and surveillance activities at community level. The methodologies that CORE PEI has developed and tested at local level will enlarge the global health knowledge base about small area planning, assessment and decision-making.

Contrary to some fears, the vertical focus of polio eradication has not eroded PVO/NGO emphasis on integrated community health development. Neither did the funding of a collaborative mechanism result in loss to individual PVO partners. In fact, participating PVOs said they attracted new donors, increased PVO funding levels and experienced new program opportunities as a result of being an implementing partner in the CORE PEI country networks. . .

At the country level, the projects experienced initial problems, which, with time, they overcame. In the USA, the CORE Polio Project Team found it challenging to accommodate information needs of multiple cooperating organizations associated with this grant, (including USAID CTO and the national secretariat directors), and assure formal, timely communication links and clear reporting guidelines achieved in more traditional top-down structures. Despite the organizational complexity of the partners' project, the external review found all partners to be responsive to the challenges and opportunities of managing country collaborative secretariats. In its nine years of operation, CORE PEI has generated an invaluable set of "lessons learned" for the management of country partnerships that link communities with national health initiatives.

The Final Review team believes that the contributions of CORE PEI are:

- **Collaboration:** it unites a diverse group of NGOs into a country-wide network with a common vision of the benefits of collaborative partnerships to fill gaps in national polio eradication programming; and adopt a coordinated strategic approach that follows national immunization policy.
- **Community Feedback and Mobilization:** It recognizes the value to national health programs of having local presence and community input to learn what is really happening on the ground;, and engage, train and motivate community volunteers to take planned actions in households and communities in cooperation with local/district health officers...
- **Focus:** Its focus on underserved areas where the virus is more likely to emerge or be imported, and where governments have few health resources in place to address the task enables better concentration of support on highest risk areas. CORE PEI adds "specificity" to "scale
- **Flexibility:** The flexibility of PVO partners to move field operations when the virus moves location, and to engage, orient, train and plan with new local NGO partners, enables a quicker response to interrupt virus transmission and halt the build-up of polio cases and contacts..
- **Country Ownership:** National secretariats do not stress outside solutions but follow national immunization policy, and respect and support adoption of local strategies for raising awareness and social mobilization, as devised by individual NGOs and community partners.
- **Community members trained in case detection and timely reporting:** Once a country achieves certification a large number of trained people will be left to maintain the kind of intense surveillance that will be needed to assure the virus has not re-emerged or been imported.

Conclusion: CORE PEI has been a visionary project, building on past success and strengths, attempting new ways of working and creating sustainable innovations. It's been a small, modest project that has reached country scale, and brought the power of dedicated non-profits and mobilized communities to interrupt transmission of the wild polio virus. Its achievements have far outstripped its funding. CORE PEI has added value to national polio eradication programs that could not have come from another source, and in the process, communities have gained and national polio programs have gained. Most of all, at-risk children living in hard to reach areas have gained – they re protected from polio.

Introduction

A. Background of the CORE Group PEI

In 1988, 191 member countries were signatories to the World Health Assembly goal for global elimination of poliovirus and paralytic polio. Adhering to the World Health Organization (WHO) strategy for polio eradication, central and state governments - with support from development partners and civil society - initiated polio campaigns, strengthened routine immunization and established a country-wide network for AFP Surveillance.

In 1999, the United States Agency for International Development (USAID) awarded an $8 million grant to the CORE Group Partners Project to implement polio eradication activities through its PVO members and their partners in selected polio endemic and polio-affected developing countries where PVO access to hard-to-reach, high risk and "silent" communities could help achieve the immunization coverage necessary to interrupt polio transmission and eradicate the virus. CORE Group is an organization that fosters collaborative action and learning to advance the effectiveness and scale of community-focused public health practices. The approximately 50 members of CORE Group are citizen-supported NGOs that work internationally in resource poor settings to improve the health of mothers, children, and communities.

Since 1999, CORE Group's PEI activities have supported routine polio immunization, AFP surveillance, and health sector and organizational capacity building. These activities have been implemented by CORE Group members, who consist of US-based PVOs and their local partners in PEI project countries, including two "graduate" countries, Bangladesh and Uganda. Current countries include Angola, Ethiopia, India and Nepal, though Nepal is closing operations, soon to be a "graduate" country, while Sudan is in the planning stage for a PEI project country

A National Secretariat office established in each country provides technical support; facilitates training, communications and coordination for the participating partner organizations; and represents the partner PVOs, NGOs, and the community voice in national and international forums including the Interagency Coordinating Committee, Technical Advisory Groups and, in India, the Social Mobilization Network[1] (SMNET).

Other partners include UNICEF and Rotary. UNICEF provides educational and promotional materials, and facilitates polio communications and social mobilization support, while Rotary draws upon its global network of members to champion the national polio eradication programs and commit to ongoing financial support.

The Secretariat is intended to ensure coordination and communications that will prevent duplication of effort, disseminate information and lessons learned and maximize the return on investment. For example, the Secretariat manages efforts of selected partner NGOs engaged in hard-to-reach communities to collaboratively prepare an action plan with their community partners in advance of each social mobilization and AFP surveillance activity in every PEI-covered community.

As with any active disease control program, strategies change over time according to local and national circumstances. By 2001, there was widespread interruption of poliovirus circulation in most countries. However, the wild poliovirus (WPV) survived in a few areas characterized by poor access to health facilities and vaccine refusals. The build- up of susceptibles in areas resulted in an increase in the number of cases. Furthermore, the poliovirus re-emerged in places that had reported being polio free. Governments and development partners realized that social mobilization in areas with high polio transmission and other high risk areas (HRA) was critical to ensure delivery of polio vaccine to all

[1] The SMNet is a partnership founded by CORE, UNICEF, and Rotary to facilitate coordination and quality of social mobilization strategies and activities supporting polio eradication in Uttar Pradesh, India.

beneficiaries to ensure interruption of transmission. The national vaccine strategies altered to incorporate more frequent rounds in HRAs and areas with high polio transmission but poor access to health services. In response, CORE PEI country programs trained and mobilized large numbers of volunteers to support government campaigns. In addition, by the time of the field review by an external team (2008), community surveillance in CORE PEI service areas had become more systematic, and the project was finding and reporting AFP cases in areas that previously were considered zero reporting.

The purpose of the individual CORE PEI country reviews (See appendices) was to assess the contributions, value added, challenges, gaps and opportunities of each country program, and to make recommendations to strengthen the country program and improve its outcomes. In contrast, the purpose of this summary review is to report on the contributions and value of the CORE PEI mechanism overall, and to think ahead to coming certification, and further ahead, to possible replication of this partnership approach in other areas, (e.g., malaria, micronutrients, and ICD). Additional key informant interviews provided recommendations and lessons learned to strengthen the CGPP projects now in operation, as well as those being planned for Africa. (See appendices.)

B. CORE PEI's goal and objectives

While CORE PEI country projects vary in their approaches, the goal is the same: *interruption of wild poliovirus transmission in the CORE PEI program areas.*

To track progress toward this goal, the CORE Group PEI/Washington office specified two intermediate objectives;

1. Immunize all children under five against polio through repealed national and local vaccination campaigns and routine immunization; and,
2. Active, community-based detection and reporting of AFP cases that will help identify all cases of wild poliovirus or help document the non-existence of polio in an area.[2]

C. Final Review objectives:

1. Evaluate the technical contributions that CORE PEI has made toward polio eradication in the CORE PEI countries, and the value added to the polio eradication effort.
2. Evaluate the National Secretariat model, its contributions to the project and to the participating organizations, opportunities for improvement, and prospects for replication.
3. Identify challenges that constrain the project and opportunities to strengthen the project and its outcomes.

This evaluation tackles a number of the following questions that are important to shaping future actions.

- Does the CORE PEI approach achieve scale and still retain flexibility?
- Does this approach support decentralized decision making, bottom-up reform and scalable innovations?
- What are the implications for expansion of the Secretariat model?
- Is the partnership approach, or coordinating mechanism, competitive with the on-going development work of member PVO organizations? Does it restrict their opportunities for development funds?
- Can countries make further use of the network of trained people, and experienced managers of networks who are left behind when temporary coordinating mechanisms end?
- What is the likelihood that a group of local PVO/NGOs in country will take ownership of the idea, and use it to come together for common planning and common training? Or, will it require supervised, planned action, perhaps on the part of the CORE Group? Is there likely to be more mission buy-in?
- Can PVO/NGOs bundle projects, approach donors and diversify their donor base?

[2] March 2003, "Managing CORE Polio Projects". Weiss W, Newberry D, Smith S, Solomon R.

The Final Review report cannot claim to fully answer these questions, but it illustrates project experiences, incorporates the interview responses of key stakeholders, and makes summary conclusions and recommendations,

D. Evaluation framework

The evaluation framework for the Final Review of the CORE PEI project is not concerned with *attribution* – that is, it does not seek to attribute changes to a particular group (PVOs/NGOs) or to a particular organization (The CORE Group). Rather, this framework is concerned with questions of *benefit* or *value of specific functions*. The final review determines whether the functions which CORE PEI enables (social mobilization and community surveillance) make technical contributions and add value to national polio eradication efforts. Similarly, the final review determines whether the functions which the National Secretariats enable (coordination of effort; and standardization of training, planning and strategic approach) contribute to project and to participating organizations, and build health system and organizational capacity in country, without duplicating existing services or adding undo costs.

Finally, this evaluation framework allows for questioning the validity of the underlying assumptions for bringing coordinated PVOs/NGOs into a national disease eradication effort, and for funding a partnership mechanism. From this, one can determine the utility of the underlying assumptions, (or what become "lessons learned" when assumptions don't hold), as well as unexpected "spin-offs" or outcomes (See appendices for an outline of the CORE PEI evaluation framework used to guide this Final Review.)

E. CORE Group PEI country programs undergoing review

The review is intended to cover the existing CORE PEI programs in India, Nepal, Angola and Ethiopia. (Earlier programs in Bangladesh and Uganda had "graduated," the functions phased into local organizations, and the Secretariats ended.) CORE PEI is concentrated on countries where it was believed that coordinated PVO/NGOs could assist the government polio program stop local transmission of the polio virus.[3]

The specific function of CORE PEI is dependent on the country and its assessment of where coordinated PVO/NGOs are most needed. There are technical ambiguities as to what happens with the virus as the virus disappears or re-emerges. The response of CORE PEI differs from country to country, dependent on strengths and weaknesses of the national polio eradication program, and its determination of need. CORE PEI India directs its work to social mobilization, as surveillance is the government's job, although CORE Group partners assist medical surveillance officers in gaining cooperation of households with suspected AFP cases. CORE PEI Nepal carries out both social mobilization and community surveillance. CORE PEI Ethiopia directs its activities to community surveillance. The functions of CORE PEI Angola have expanded from community surveillance to a greater role in social mobilization.

F. Review team's assignment and methodology

External reviewer Lora Shimp, Senior Technical Officer at IMMUNIZATIONBasics[4] and her colleague Tasnim Partapuri and team were responsible for the review of CORE Group PEI India and Nepal. External evaluator Abdelmalik Hashim and a team headed by Filimona Bisrat, National Secretariat, CORE PEI Ethiopia, were responsible for review of the project in Ethiopia. External reviewer Ben Schwartz, CDC, and Dora Ward, CORE PEI Technical Officer, designed the instruments for assessment in Angola, and wrote the background information on Angola used in this Final Review. (See appendices for the individual country review reports.)

Consultant Dory Storms led the external evaluation team, developed the evaluation framework, summarized the findings from the country reviews, designed and conducted stakeholder and key informant supplementary interviews, and drafted the Final Review summary report.

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[3] For reasons specific to country conditions, USAID did not select Nigeria to be in the CORE Group PEI program, although it is a country where WPV outbreaks remain of great concern.

[4] JSI/Immunization Basics, Washington DC

Each review team member had a contract which listed background, consultancy objectives, specific tasks and deliverables. In addition the team members each received a copy of the evaluation framework, and examples of the assumptions about PVO/NGOs that may help or hinder their performing the functions that are expected to achieve certain goals of national polio eradication programs. The reviewers were to note if the assumptions were found to be incorrect, if the functions were not performed or performed poorly, and whether the functions met expectations for results. The team evaluators were also given a semi-structured questionnaire to guide their interview of the multiple stakeholders. The evaluators worked closely with the Secretariats, and a local review team, and these persons are noted in the individual country reports.

Except for Angola, the members of the review team were able to spend time in the assigned country, hold interviews, visit project areas, prepare a summary presentation of findings for the local office, and then prepare a final report. Unfortunately the time chosen for the review was not optimal for Angola due to elections and anticipation of possible civil disorder. A local consultant was trained by the CORE Group PEI Headquarters Technical Officer to use structured interview forms and questionnaires to obtain necessary information, and the staff member drafted background materials and a history of the program which has been incorporated in this report where possible.

G. Assumptions in summarizing review team's findings

This CORE PEI Final Review draws upon the findings from three country reports (India, Nepal and Ethiopia) plus the Angola background material, and supplements it with information obtained in interviews (by phone, in-person, or email) with stakeholders and key informants in the USA or abroad. In summarizing the findings of the individual CORE PEI country reviews, a main assumption is that although the polio eradication programme is global, each country's polio eradication effort is specific to that country, and differs in its history, nature of the polio problem, the specific PVO/NGOs participating in CORE PEI, the style of coordination of effort, and the linkage with government. The intent of the summary is to identify patterns encountered in effectiveness, efficiency, and acceptability of operations across PEI countries, and over time.

The individual histories of the CORE PEI country programs are covered in numerous quarterly and semi-annual (six-month) reports over the years 1999-2007 and no attempt was made to detail that history again. Instead, the Final Review concentrates on the pattern of benefits, contributions and value added by the overall CORE PEI project after 8-9 years in existence.

The Final Review also summarizes challenges found to constrain the project and opportunities to strengthen the project and its outcomes. The review team assumed that community-based health programs are not problem-free in their growth and development, nor is change problem free. The reviewers recognized that all CORE PEI stakeholders had to work out issues that arise in growing a project, and forming new working relationships. The team looked for successful ways of introducing change and innovation in country partnerships that could benefit hard to reach communities.

The summary of the review team findings does not focus on the performance of particular participating organizations or particular polio eradication country programmes. Those issues are covered in the country reports. (See appendices.). The assumption behind summarizing the vast array of final review data was that there is a need and demand for information about strengths and weaknesses of health service mechanisms that focus on reaching the unreached, under varying conditions of time, culture and resources. The intent of the summary effort is to evaluate a partnership coordinating mechanism – that has been replicated in several countries at different times,-- and to determine the value and potential of such a mechanism, in the event others wish to replicate the mechanism, or adapt the idea to other vaccine preventable disease programs covering children in difficult to reach populations..

H. Structure of the Final Review Report

The reader will find that the Final Review of the CORE Group's polio eradication initiative addresses elements that are in common across current CORE PEI country projects: the coordinated participation of local PVOs and NGOs in planning and implementing social mobilization and household/community immunization education; and the linkage of the coordinating mechanisms, (secretariats) with national immunization committees, district/local health offices. It documents the value those elements are perceived by key stakeholders to add to national polio eradiation programs. It evaluates the success the CORE Group PEI implementing partners have had in carrying out the vital functions of social mobilization and community surveillance. It also highlights the technical contributions CORE Group PEI has made to national, and potentially, global polio eradication. It discusses the challenges and opportunities ahead of CORE PEI, and presents insights of key informants for strengthening current CGPP activities, and avoiding past mistakes. The Final Review closes with thoughts about planning for certification, and the end of the secretariats and the PVO/NGO polio partnership. It considers the possibilities for replication or adaptation of the coordinating mechanism to other government programs for prevention of childhood disease.

There are nine distinct sections that follow this introduction.

- Section 1 briefly describes the organization and structure of the coordinating mechanism, its partners in each CORE PEI country and community workers; provides an organigram for the reader, and charts the roles of the groups forming CORE PEI's working relationships.
- Section 2 details the inputs, outputs, processes, outcomes and impact indicators of CORE PEI's progress toward accomplishing Immunization and active surveillance/reporting objectives, as drawn from the field reviews and reports.
- Section 3 reviews main benefits of CORE PEI' strategic approach; identifies CORE PEI's technical contributions to national polio eradication/national health informatics; presents insights from key informants about CORE PEI's value added to different levels of national polio eradication programs, and what will be left in place when CORE PEI ends.
- Section 4 summarizes the successes and gaps of project documentation, and CORE PEI's innovative effort at building local capacity to understand, interpret and use district health data for tracking neonates/infant defaulters and demark areas of social mobilization and surveillance.
- Section 5 is concerned with the National Secretariat model – its contributions to the project, contributions to participating organizations, and opportunities for improvement and prospects for replication.
- Section 5 presents the thoughts of key informants about the "surprises" or unexpected elements (both positive and negative), which has marked their experience with CORE PEI
- Section 7 summarizes the challenges and opportunities. One subsection presents remarks from the country reviews about challenges that constrain CORE PEI in country; another subsection contains remarks from the country reviews about perceived opportunities for CORE PEI in the country, or region.
- Section 8 summarizes the expectations about the functions that coordinated PVO/NGOs would fulfill in national polio eradication programs; it charts the validity of those assumptions in comparison to findings of the external review team; and discusses the implications for replication of the CORE Group partnership mechanism if similar functions are needed in other disease prevention programs elsewhere.
- Section 9 ends this report with thoughts about what might be expected of the national secretariats PVO partners, and CORE PEI/Washington during the time of certification in CORE PEI countries. It reviews key lessons, and challenges all stakeholders in CORE PEI to document and disseminate information about the achievements, benefits and added-value of this visionary project.

Section 1: CORE PEI, the Coordinating Mechanism under Review

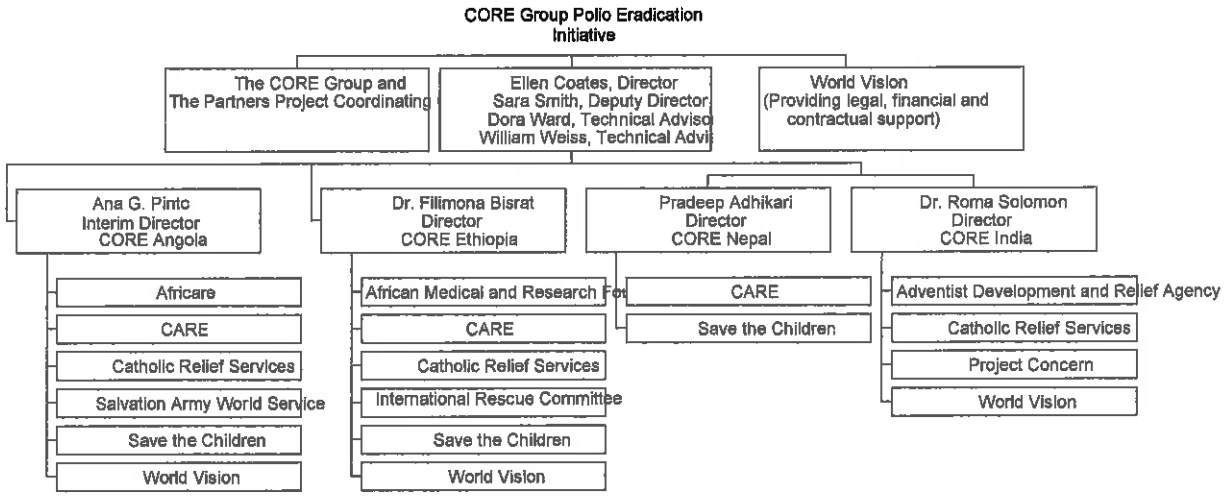
A. CORE Group Polio Eradication Initiative (CORE PEI)

CORE PEI is a partnership structure established for a specific, short-term (≤10 yr) purpose: to coordinate PVO/NGO involvement in national and community polio eradication efforts. CORE PEI was never intended to be permanent. Unlike most organizations that are free-standing and self contained, CORE PEI is marked by the multiple relationships it has at every level, both financial and administrative. The structure may seem difficult to grasp, because it does not follow a top down, on-line authority, as in the military or in government. Instead, CORE PEI operates at three levels, and coordinates activities with partners appropriate to that level (1) Washington DC office; (2) country or national level, and (3) the PVO/NGO program implementation or community level.

CORE PEI is a coordinating mechanism, which involves collaboration between a Prime *Grantee* (World Vision, Inc.) and *Sub Grantee* (The CORE Group, Inc.).The prime grantee is also the *Host PVO* for the Washington office of CORE PEI, and houses the office's Director and small staff. The Director of CORE PEI relates to USAID, World Vision, the CORE Group, US-based PVOs, and WHO, UNICEF, CDC, offices, in addition to less frequent contact with other groups involved in global polio eradication.

The organizational structure in the CORE PEI countries is fairly similar, though there are minor differences in office location, number of staff, and partners. Each country has a *Country Host PVO*, which usually houses the office for the CORE PEI National Secretariat, a Secretariat Director, and in some cases, a Technical Advisor or an administrative person. Each National Secretariat has a designated group of in-country PVO/NGO partners, (including the Host Country PVO), which have agreed to participate in the CORE Group PEI project. The organigram for CORE PEI is below (Figure 1).

Figure 1: CORE PEI Organigram



CORE PEI country partners have changed while growing the project, due to a change in PVO/NGO program focus, or change in distribution of the polio virus making another PVO/NGO service area more relevant for support of the national polio program. Initially the project was built off of Child Survival project areas. At the time, the virus was in many places. As the virus's range shrank, CORE PEI had PVO/NGO partners in areas that were not priorities. It was difficult in some countries (Angola for example) to get the PVO/NGO partners to shift location. The partner organizations couldn't move because they had add-on funding only, and did not have sufficient funds to support a polio eradication operation by themselves in new areas. So the partners looked for local NGOs to partner with in the areas where the virus was present, and they recruited, trained, supervised and supported the implementing local NGOs

now part of CORE PEI. NGO partners may be represented directly in Secretariat meetings, or indirectly, through PVO partners working with those local NGOs to stop local transmission of the polio virus.

Allocated funds flow from USAID to the Prime Grantee, who then distributes the money to the USA offices of the Host Country PVOs. It is the USA office of the Host Country PVO that provides funds to the Host Country PVO for its usual country operations given their program funding, and, in addition, releases the special CORE PEI funds for PEI field implementation only. The Prime Grantee distributes funds to the Secretariats for Secretariat activities only.

The National Secretariats chiefly interact with in-country partners including government, WHO, UNICEF and Rotary offices engaged in planning and managing the national polio eradication program. The CORE Group partners have multiple relationships for coordinating field implementation. For example, in Angola, the CORE Group partners work with the Municipal Director of Health, the Director of Public Health, the EPI Manager, the Surveillance Officer. And, at the most basic level of care, the partners interact with the Health Unit Director, Unit EPI Manager, and Unit Surveillance officer.

Partners are allowed both in-kind and cash to make match. USAID expects US- based international PVOs to match 25% but lowered the match to not more than 5% from the field (local NGOs). The match the PVOs show often pays for parts of salaries, benefits, office rent, etc. CORE partners can leverage money for treatment, or facilitate access to treatment or rehabilitation for polio survivors. The USAID grant cannot pay for that, but match money could be used for it. Sometimes the implementing partners report on helping polio survivors but do not request remuneration. For example, in India, World Vision brought together a number of paralyzed children, and transported them by bus to a hospital/therapy center where they could have surgery, or be fitted for braces, etc.

B. CORE Group PEI community workers

All four CORE PEI countries have a similar operational structure. The CORE PEI Angola evaluation team describes the general pattern as follows: *The critical ingredient to the CORE PEI strategy is the community volunteer. It is the community volunteer who maintains the relationship with the mothers, children and communities in the service area. The project provides basic supplies needed to perform program activities, but provides no monetary reward. Some PVOs provide incentives such as t-shirts, caps to volunteers. All volunteers must be at least able to enter numbers on monitoring tables to indicate their activities. In Angola, the Community Volunteer Focal Point, also a trained volunteer, supports the volunteer through reviewing records, observing home visits and health education activities, communication with key community leaders and disseminating information from the PVO staff. All focal points must be literate, (basic reading ability and ability to explain content to other volunteers.) All volunteers and focal points must commit roughly one hour a day on the CORE PEI project. Some PVOs choose to provide bicycles to focal points. CORE PEI motivates volunteers primarily by providing ongoing training and supervision. The PVO supervisors are responsible for supervising the volunteers and the volunteer focal points; they conduct trainings, records review and supervisory visits, including accompanying volunteers in their activities to provide feedback and coaching volunteer focal points in their efforts to engage community leaders. The PVO coordinator supports and supervises the supervisors through training of trainers and accompanied supervisory visits and serves as the official technical point of contact between the Secretariat staff and the PVO. The Secretariat staff provides training, oversight and onsite supervision to the PVO coordinators, as well as representing the CORE PVOs to stakeholders, setting overall strategic and technical direction and directing M&E activities.*

CORE PEI Nepal has a slightly different type of worker, but still a community volunteer, whose role is described as follows: *CORE PEI mobilizes and trains female community health volunteers to serve as active surveillance volunteers assisting with AFP and VPD case identification, reporting, and follow-up in CORE PEI Group service areas. CHVs come from and work in their own communities.*

C. CORE PEI's working relationships

Table 1 describes the roles of the various constituencies that form CORE PEI's working relationships:

TABLE 1: Roles of the Groups Forming CORE PEI's Working Relationships

Groups	Roles and Responsibilities
INVESTOR' or DONOR (USAID Grants and Contracts Officer; Program Officer)	▪ Set financial accountability standards ▪ Specify intended Outcomes and Indicators (i.e., accountability standards for "results") ▪ Select countries eligible for CORE PEI operations ▪ Monitor use of grant funds
PRIME GRANTEE – World Vision US	▪ Provide mechanism for deposit of grant funds ▪ Financial accounting and financial management ▪ Grant oversight ▪ Technical oversight ▪ Monitoring, evaluation, and reporting
SUB GRANTEE - CORE GROUP	▪ Facilitate access to international PVO partners ▪ Dissemination of information on CORE website
CORE PEI/WASHINGTON DC OFFICE	▪ Initial solicitation of country partners ▪ Integrated leadership ▪ Global strategic planning ▪ Allocation of resources among countries ▪ Organize knowledge about different country programs and use to revise strategic plans ▪ Reporting as required to donor ▪ Sponsor reviews and assess progress toward objectives ▪ Trouble shoot ▪ Train partners in advance planning reports needed for adequate financial management ▪ Train partners in M&E data collection needed by polio program ▪ Provide TA to country projects
INNOVATORS (GLOBAL POLIO EFFORT) – WHO	▪ Country leadership ▪ Decision analysis ▪ Problem identification ▪ Problem-solve ▪ Set outbreak response practices, technical indicators and reporting procedures ▪ Set surveillance practices and Indicators Establish need
STATE (MINISTRY OF HEALTH)	▪ Set goals and priorities. ▪ Allocate resources ▪ Grant approval or authorization for CORE PEI to be in country ▪ Determine resources requirements for special polio campaigns and related events ▪ Integrate resource contributions of various partners in special campaigns and events ▪ Monitor outbreak response ▪ Participate in training of CORE PEI partners
CORE PEI COUNTRY SECRETARIAT	▪ National strategic planning for PVO/NGO effort to eradicate polio ▪ Manage the organization ▪ Managing politics ▪ Facilitate (with partners) allocation of resources among various partners in country ▪ Facilitate coordination among PVO/NGO partners ▪ Link PVO/NGOs to national and international decision-makers ▪ Provide TA

OPERATIONS ENGINE – the PVO/NGO PARTNERS	▪ Day-to-day operations management ▪ Management controls ▪ Human resources - staff/volunteers/trainers/data collectors ▪ Materials and equipment ▪ Logistics ▪ Advance planning for operations ▪ Generate accurate, timely requests for funds to pay for costs of scheduled activities ▪ Data collection on population in service area, including current polio immunization coverage and population characteristics. ▪ Data collection on service inputs, outputs and outcomes and impact, as needed by donor. ▪ Enroll community leaders and religious leaders as volunteer spokespersons ▪ Enroll children under 10 yrs and adolescents in polio education and social mobilization (only one country) ▪ Train and supervise key people in community, (such as housewives, farmers) to conduct community surveillance ▪ Design communications to overcome complacency issues, rumors about vaccine ▪ Feed-back to volunteers working in surveillance, re-energize mobilizers
THE 'CUSTOMER' – (Community members, Residents of PVO/NGO service area)	▪ Express demand for services, and satisfaction with quality of services and how provided ▪ Community leaders engage residents in polio immunization and surveillance ▪ Key people in community, (housewives, and farmers) volunteer, take pride in work and receive measure of community status. Volunteers for community surveillance get considerable training and supervision, which is motivating. ▪ Children and adolescents engage in educating peers and adults about polio (one country)
ORGANIZATIONS PROVIDING TRAINING, COMMUNICATIONS MATERIALS & SERVICE (Rotary, UNICEF)	▪ Collaboration, not competition ▪ Share information and materials ▪ Coordinate for geographic coverage ▪ Participate in training of CORE PEI partners

Section 2: Indicators of CORE PEI Progress toward Accomplishing Immunization and Active Surveillance/Reporting Objectives

A. INPUTS

A1. Input indicator: CORE PEI increases PVO/NGO participation and funding to stop polio transmission in local areas

CORE PEI brings together the approaches and strengths of the individual partner organizations to link the community – through PVOs – with the national polio program and norms. CORE PEI coordinates the planning and capacity building on polio-related activities, forming a strong and widespread partnership for field implementation, and streamlining communications with national/international health partners.

The evaluation team documented two input indicators for CORE PEI: number of NGO/CBO partners and amount of funds given to partners for implementing PEI, by country, 1999-2007. The CORE PEI partners included 7 partners in Angola, 10 in Ethiopia, 5 in India and 3 in Nepal. (See Appendix 3 for detailed list.)

Donor funding to the CORE PEI collaborative network accelerates support to national and local vaccination campaigns and routine immunization, and facilitates community identification of AFP. Beginning in March of 1999 and continuing through September 2008, USAID awarded the project a total of US$24,999,601 covering eight years of Polio Eradication Initiative (PEI) activities. Of that amount, the partners spent US$24,975,076, and contributed an additional US$2,607,933 from their own resources. PEI activities, and funding, ended on September 30, 2008. This grant was re-competed in 2007, and again World Vision and the CORE Group were awarded the grant with a ceiling of US$30 million dollars to continue the CORE PEI project activities through September of 2012.

USAID missions in CORE PEI countries also have demonstrated their confidence in the CORE Group's partnerships to stop transmission of the WPV in polio-affected high risk areas. In total, the four USAID missions have awarded slightly more than US$8.5 million to the National Secretariats to expand the local and national polio eradication work of the PVO/NGO partners.

Table 2 presents the second input indicator, *donor funding*, for each of the CORE PEI countries, by whether USAID funds came from the Global Office, or from the USAID country mission

TABLE 2: USAID Funding of CORE PEI, 1999-2007

Award	Date	Global	Mission-India	Mission-Angola	Mission-Nepal	Mission-Ethiopia	Total Obligation
First Award	March 11, 1999	$ 2,201,000					$ 2,201,000
Modification #2	February 28, 2000	$ 100,000					$ 100,000
Modification #3	June 14, 2000	$ 1,550,000					$ 1,550,000
Modification #4	December 15, 2000						$ -
Modification #5	August 8, 2001	$ 2,000,000	$ 100,000	$ 200,000		$ 200,000	$ 2,500,000
Modification #6	July 3, 2002	$ 1,500,000					$ 1,500,000
Modification #7	September 18, 2002		$ 1,428,000	$ 500,000		$ 200,000	$ 2,128,000
Modification #8	September 12, 2003	$ 1,600,000	$ 1,122,000	$ 1,000,000			$ 3,722,000
Modification #9	June 8, 2004	$ 1,320,000					$ 1,320,000
Modification #10	August 16, 2004		$ 1,425,000		$ 100,000		$ 1,525,000
Modification #11	July 20, 2005	$ 2,301,000	$ 900,000				$ 3,201,000
Modification #12	September 25, 2005	$ 699,000				$ 200,000	$ 899,000
Modification #13	September 20, 2006	$ 3,153,601	$ 900,000			$ 300,000	$ 4,353,601
		$ 16,424,601	**$ 5,875,000**	**$ 1,700,000**	**$ 100,000**	**$ 900,000**	**$ 24,999,601**

(Source: World Vision, Inc.)

A2. Input indicator: CORE PEI provides support to local, provincial and national ministry of health personnel for government polio eradication activities.
In addition to social mobilization for participation in NIDs and SIAs, CORE PEI has provided other support to government polio eradication efforts. These include:

Angola: Transport for vaccination supplies/personnel; Telecommunications equipment to aid local health posts in case investigation

Ethiopia: Telecommunications equipment to aid local health posts in case investigation

India: Transport for Auxiliary Nurse Midwives to health and outreach camps where routine immunization (RI) is low; has built capacity on polio-related activities, particular in blocks

Nepal: Vaccination supplies/personnel

B. PROCESSES

B1. Process indicator: CORE PEI's focus on the use of detailed social mapping for quality micro planning results in a greater % of communities being mapped as aid to identifying X houses (unvaccinated children in household) and defaulters

B2. Process indicator: CORE PEI's innovative use of government polio NIDs/SNIDs/SIA campaign and RI data, supplemented with data from child/pregnancy registers, improves the quality of management decision-making, enables mid-stream changes, and keeps costs of data collection low. *(Source: Interviews and semi-structured questions of representatives of MOH, in-country partners and PVO/NGO partners.*

It is an axiom that data should be useful for program management decisions. However, this is usually interpreted as using data that one collects anew, rather than making good use of existing data and supplementing it when necessary. Given the limited budgets, CORE PEI PVOs used as best as they could the data that were available: NID/SNID round coverage, RI coverage in Community Mobilization Coordinator (CMC) areas, and supplemented this with data from child registers. India provides the best example of utilization of government coverage data. In India, the CORE PEI partner could quickly identify areas or issues for improvement, establish priorities for action and follow-up on X houses to improve OPV coverage.

B3. Process indicator: CORE PEI's strategic approach improves quality of field work to identify and link unimmunized children with immunization/polio services. *(Source: Interviews and semi-structured questions of representatives of MOH, in-country partners and PVOs/NGOs*

CORE PEI bases planning on an underserved/HRA strategy, which uses mapping and data to identify areas with low or no immunization coverage, monitor RI status of individual children, and identify houses missed in densely populated urban areas. In these high risk areas, CORE PVO partners find potential community resources and key NGO and community partners, and encourage their participation in the local "stop polio" effort. Following training, community volunteers carry out newborn tracking and encourage mothers to bring infant for BCG and zero dose of OPV. Volunteers go house-to-house and identify houses missed in RI or campaigns, (aided by detailed newborn, routine immunization, and pregnant women registers). They encourage child participation in RI to complete vaccination series. In addition to tracking specific households/children without adequate vaccination coverage, local partners also are able to identify and address causes of resistance long before these problems erupt at higher levels.

B4. Process indicator: CORE PEI contributes to improving the quality of NIDs and SNIDS *(Source: Interviews and semi-structured questions of representatives of MOH, in-country partners and PVO/NGO)*

CORE PEI has supported micro-planning, implementation, monitoring and evaluation of NIDs and SNIDs at the district level since the beginning of its program. In Nepal, CORE supported districts have reported coverage above 90% for most NID, SNID and mop-up rounds which has been validated through Rapid Convenience Sample surveys (RCS) conducted by CORE PEI in its program areas since 2006. The findings from these RCS are used to determine where program improvements are needed and are shared with the district and national government and partners to improve planning, implementation and follow-up. The baseline survey conducted by CORE Nepal in August 2008 also found that 94% of the mothers interviewed with children 12-23 months of age noted that their child received OPV during the most recent SIA (690 of 755 mothers).

B5. Process indicator: CORE PEI extends the reach of surveillance activities by ensuring the quality of community-based AFP surveillance. *(Source: Interviews and semi-structured questions of representatives of MOH, in-country partners and PVO/NGO*

CORE PEI has engaged trained volunteers in surveillance and reporting of AFP cases, except in India where the government has responsibility for active surveillance. However, even there, community mobilizers do look for AFP cases during house-to-house visits to raise awareness and educate about polio immunization campaigns. . When a AFP case is detected, CORE Group partners assist with case investigation and aid in developing a follow-up strategy '

CORE PEI also works with health facilities and outreach clinics to ensure community awareness about the need to report possible cases. Although the primary focus is on AFP case detection and awareness, CORE PEI sponsored surveillance teams also disseminate information to villagers on

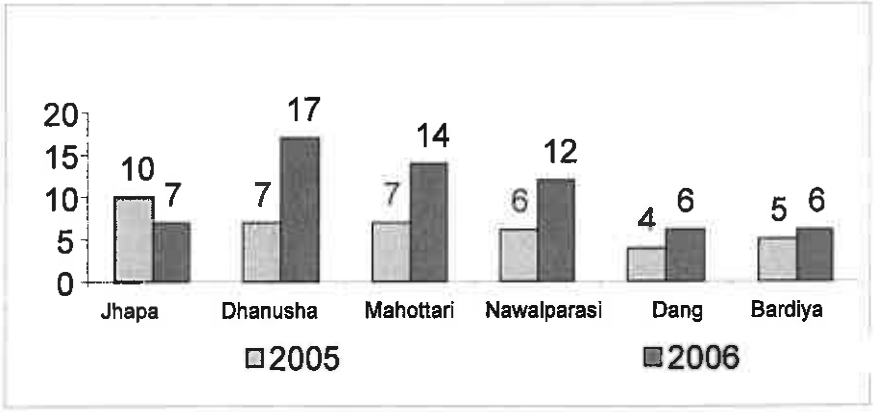


Figure 2: AFP cases reported in CORE Nepal districts, 2005 and 2006.

safe health habits (like going for vaccination, washing hands, and using toilets) to help reduce deaths due to vaccine preventable diseases (VPDs), diarrhea, pneumonia and other common diseases. Target audiences for these surveillance activities include: traditional birth attendants, traditional healers, teachers, religious leaders, health facility management committee members, and NGO/CBO members.

In CORE PEI Nepal the eight districts currently receiving support from CORE are meeting the non-AFP case reporting rate (i.e. 2 cases/100,000). Community-based surveillance began in 2004 and the volunteers have continued their effort. In most of the CORE-supported districts, AFP reporting increased from 2005 to 2006, as shown in the Figure 2 above.

The CORE PEI Nepal review team did not find substantial differences in the reporting of AFP cases by CORE supported Active Surveillance Volunteers compared to AFP cases reported from non-CORE districts.

B6. Process Indicator: CORE PEI combats increasing message fatigue among communities, maintains community interest, and motivates volunteers by expanding

training on preventive community health actions linked to polio messages. *(Source: Interviews and semi-structured questions of representatives of MOH, in-country partners and PVO/NGOs)*

In India, some communities are antagonized by the frequency of the rounds, and the intense concentration on polio. It's become a source of resistance. This antagonism causes difficulties in reaching the remaining X houses, and continuing the messages on polio. The health development expertise of the CORE Group PVO partners has enabled an innovation, or technical "spin-off, that responds to those community concerns. Expanding training on preventive health practices keeps motivation high for the volunteers because with the additional training they can be greater help to their communities. In India, for example, CORE PEI has sponsored;

- Sanitation drives and drain clearing with community participation;
- Garbage collection through specially designed rickshaws
- ORS demonstrations and IEC on prevention of child diseases;
- Construction of household latrines,
- Community libraries and health information centers, etc.

C. OUTPUTS

C1. Output: CORE PEI achieves scale with the number of community volunteers trained to support NIDs, SNIDS, and RI; and improve AFP case detection and reporting

CORE PEI achieves *scale* with its efforts to eradiate polio in local areas through community-based strategies. It has trained almost 250,000 'mobilizers" (community-based volunteers) to provide essential, culturally relevant information about polio to mothers and caretakers, promote good child immunization practices, follow-up defaulters, track unimmunized children, mobilize communities to support immunization campaigns, correct false information and dispel rumors about immunization campaigns. Except for India, CORE PEI also trains the volunteers to conduct active surveillance for AFP cases, and trace case contacts. (In India, surveillance is the responsibility of the Ministry of Health, but CORE PEI assists the medical surveillance officer by reporting suspected AFP cases and has facilitated transport of stool for analysis.)

Because of CORE PEI, many communities will have trained farmers, housewives and other "mobilizers" to maintain active local surveillance once a country achieves certification. Surveillance capacity will be needed to assure the virus does not re-emerge or be imported to local areas. This collaborative network of PVOs will also have the capacity to support NGOs in other national, regional and community disease initiatives, if needed in the future.

C2. Output: CORE PEI areas are associated with fewer % remaining (X houses over each subsequent NID round. *(Data comes only from the India review. Documentation was not sufficient in the other CORE PEI country sites to establish this output indicator.)*

As the India final review report says: The number of children immunized during NIDs/SNIDs rounds varies from month to month, but on average, only between 4-7% are not vaccinated in CORE-supported areas, as reported through CMC registers and CORE NIDs/SNIDs data (see figure 3 below). Although this represents a remarkable effort, tracking and ensuring vaccination of the children in the high risk areas in which CORE works ia a continuingchallenge for ensuring interruption of WPV circulation.

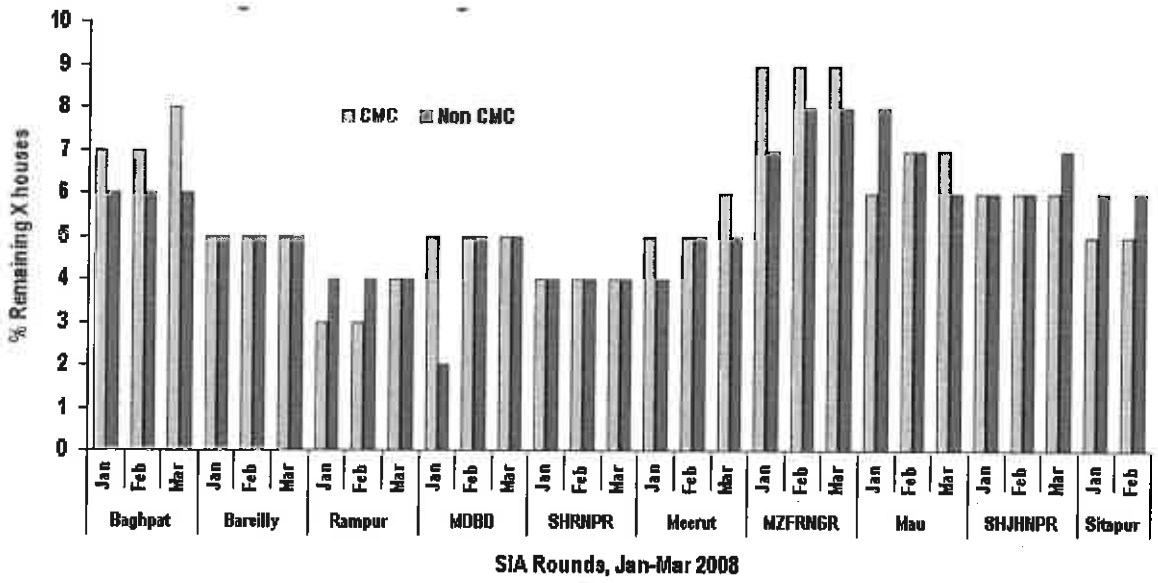


Figure 3: % remaining unvaccinated (X) houses in CORE and non-CORE areas in January, February and March 2008 polio rounds

C3. Output: CORE PEI training in Lot Quality Assessment Surveys results in trainee application of LQAS in health programs that include EPI interventions.

Capacity building is not unidirectional. That is, there are "spin-offs", ways in which enhanced capacity enables creative application of newly learned methods, as well as use in polio programming. This is best seem by a report from CORE Group Ethiopia. The Secretariat conducted LQAS training, with CORE PEI/Washington assistance, for the partner PVO/NGOs and partner district health staff. Although the Secretariat did not carry out a follow up evaluation of the training, the Director could provide examples of trainees applying LQAS in their health programs. Among the applications mentioned are the following:

1. Save the Children used LQAS in their final evaluation of the Child Survival project in Liben Woreda; (this includes child immunization coverage)
2. CARE used LQAS at least twice: for their Child Survival project midterm evaluation and in a project dealing with female genital mutilation.
3. World Vision used LQAS to assess one of their nutrition programs;
4. Christian Children's Fund used it in several sites including a final evaluation of a health program in Sodo woreda
5. International Rescue Committee carried out a LQAS survey of their surveillance/routine EPI support program under CORE in 2 woredas, and assessed a health program in a refugee camp in Tigray Region.

Since support of routine immunization systems is an objective of CORE PEI, use of LQAS for assessing health programs that include EPI interventions appears active and an appropriate application of the training received by CORE.[5]

[5] Weiss, W personal communication, via CORE Ethiopia,

D. OUTCOME REVIEW

D1. Coverage Outcome: in India, booth coverage has increased in areas where CORE PEI supported PVOs and NGOs are active. In Nepal, community based strategies are associated with Increase % children <5 vaccinated. In Ethiopia, routine DPT3 and measles coverage has improved from approximately 35% (both) in 2003 to over 70% coverage for measles and over 75% for DPT3 since the project started

The final evaluation team found that two country programs had developed the capacity to collect and report on outcome or impact. In part, the lack of documentation of the CORE PEI polio eradication service results in Angola in particular, and to some extent in Ethiopia was due to the Secretariat and CORE PEI/Washington not pushing data collection as a priority in times when the virus moved, and in part it was due to not being able to solve various biostatistical issues. These issues include lack of clarity about the denominator population due to poor census figures, or movement across borders or catchment areas to use services, and discrepancies between government demographic reporting areas, and the service areas of NGOs.

Fortunately it was possible to obtain information in two country reviews (India and Nepal) on the reported OPV3 coverage in CORE-supported districts (past and present) versus the reported national average. These are not case-control data to attribute differences in immunization achievements to a specific agency, organization or intervention; however, it does reveal that the high-risk under-served areas where CORE PEI is working are associated with achieving higher immunization coverage in NIDs.

Figure 4 below compares the reported OPV3 coverage in CORE PEI Nepal (past and present) and the national average. 2000-2006.

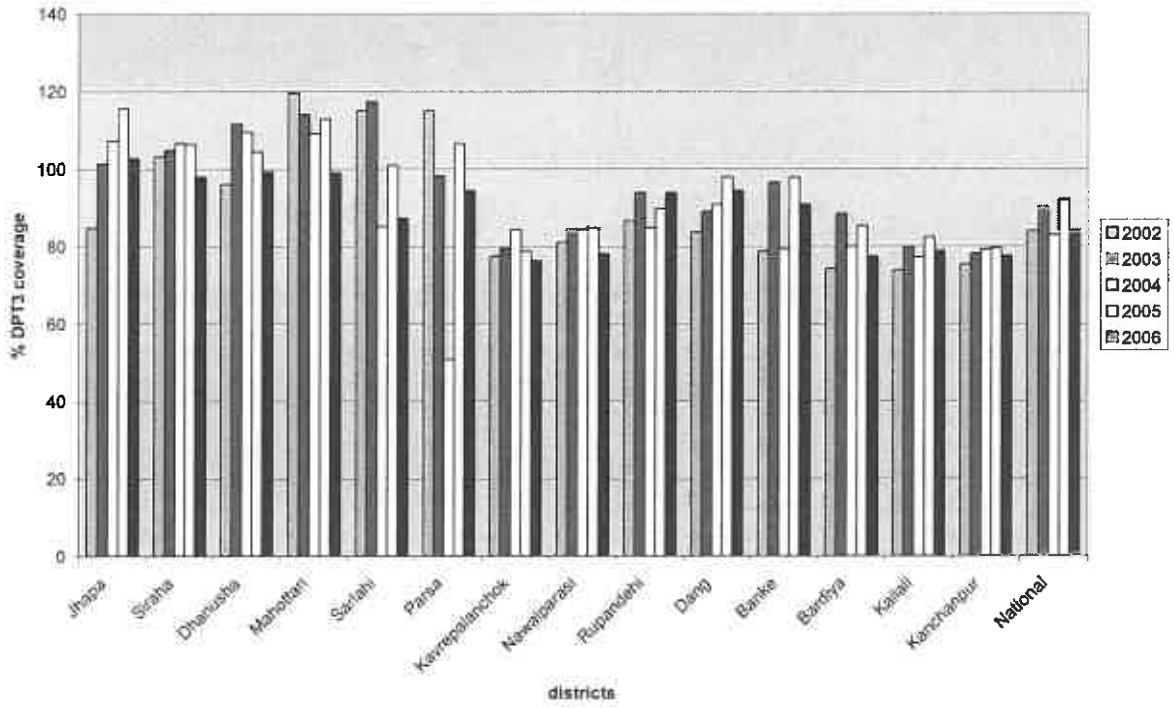


Figure 4: Reported DPT3 coverage in CORE-supported districts (past and present) and national average in Nepal, 2000 – 2006, routine EPI data

Figure 5, taken from the country report, shows that in India, booth coverage has increased in areas where CORE-supported PVOs and NGOs are active. For example, percentage booth coverage in CORE-supported areas was between 50 – 65% in 2005 and early 2006 polio rounds, with an average at approximately 55%. As rounds and intensity of support continued, booth coverage increased in CORE-supported areas to between 55 – 80%, with an average at approximately 65 - 70% in 2007 and 2008 rounds (see figure below).

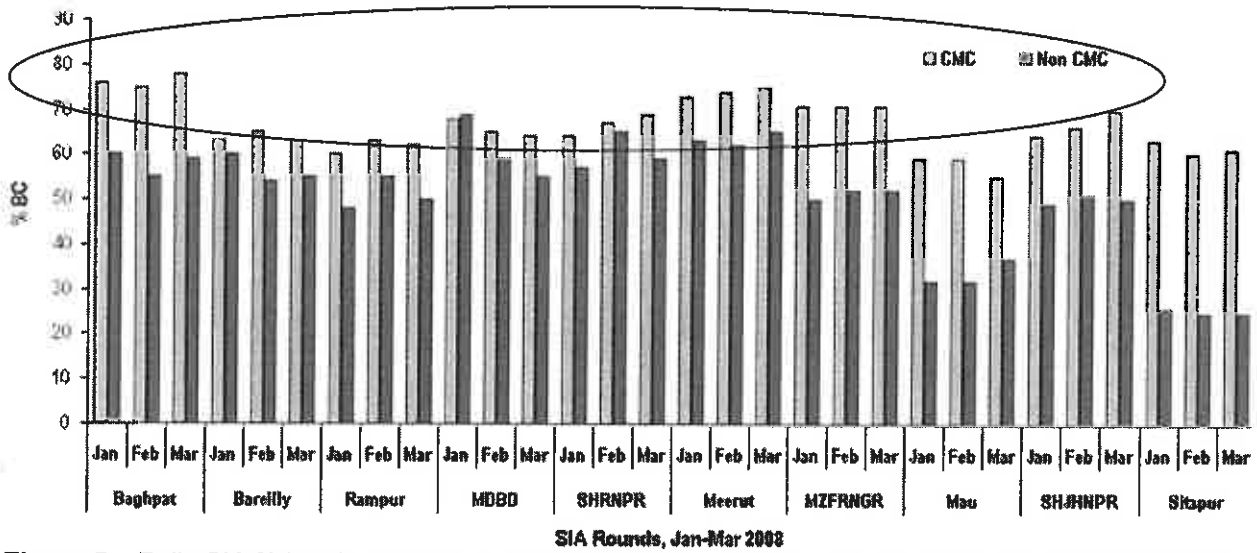


Figure 5 : Polio SIA % booth coverage in CORE PEI India areas in January, February and March 2008

D2. Outcome: Community based surveillance volunteers are associated with strengthening disease surveillance and promoting child immunization

CORE Ethiopia and its 11 local and international NGO partners have trained 2500 community volunteer surveillance focal persons who are working in 53 *woredas,* or districts, in 7 regions. From 2005-2007, the CVSFPs reported approximately 95 AFP and 170 measles cases to the local health facility. Annually the surveillance volunteers now are reporting an estimated 30 -40 suspected AFP cases, or an average of 3 cases a month. A case study in two woredas using LQAS methodology showed that in the CORE *woreda*, AFP surveillance consistently remained at 2/100,000 or higher and that measles cases were being reported in a previously silent zone. .[6]

D3. Outcome: CORE PEI's achievements in changes in the % of zero-dose children identified during each NID round could not be determined.

This outcome indicator was not documented by CORE PEI country programs.

D4. Outcome: CORE PEI's achievements in improving timeliness of AFP case detection and reporting could not be determined.

CORE PEI Washington requested CORE Polio Projects using project funds to improve the timeliness of AFP case detection and reporting to report on "Percent of AFP cases – among those identified by the official government surveillance system – with two stool samples taken 24 to 48 hours apart and within 14 days of onset of paralysis." Presumably the PVO effort in training and educating people about detecting and reporting cases of AFP would result in more timely identification of AFP cases. However the country Final Review team could not obtain data about the timeliness of identification of AFP cases. This

[6] Smith, Sara. Abstract of TAG talk by Dr. Filimona Bisrat. September 2008.

outcome indicator was not documented by CORE PEI country programs, or at least, was not seen by the Final Review team.

E. IMPACT – *CORE PEI's service areas have yet to achieve the goal of complete interruption of transmission of wild poliovirus, despite several years of no transmission, the p1 virus re-emerged or p3 has grown stronger. None of the four CORE PEI countries has been certified polio free by end of 2008.*

The key impact indicator is the WHO defined AFP rate per 100,000 children under 15 years of age per year, by type of AFP. The CORE Group Polio Partners are only one of many partners in the national efforts to stop transmission of the wild poliovirus. They have used government available information, supplemented with local child registers, to improve the quality of their activities in the service areas. In some cases the PVOs have carried out a few case studies to assess service quality, and outcomes. However, largely it has been beyond their means to document outcome and impact.

Despite the continuing challenge of reducing WPV cases in the HRAs, there is some evidence that CORE PEI's work in India is contributing to interupting transmission of the virus. For example, there has been a decrease and interruption of WPV type 1 circulation in the CORE-supported blocks, with the last case reported in May 2007. In terms of general trends, in high population districts where CORE has been working, there has been a marked decrease in cases through intensified NIDs/SNIDs and community mobilization in 2007 and 2008.

Beyond these observations of changes in WPV cases, it is going to take a special research effort, in partnership with organizations that have such technical expertise, to help CORE PEI assess the results of the community-based services to stop the transmission of poliovirus, increase the % under 5 immunization coverage, and improve the timeliness of AFP case detection and reporting.

To be clear, the Final Review team did not find that CORE PEI has adversely affected the national polio program, or decreased support for the polio program, or decreased immunization coverage. Just the opposite; in fact the review team found quantitative evidence in both Ethiopia and India of higher booth coverage and higher % children <5 immunized associated with CORE PEI areas than country averages or non-CORE PEI areas. However, in general, PVO/NGO documentation in CORE PEI was insufficient to provide information on most USAID polio outcome indicators, or measures of impact in all of the CORE PEI project areas. Technical assistance will be needed to obtain stronger documentation in the CORE PEI countries. This issue is discussed in greater detail in Section 4, following the presentation of the Final Review's conclusions about technical contributions, and value added, which is covered in Section 3.

Section 3: Benefits and Technical Contributions that CORE PEI Has Made Toward Polio Eradication in the CORE PEI Countries and the Value Added to the Polio Eradication Effort, and to Stakeholders

A. Main benefits of the CORE PEI approach: Flexibility, Collaboration, Prevention

1) CORE PEI is a flexible mechanism that can respond to moves of the poliovirus

USAID originally intended the CORE PEI program areas be built onto existing Child Survival programs. Add-on funds were sufficient to support ancillary polio eradication activities. However, in early 2002/3 the initial CS areas achieved zero reporting of cases, but, unexpectedly, the virus moved to new areas. CORE PEI responded with remarkable flexibility and tremendous effort by the Secretariats and the partner organizations, to follow the virus to the new areas. This shift occurred more easily in some countries than in others, and in those projects that had more than add-on-funding for polio efforts. But the basic pattern was that CORE Group partners moved their PEI operations to where the virus was appearing, built additional partnerships with local NGOs working in the new outbreak areas, and there initiated quality training and consistent technical operations under often challenging conditions.

CORE PEI's flexibility is remarkable in its response to movement of infectious disease. This can be attributed to the:

a) Commitment of CORE Group partners to ridding local areas of the polio virus;
b) Learning that US-based PVOs have obtained from a decade or so of forming partnerships in disease prevention with local NGOs engaged in improving social-economic conditions for local families and communities;
c) Recognition that the local presence of NGOs has gained cooperation of local leaders, established trust of resistant populations, and motivated participation of community volunteers in local development activities.
d) Effective transfer to local NGOs the technical quality and consistency of CORE PEI's strategic approach, planning, training, and implementation of strategies, consistent with global and national polio eradication guidance.
e) Working within a political context that is committed to national polio eradication, and where there is leadership and organization of care processes to further that goal. This context allows CORE PEI to focus on stopping the virus in local areas, and concentrate on the adaptations needed to move to new areas when the virus moves.

2) CORE PEI mobilizes strong partnership for implementation of prevention strategy

Some conclusions regarding PEI's ability to mobilize partner prevention efforts include:

- CORE PEI increases PVO/NGO participation and funding to stop polio transmission in highest risk areas
- The collaborative approach of PVO/NGO partners has strengthened relationships between communities and block/district health staff, also with ministries of health and national and international organizations (UNICEF, WHO)
- National Secretariat has promoted a standard strategic approach and uniform quality and consistency of training, which has strengthened PVO/NGOs to increase quality and efficiency of polio eradication practices in local areas.

B. CORE PEI'S technical contributions to polio eradication in the CORE PEI countries and beyond

1) Developed & tested methodologies applicable to child health programs at the local level

Despites constraints, breaks in continuity, and continuous refining of their data systems, CORE PEI has made fundamental contributions to polio eradication at the local level that includes:

- Newborn tracking - Identify newborns and pregnant women and encourage mothers to bring child for zero dose of OPV and link newborns and pregnant women with immunization/polio services;
- Monitoring RI status of individual children in the service area and encourage participation in RI to complete vaccination
- Analysis of data from polio campaigns, RI and registers to identify and map high risk communities and missed houses, and more effectively direct follow-up to improve OPV coverage (e.g. follow-up in X houses to improve coverage)

CORE PEI has developed and tested methodologies and scalable innovations at the community level that will contribute to enlarging the global health knowledge base about small area planning, assessment and decision-making. What the PVO/NGO partners have learned about quality neonatal-tracking, registers, and community surveillance is of value to future partnerships between national health programs and local implementation efforts, beyond the CORE PEI countries.

2) *Contributed to national picture of health informatics*

- Standardized data collection and reporting have "formalized" involvement of PVO/NGO partners in immunization data collection and analysis, and demonstrated value of community linkage for reporting AFP cases in zero reporting zones.
- Better documentation and use of new and existing health information has increased quality of micro-planning and efficiency of planned communications, social mobilization, and follow-up in communities with limited or no access.

C. CORE PEI'S 'value added' to the various stakeholders in the polio eradication effort, as reported by key informants

For national and global polio eradication: *CORE PEI has enabled better concentration of support in high risk areas and has increased program managers' knowledge of what is happening to the polio immunization program at local levels*

Quotes:

- *The CORE Group PEI participation in the national polio programme has stimulated a bigger and bigger recognition of the importance of engaging the hard to reach communities if we are to reach health program goals. WHO has the leading role in polio eradication, but they do not have a community presence. The knowledge of what the CORE Group is doing with communities has increased, and the work is regarded of great value.*

- *The value added of CORE PEI for national and multinational organizations working on global polio eradication is primarily the fact that the Secretariats have been able to engage partners in eradication in high-risk and hard-to-reach areas. These are areas in which even the governments can't work.*

- *The Secretariats are very engaged in what is happening in the communities where there are PEI volunteers. The Secretariats are the eyes and ears of the national immunization programme. Communication up the line usually lags what is known by staff in the field, and staff knowledge lags what is known by community members. Because PEI works through local NGOs and community volunteers, more than usual, communication in PEI occurs in "real time", that is, it occurs earlier, rather than later.*

- *CORE Group PEI membership on national immunization coordinating committees transmitted community opinions on how the immunization program was working and identified local barriers to immunizing all children.*

For families and local communities in hard-to-reach areas: ***CORE PEI has raised polio awareness, created immunization demand, and engaged participation in stopping local spread of the poliovirus***

Quotes:

- *CORE PEI has raised awareness of a childhood affliction that can be stopped; encouraged the participation of people in stopping the spread of polio; and created a demand for child immunizations and other prevention activities in their communities.*

- *The overall value of CORE PEI has been immense for the community volunteers. All have worked hard, exploited their potential to the maximum, and made significant strides towards the goal of polio eradication.*

For partner PVO/NGOs: ***CORE PEI provides a good model for collaboration within countries to achieve country level impact and ownership***

Quotes:

- *The approach of CORE Group PEI has been very positive—joint collaboration within a country, working on similar things with similar strategies and having a country level impact. It is important to collaborate within countries. In PEI the NGOs engage at a country level with the project led by the MOH and global stakeholders, and impact at country level scale.*

- *CORE Group PEI has exposed PVO/NGOs to state of the art approaches to community-based surveillance. It has provided them with intense, high quality formal and informal training in technical skills and data management.*

- *CORE PEI provided a good model of working not only closely with, but for the government at all levels. It also picked up good practices from other development agencies*

- *The secretariats have gone a long way towards making PEI very specific to a country. Each Secretariat has facilitated the partnership and communication among all stakeholders for each country's polio eradication programme. The national secretariats and the partners think of what they do as <u>their</u> program, not as something imposed from the outside.*

For local NGOs: ***CORE PEI facilitates engagement of local NGOs in a global program, makes possible local NGO collaboration with the national immunization programme, and integrates NGO community-based work with district health services***

Quotes:

- *PEI has highlighted the work being done by NGOs to reach hard-to-reach populations, and has actively involved local NGOs in a global program to eradicate polio. This is something that might not have occurred without the CORE Group partnership to facilitate and support their engagement.*
- *Standardized objectives, methods, plan of action, and message over many NGO service areas, while allowing bottom-up decision-making about where and how to implement within each service area*

- *PEI gave PVO/NGOs a small part of a larger, very important effort on a global scale. PEI also achieved more collaboration and integration of local NGOs with district health services. This will yield more benefits down the road.*

For CORE Group: *PEI has brought global visibility and credibility to CORE Group and proved PVO/NGOs can be effective on a broad scale*

Quotes:

- *The CORE Group in the USA advocates for community based approaches to improve and protect maternal and child health. PEI has demonstrated that working through the community increases child polio immunization coverage, and improves the detection of polio cases in what was previously declared polio-free areas.*

- *PEI has shown that similar CORE Group partnerships, working as part of national polio eradication programmes, are effective in different countries, despite differences in partners (e.g., international, national, and local NGO) The CORE Group in the USA can be proud of this proof of effectiveness on a broad scale.*

- *There were flashes of brilliance (PCI with partners like WIF; ADRA with school volunteers; World Vision successfully dealing with the most resistant populations in the country, etc.). These stood out and put CORE on the map as a responsible and committed member of the Immunization Coordinating Committee.*

- *PEI has brought global visibility and global credibility to CORE.*

- *PEI has brought the CORE Group visibility among important actors that it would never have gotten otherwise. UNICEF, WHO, and Rotary had to learn about CORE, but CORE Group PEI's contribution to achieving the goals of national polio immunization programmes has led to greater appreciation of the values CORE represents – grass roots participation, focus on the family, and strengths of the community`*

- *CORE Group USA should find the PEI success critical to obtaining monies for additional targeted maternal and child health programs.*

D. Conclusions regarding CORE PEI'S 'value added', and what will be left in place

In summary, the qualitative evidence is that CORE PEI adds "value": by supporting government's efforts in areas of recent polio transmission, and focusing on high risk areas, as indicated by levels of children's immunization status.

- Planning with partners based on epidemiological and program data and focus on unvaccinated children and "underserved" areas enables better concentration of support on highest risk areas.
- CORE PEI local support to highest risk areas adds "specificity" to "scale" of government efforts

Further, CORE PEI has created a larger pool of trained human resources to assist with social mobilization and surveillance at local levels; and this capacity-building has significant potential long-range value..:

- In countries, PEI has in place local NGOs that have experience collaborating on specific district health activities to reach hard-to-reach communities.
- Once a country achieves certification, a number of trained people will be left in communities who have the capacity to maintain the intense local surveillance that will be needed to assure the virus has not re-emerged or been imported.
- The collaborative network of PVO/NGOs has capacity to support other national, regional, district & community childhood disease prevention initiatives.
- At the country level, CORE PEI has in place strong management, experience in coordinating community-based NGOs with government programmes, and high quality technical guidance that can help move the NGO collaboration beyond polio.

Section 4: CORE PEI's Progress (1999-2008) in Growing Local Capacity to Understand, Document and Use Immunization Data to Improve Quality and Efficiency of Local Polio Eradication Practices

A. Context

Improving documentation and use of information is recognized as both important and difficult to achieve. There is agreement about the benefits: shared information accelerates learning about relevance of inputs to improved outcomes, and speeds the process necessary to increase quality and efficiency of practice. The difficulties are also apparent: few health professionals are trained in informatics, advanced management information systems (MIS), and computer skills; and even fewer community-based programs have such health professionals on staff, though depending on funds, a program may have access to technical assistance for developing a practical, focused health management information system.

There was, (and continues to be), intense national and international pressure to reach polio eradication goals The PVO/NGO partners are very responsive to this pressure. Historically, PVO/NGOs are action oriented, and have focused more on provision or facilitation of services than documentation of services, or, than documenting PVO/NGO performance. Consequently, PVO/NGOs often underestimate the amount of work and technical expertise it requires to build a quality, efficient, up-to-date HMIS for any program addressing infectious disease, including eradication of polio.

Even when TA is a line item in the program budget, assistance in improving metrics can't occur until program leadership recognizes the need and asks for help in building a practical, user-friendly HMIS. That does not always happen. Experience gained in child health and infectious disease projects suggests that programs most in need of technical assistance, are slower to identify the need, often fear they will be stigmatized by admission of deficiencies, or perceived inability to construct an adequate HMIS. Further, they don't entirely trust that external TA will be practical and relevant to their particular situation.

There is some truth in such concerns. For more than a decade, the international health profession has concentrated first on improving clinical health data and more recently, national health information systems. But, there has been a paucity of research on best practices for documentation, sharing, linkage and use of small area health data, the very knowledge that is essential for community based programs. Technical problems abound: What are the methods to determine the proper denominator in small area analysis? How to identify "high risk" houses and communities? How to improve timeliness of reporting under field conditions, especially those challenging areas where NGOs typically work? Are there reliable, evidence-based, recording and reporting formats for non-literates, or persons with low literacy? What are appropriate indicators to measure social mobilization? Using local skills and available computer software, what is the best way to present data to communities, or share with partners, or report to government, or the donor? Given the lack of an evidence base for good practices in documentation and use of small-area health data, it is no wonder that field staffs are ill-prepared to build a community-based HMIS, and understandably, are cautious about seeking TA to improve quality of the information system.

B. Framework for improving documentation quality and efficiency

Given this context, USAID specified in its CORE PEI agreement, the goals, objectives and core set of indicators to guide technical management of polio eradication efforts. In addition, the CORE PEI national secretariats and partners in each country could refer to the Agency's published framework for polio, which presents the core set of indicators recommended to track progress and measure results of polio projects.

Consistent with other aspects of this partnership project, responsibility and authority for documentation, management and use of data, are spread among the various partners, The CORE PEI Washington office has responsibility for communicating to CORE PEI country Secretariats the donor's reporting requirements and recommendations, as well as requesting any information that is needed by the

Washington office to administer the CORE PEI grant, fulfill evaluation obligations, and document project achievements and challenges. The National Secretariats bear responsibility for facilitating quality training for documentation, sharing and use of health information for management decision making, and assisting with country evaluations. The PVO/NGO local partners, who implement the strategies to assist national government with polio immunization campaigns and community surveillance, are responsible for building a health management system that tracks progress toward project objectives.

There is much a PVO or NGO partner must learn and do in order to achieve a quality HMIS that enables a community-based project to better target social mobilization for immunization campaigns, increase immunization coverage of infants and young children, track defaulters, and survey households for AFP cases. Namely, the essential elements include:

- Use of data to identify and target high-risk communities and houses missed in densely populated urban areas.
- Segmentation of audiences and tailoring messages to different influencer groups
- Pre- and post testing of information and skills transmitted in health worker training
- Periodic monitoring to determine effectiveness of social mobilization.
- Documentation and timely reporting of home visits, including information shared, vaccination follow-up , and surveillance
- Periodic monitoring to determine program impact and identify gaps at community level

USAID recognized that PVO/NGO partners needed to build capacity in order to develop a quality data system to collect, analyze and report on the specified indicators and possible other data of national interest. USAID set aside money in the CORE Group country budgets for obtaining technical assistance to refine project operations. TA could be used, for example, to improve documentation for targeting, as well as assessing efficiency and effectiveness of polio activities.

C. Changes in CORE PEI project documentation and reporting, 1999-2008

Initially the CORE PEI Washington office requested the CORE PEI country programs to submit quarterly, then six month reporting, on each of five areas:

1. Building partnerships
2. Strengthening existing immunization systems
3. Supporting supplemental immunization efforts
4. Helping to improve the timeliness of AFP cases detection and reporting
5. Improving documentation and use of information for improving quality of activities.

PVO/NGO partners documented their achievements in each of the areas, used quantitative figures (mostly counts of activities) and provided anecdotes supporting their points. Partners varied greatly in their reporting; some were quite detailed. Initially, national secretariats were tasked with consolidating the information, delaying production of the country CORE PEI reports. Anecdotal information in the country reports gave a sense of what was happening due to CORE Group partner's presence in the polio program, though the partners were not reporting on the polio indicators specified in the USAID framework. (For example, a country report might provide information on zones now reporting AFP cases, but previously had been zero reporting – although the report would not contain information about the timeliness of case detection and reporting, a USAID indicator .)

At the field level, PVO/NGO's project documentation lagged behind capacity-building of health staff and volunteers to plan and implement activities to support existing and supplemental national immunization activities, design local communications; and establish working linkages with local and district health services, and community leaders. At the Secretariat and partner level, documentation lagged behind the priority development of coordinating mechanisms among CORE PEI's partners, and facilitating training in different methods of data collection.

Over time, due to feedback from partners and the perceived reporting burden, the CORE PEI Washington DC office allowed countries to develop and use their own formats instead of a standard format. That the goals of eradication could be better reached by the use of a quality HMIS was acknowledged, but the

path was not clear. There were little incentives to obtain TA to assist with construction of a quality HMIS. And, CORE PEI Washington gave no incentives to PVO/NGO partners for reporting on USAID polio indicators, or for reaching certain steps in construction of a quality HMIS. The uppermost challenge in the minds of the CORE Group partners was the need to move into new areas quickly with a small budget to support operations where the virus was circulating or surveillance was poor, and find potential new NGO partners. So, documentation of program results lagged behind practical management concerns of tracking new births, finding defaulters, and identifying X houses.

Given the variability in reporting capacity, by 2003, CORE PEI Washington decided that the best approach in the situation would be for the PVO/NGO partners to support the district or the province's own information system. *This was a critical decision that ultimately contributed to the quality and efficiency of the national system of health informatics.* The Washington team rightly did not see the benefit of doing many surveys to evaluate campaigns because NIDs were consistently achieving high coverage, and low budgets limited the number of surveys the projects could support. "The main thing is we were too small to do it all and do it everywhere so we used existing information to set priorities" one interviewee said.

The district's information system became the CORE PEI project's information system and the partners tried to use such information to set priorities for areas of geographic and technical attention. There were both drawbacks and benefits to this approach. Concentrating on the district's information system was an impediment to attributing results to CORE PEI's participation in government polio eradication programs, but it was a boon for improving the quality of the immunization data collected by district health authorities, and improving the efficiency of using existing data to improve management decision-making. PVO/NGO partners trained vaccinators to record vaccinations correctly and/or helped district health management teams to better study and analyze their existing immunization data. Analyses of data from polio campaigns, RI and registers have improved efficiency by more effectively directing follow-up OPV action.

When the CORE PEI grant was re-competed and then again awarded to the CORE Group Polio Partners, USAID acted to improve documentation further by allowing financial support for baseline household surveys in local service areas, and permitting national secretariats to add a data assistant position. Country Secretariats were encouraged to use USAID technical mechanisms, such as IMMUNIZATIONBasics, to build a strong, functioning HMIS that supports the district's own information system, but also documents results of the implementing partners' mobilization and community surveillance efforts..

D. Emphasis of CORE PEI partners on good documentation practices and use of district health statistics to improve social mobilization and surveillance efforts at field level

Program managers and other health professionals expect a management information system to provide donors and the public with open, transparent and timely information and data on a program. Performance measures help answer the question of how efficient and effective a program is with donor funds. The CORE PEI team in DC did specify a set of indicators to fulfill USAID grant reporting requirements and use to track progress by the country projects. But, the PEI mechanism was never designed to monitor its own activities to drive decisions in the field. Instead, the mechanism was designed to marshal NGOs, located in high polio-risk areas, to aid a government's polio eradication programming by social mobilization, gaining the participation of local citizens in immunization campaigns and assisting government health staff with community household AFP surveillance.

Although PEI was a coordinating mechanism, charts and graphs about PEI' coordinating activities (e.g. # coordinating meetings, # staff trainings, or # site visits), don't tell us whether PEI is achieving the results wanted:--stopping transmission of the polio virus in the PEI project areas. The evaluation revealed that PEI country secretariats and partners did not dwell on documenting measures of management performance. The CORE PEI Team at the DC office was able to fulfill USAID reporting requirements based on material sent in by the secretariats, but the country PEI staff really did not analyze or use information on "burn rate" of donor funds or on coverage of the eligible population groups– information important to assessing and improving management of a project..

It is a management truism that "what gets measured gets done." In retrospect, key informants for the PEI evaluation said that the low priority given to tracking project progress was a missed opportunity. Weaker NGO partners failed to strengthen their management information systems, while the more sophisticated partners completed their reporting exercise without project management growth, improved tools, or even enhanced expertise. Also, there were documentation issues, especially when data were needed to summarize project performance for publication.

On the other hand, the CORE Group PEI country partners wisely spent considerable effort on informal, on-the-job training of staff and volunteers to (1) collect accurate and complete information about child health, and (2) participate in micro-planning sessions to review, understand and use district statistics about polio immunization coverage, reported AFP cases and confirmed polio cases. They have supported formal training in assessment techniques, M&E activities and software design. These efforts have been successful. *At the field level, there is a growing appreciation of good documentation practices, keeping quality registers, and interpreting statistical data to identify where more services are needed, and which families to contact.*

CORE PEI India, Ethiopia, and Angola, in particular, have done outstanding work in growing accountability for results. When CORE Group polio projects are phased out, they will leave in countries a number of local people who are trained to use government health data for micro planning and implementation of disease prevention programs, as well as persons trained to assist ministries of health with disease surveillance. This is a reservoir of trained volunteers with a working knowledge of good epidemiological practices. This is a potential public health work force for future global mortality reduction programmes.

E. Examples of CORE PEI's support to increase quality and efficiency of local documentation and use of data

Over time there have been changes in CORE PEI's data requirements, format, and methods of data collection, analysis and use. CORE Secretariats provide support to train PVOs in the changes and use of resulting data; the PVOs in turn build similar capacity in local NGOs working in the polio program. However, each change interrupts continuity and requires reorientation of the service providers, and the health care workers at various levels.

Each CORE PEI country has a slightly different history of development of its HMIS for polio immunization.[7]. However, the experience of CORE PEI India illustrates the general steps needed to develop a quality HMIS that provides data for field decision-making as well as documents program results. The India National Secretariat and partners had a fairly good information system from the beginning, but local data racking was insufficient for most of the early period 1999-2005.CORE PEI India Secretariat and partners wisely used TA monies to further improve project documentation. At the request of CORE Secretariat in India, IMMbasics has been involved since late 2007 in recommending monitoring tools. During 2005-2008, CORE/India partners made multiple revisions and sought TA to improve adherence to work plans, better track children's immunization status and analyze missing children data, as well as improve formats, headings, and user friendliness of forms. By 2008, the final review team found monitoring within CORE PEI India has been strengthened to track key indicators. Data are being substantiated in the field and analysis is being improved and findings used at the field level. CORE India has partnered with UNICEF in trainings to improve data consolidation and presentation.

Two case studies (CORE PEI India and Ethiopia) on the following pages illustrate the long process of helping country PVO/NGOs increase the quality, efficiency and use of data to make decisions and assess results: The case study from India shows that the construction of a useful information system, and associated capacity building, has required time and directed effort to make revisions and updates to simplify, and both formal and informal training to increase the capacity of staff and volunteers to make good use of immunization data for social mobilization.

[7] Angola and Ethiopia concentrate on community surveillance/ reporting.

HOW CORE PEI INDIA HAS BUILT CAPACITY OF COMMUNITY-BASED WORKERS TO UNDERSTAND AND USE IMMUNIZATION DATA, 2000-2008

(Case Study by Dr. Roma Solomon)

- *In 2000, when we started working, our mandate was not very well defined. The community mobilisers were called 'Volunteers' and very simple data was collected from the PVO/NGO partners like names of their work areas; meetings held; support to NIDs/SNIDs (including participation in micro-planning, IEC activities, training workers, manning booths, transportation of volunteers and vaccines to booths, house to house visits, monitoring activities); support to AFP surveillance and to 'Mop Ups'.*

  We would explain the objectives and strategies to support the national polio eradication program to the point person from the PVO partner and s/he in turn would come up with various activities. The volunteers, e.g. school children, nursing school students, teachers, community-based project workers, etc. would then go around the communities, spreading awareness, assisting with vaccine transport, bringing children to the booths, etc.
- *In 2001, we developed a training curriculum to impart basic knowledge of routine immunisation, and improve surveillance of AFP and other childhood vaccine–preventable diseases among field level staff.*
- *In 2002, all the PVO partners were guided to consider the following indicators for selection of project sites: # Polio Cases per block and # AFP cases per block. Within the coalition also, it was agreed that the PVO partners would avoid duplication of resources and efforts by demarcating their areas of work .Effective NGO partners who had earlier worked in other districts were encouraged to shift to 'hot' districts.*
- *By 2003, CORE India secretariat started working intensively on improving documentation and using information for improving the quality of their efforts. We also joined the Social Mobilisation network with UNICEF & Rotary, assuring uniform training and collection of data for social mobilization.*
- *In 2004, CORE and UNICEF CMCs were both using the registers developed by UNICEF India. Basically, the data collected pertained to each CMC's allocated children and their participation in SIA rounds.*
- *In 2005, CORE India commissioned a software company to develop Access 2000 based HMIS. This required the NGO level (CMC & BMC) data to be exported to its PVO every month. The PVO would then send the consolidated data to the secretariat. The software proved disastrous, both in terms of being highly user unfriendly and also very labor intensive. It also caused a great deal of confusion and consternation in the field leading to loss of morale. The same year, CORE PEI developed its own CMC register which included not only SIA round data but also RI data. Both the register and the MIS required intensive training at all levels, i.e. CMCs, BMCs, SMCs and SRCs.*
- *In 2006, an M&E Advisor joined the secretariat and the MIS was scrapped. The M&E Advisor designed a simpler MIS and held training sessions for all BMCs and SMCs, painstakingly explaining each pre-tested new format for the BMC and CMC registers. The revised, simplified MIS consists mainly of CMC and BMC registers (at village and sub-district level) that are collated and computerized at district level and an electronic copy is sent to CORE PEI India secretariat. The CORE PEI India secretariat gave first hand training in MIS to all the field staff at block level., especially in recording data correctly and completely in CMC registers, data collation in BMC registers and then computerization of data. These formal trainings were followed by hands-on training by all CORE PEI staff during their field visits and if any errors were found, we helped them understand these and make corrections. Such data quality checks enhanced overall data quality in the field. The whole process also helped CORE secretariat get insights into the type of changes that MIS required intensive training at all levels, i.e. CMCs, BMCs, SMCs and SRCs.*
- *Since 2006, CORE PEI India has conducted a cascade model of training of the field staff. CORE secretariat make a training schedule, and train all field staff at district and sub-district levels in the use of the MIS., The sub-district level staff further trains the community mobilizers working at villages/urban wards.*
- *Both in 2007 and 2008 registers were modified as per feedback from the field.*
- *Since 2008, the CMC trainings have been made residential for 2-3 days. Secretariat staff constantly check CMC and BMC registers during their field trips*

The case study from Ethiopia shown below is illustrative of some unique issues that arise in capacity building to collect, understand and use data in places that are hard-to-reach, and have few volunteers who are literate. Despite the challenges, CORE Group PEI Ethiopia has developed remarkably robust, resilient, community surveillance. They have used data to support presentations and publications documenting successful outcomes of the PEI partnership in Ethiopia.

HOW CORE PEI ETHIOPIA HAS BUILT CAPACITY OF COMMUNITY-BASED WORKERS TO UNDERSTAND DATA AND CONDUCT SURVEILLANCE, 2000-2008

(Case Study by Dr. Filimona Bisrat)

- *Our service areas cover about 5,000 people. About 75% of the CORE Group PEI work has been located in very difficult hard-to-reach areas, where even health clinics are not operating. Only the volunteers coming with the support of their communities can reach those communities.*
- *We partner with local NGOs who are usually the only ones doing direct community work in hard-to-reach areas. We use whatever is the NGOs' approach to the communities, and adapt it for polio surveillance.*
- *In the highlands there are people who can read and write, but in the hard-to-reach areas, there are few who can read, or record health information. This affects how we carry out capacity building at the local level to use data.*
- *Ethiopia Secretariat carried out formal training for salaried staff of its Partners, but has not found formal training as effective or transferable with local NGOs. The international NGO partners have the capacity to do cascade training with staff, but local NGOs do not have the capacities to conduct subsequent training activities with either their staff or adapt the training to the literacy level of community workers. Instead we have found informal training is a better way for us to build capacities of community volunteers and local NGOs.*
- *The Secretariat holds monthly meetings for the community volunteers working in polio eradication. These individuals are elected by their communities and are unpaid. The community volunteers visit high risk households, and give three days of their time a month to household polio surveillance.*
- *At the monthly meetings the community volunteers discuss challenges, problems regarding surveillance for AFP cases, or, for example, occurrence of measles. At this meeting, the volunteers also participate in joint planning for the next month's community based surveillance and mobilization for immunization. These meetings build local capacity to build awareness of health issues, and work out, at the local level, practical, realistic and culturally acceptable, community-approved ways to improve child polio immunization coverage and detect AFP cases existing in the communities.*
- *At the District level, the Secretariat engages with other stakeholders in planning and agreeing on protocols, schedules, follow-ups. We meet regularly with the other stakeholders at the District planning meetings. The presence of the Secretariat brings necessary information to District planning regarding community work and health issues in these hard-to-reach areas.*

F. Summary of CORE PEI's progress (1999-2008) in documentation and use of data

The final evaluation team found that the CORE Group Polio Partners in each of the countries under review had struggled, to lesser or greater degree, with the development of a practical, focused health management information system for tracking neonates/infant defaulters and home visits; refining targeting of activities; and making program management decisions. USAID's core set of polio indicators were not well enforced by CORE PEI Washington, National Secretariats, and partners. Indeed, the partners influenced what data were collected and reported, to the detriment of being able, as a total project (across countries), to document technical achievements and value added by this coordinating mechanism.

The difficulty in developing a useful HMIS appears not because of a lack of accountability, but because the uppermost challenge in the minds of the CORE Group partners was the need to move into new areas quickly, find and train new NGO partners, and with a small budget, support operations where the virus was circulating or surveillance was poor. Documentation of program results lagged behind practical management concerns of capacity building of NGO partners; tracking new births, finding defaulters, and identifying X houses.

The final review team found that USAID's specification of CORE PEI goals, objectives and indicators, and the assurance of a TA line item in the country budgets were not sufficient actions in themselves to jump-start quality documentation of CORE Group polio projects. Both donor and grantees are committed to "accountability for results" and both Secretariats and implementing partners are committed to data collection, sharing and use. However, CORE PEI's primary strategy for changing documentation behavior was to train or provide written material. Until 2005, a framework for supervised, planned actions for small area analysis was not in place. (Even by 2008, the public health profession does not have a published evidence base adequate for guiding PVO/NGO choice of documentation and analysis practices at community level for assessing results of social mobilization or community surveillance.)

With time, the PVO/NGO implementers have moved to strengthen their recording and reporting mechanisms. They are analyzing and using the resulting information to improve decision-making and targeting of local efforts to increase OPV coverage, and improve surveillance for AFP cases. Now, nine years into the project, the PVO/NGO polio partners are beginning to track key indicators and present to a wider technical audience the achievements and lessons learned in CORE PEI within their respective countries.

Throughout this project, the USAID CTO for CORE PEI has consistently stressed the importance of the CORE PEI Washington and the National Secretariat offices sharing information on project inputs, outputs and outcomes with other organizations promoting polio eradication, disease surveillance and reporting. Now, information sharing is occurring. Recently the Director of the Ethiopia Secretariat for CORE PEI Ethiopia shared the progress and results of Ethiopia's community surveillance with an All-Africa TAG meeting, and scheduled presentations at other present technical conferences. Similarly, the USAID CTO has urged the leadership of CORE PEI and the Secretariats to submit technical papers to well-recognized, peer-reviewed technical journals, detailing the outcomes of this partnership mechanism. Several papers are now in draft, or in the review process. CORE PEI Washington has recently designated a staff member to coordinate documentation activities.

A short-coming of CORE PEI still to be remedied is that there have been almost no planned national, regional or USA CORE Group PEI-focused meetings/workshops to exchange lessons learned, or transfer the learning about the community-government linkage in the polio program to other country child health programming. While CORE PEI India was instrumental in building SMNet in India, the CORE PEI Secretariats have not yet developed a framework for a partnership structure linked to national health informatics that can continue upgrading quality of local health documentation and efficiency of data use once a country is certified free of the wild polio virus. .

G. Successful ways CORE PEI partners used data to engage and motivate community workers, staff and other stakeholders in good operational practices

PVO/NGO partners have been creative in finding ways to motivate engagement in polio eradication and adoption of good practices. CORE PEI India and Bangladesh provided several such examples of engaging support of volunteers and staff , at various levels or across sector, in social mobilization for immunization coverage; campaign/RI micro-planning, and community-based AFP surveillance.

→CORE PEI India introduced the measure of marking, with a red flag, those community areas that had less than expected RI coverage. This kindled an urgency to reduce or completely get rid of red-flags by

increasing RI coverage. The presence of red-flags prompted the field team to plan special initiatives like Health Camps in CMC areas that were flagged. As the name suggests a red-flag is just an icon/symbol but somehow no one wanted those red flags in their areas and they worked towards increasing RI coverage, and thereby reducing the number of red-flagged areas.

→*District level managers presented PEI program data at various district and sub-district forums.* These presentations of the enhanced data quality, (aided with laptops), built confidence in the managers to use the data, and increased the confidence of other stakeholders in CORE PEI's data.

→*The CORE PEI India Secretariat held quarterly review meetings at the national level where PVO and district level managers discussed 'next steps" based on the previous quarter's program indicators.* The CORE PEI secretariat provided the PVOs and district managers some guidelines in the form of presentation templates or themes to analyze the program and this helped all to look at the program's progress from different angles.

→*CARE Bangladesh was able to conduct an aggressive active and passive search for AFP and for polio cases though 4,000 road and agriculture projects.* CARE Bangladesh paid field workers $1 per month of PEI funds to conduct these surveillance activities the first year of operation. By the second year the local CARE projects refused the PEI funds and paid the field workers out of their project funding because these field workers were so motivated and energized by the recognition they received that the CARE road and agriculture projects flourished.

H. Recommendations for a project HMIS if replicating CORE PEI in other countries

Key informant interviews yielded practical suggestions and recommendations to those considering replication of CORE PEI elsewhere. The key recommendations for developing a health management information system are summarized below;

1) *Keep your MIS simple but effective*

- For the PEI end user, the MIS should be easy to learn, easy to use, and as less time consuming as possible. For the PEI M&E managers, the MIS should be flexible enough to allow change in indicators. (For polio, flexibility is a very important criterion, due to the virus's ability to move locations.) Also, the MIS should be easy to train. At each step the M&E managers should listen and take feedback from the field staff responsible for collecting, analyzing and using immunization data.
- Sophisticated software does not work to increase use of data among community based workers (paid and unpaid). Sophisticated software makes data management and reporting far easier but at the same time it can increase secretariat dependency on an external agency. Instead, what worked best in PEI were simple tools and very good training followed up by hands-on [on-the job] training.

2) Concentrate on building field capacity in quality data collection and entry to give workers and stakeholders more confidence in using data

- Data quality checks in the field can help field staff to understand and correct errors in recording dates, complete all items, and improve data entry.
- On-the-job, informal training is effective in situations where volunteers do not read or write. Formal training programs are possible only when the partner has the capacity both to
    - Understand and carry through on cascade training and
    - Adapt training content, methods and materials for non-literate volunteers.

Section 5: The National Secretariat Model

A mechanism for a PVO/NGO country partnership is a very powerful idea. The literature on partnerships has documented the effectiveness of voluntary partnerships at achieving stakeholder involvement and collaborative strategic planning on limited funding. When a Final Review of the CORE PEI grant was initiated in 2008, it was an opportunity not only for review of the project activities in the field, but also to look in-depth at the achievements, challenges and lessons learned by the CORE PEI partnerships in country. It was also important to review the structure, function and management of those partnerships. A set of partners is not enough to achieve objectives of a grant. A partnership needs a management vehicle like a secretariat to facilitate the implementation of work plans and communication with other stakeholders.

Thus, the Final Review included visits to the CORE PEI country secretariats, and subsequent follow-up interviews by phone and internet, as well as field observations of project activities. The Secretariat Directors were very cooperative and responded to a structured interview and furnished information on achievements, challenges, and identified lessons learned for a successful partnership structure and process to stop polio transmission. Their information was supplemented by interviews with other key informants, including leaders of host country organizations, current and former CORE Group Polio Team personnel, and CORE Group members from PVOs that were CORE PEI country partners.

This section details what was learned from the review of the CORE PEI country partnerships, beginning with the history and design of the Secretariats --their structure, function and management -- and moving to perceived achievements, challenges and recommendations. It draws on material from the field reviews, key informants and unpublished material furnished by CORE Group.

A. History and design of CORE PEI secretariats and relation to US grantee

In 1998, at the request of USAID, CORE's NGO members submitted a proposal describing how they could play a significant role in the global eradication of polio; especially in high-priority polio countries, where communities were remote, in conflict, resistant to vaccination, or marginalized. According to a CORE Group history, the Group's vision for the Polio Eradication project was to involve CORE member NGOs and their partners in accelerating the eradication of polio in high-priority countries, while leaving behind an infrastructure that could be used to address other health priorities. To this end, the CORE Group proposed developing, in each selected polio priority country, collaborative networks of NGOs with the capacity to accelerate other national and regional disease control efforts.

USAID funded the CORE polio eradication initiative and when the project drew to a close nine years later, USAID had invested $25 million and the PVO community contributed $2.6 million from their own resources to substantially improve immunization coverage, reduce polio cases, and contribute to ascertaining and monitoring polio free status through surveillance. By 2007, an estimated 30 million children under the age of 15 in Angola, Ethiopia, India and Nepal had benefited from CORE PEI's efforts in community-based social mobilization, strengthened immunization service delivery and enhanced disease surveillance systems.

In September 2007, CORE Group responded to and won a competitive $30 million USAID proposal to continue polio eradication efforts in Angola, Ethiopia, India and Nepal over the period 2007 – 2012. (Previous CORE polio project efforts in Bangladesh, DR Congo, and Uganda had concluded, and the

networks were not sustained.) At the time of the Final Review, the CORE Group polio eradication initiative was working with 13 partners on 19 projects active in Angola, Ethiopia, India and Nepal.

At the U.S. level, the CORE Group polio partnership activity is "hosted" by World Vision, a CORE Group member organization. World Vision holds the fiduciary and legal responsibility of the grant, and provides sub-grants to each implementing CORE Group member NGO or partner organization, and consulting agreements to country secretariat staff. The CORE Group's Polio Project Coordinating Committee serves as the project's advisory board. It is chaired by the Vice-Chair of the CORE Group's Board of Directors, and includes members from the CORE Group Secretariat and NGO members involved in the polio project. CORE Group receives a small sub-grant to support and disseminate polio communications, and to provide policy guidance to ensure the project is linked with ongoing CORE Group directions.

Over the nine year period of CORE PEI, four staff members were seconded by different CORE member organizations and a university to oversee the management and implementation of the project, provide technical assistance, and represent the project at international meetings.

Initially led by David Newberry at CARE, the CORE PEI Team in Washington DC included staff seconded from CARE, World Vision, and the Johns Hopkins University Bloomberg School of Public Health. Ellen Coates, seconded from World Vision, has been the Director of the CORE Group Polio Project during the final year and a half of the CORE PEI grant and has overseen its Final Review.

The CORE Group PEI grant allowed the CORE PEI Team in DC to work as direct agents for review and funding of PEI country projects where a group of PVO/NGOs in a polio endemic country agreed to form a collaborative network to take part in the national polio eradication effort led by the government and ICC. The CORE PEI Team met with interested PVOs in country and explained the idea of the partnership and its mission. The CORE PEI Team also worked in each country with the Interagency Coordinating Committees for polio eradication to assure the CORE PEI country network would be directing network efforts to the appropriate high-polio risk national, district locations with full collaboration of the on-the-ground partners and without duplication of activities.[8]

As with all new programs there were initial problems to be resolved, and it took a while for the secretariats to really gain the trust and acceptance of the ICCs, but over time the CORE PEI coalitions have evolved into responsible and committed members of a coordinated national approach to stopping transmission of the wild polio virus. A description of their functions achievements and good practices follows.

B. Structure and functions of CORE PEI national secretariats

In CORE PEI countries, CORE has established a network of NGOs who work together to strengthen routine immunization; assist with special campaigns, and community-based surveillance, depending on the country needs. These formal networks are called *National Secretariats*, and are staffed by full-time directors. Each secretariat is independent of its host organization (a CORE member PVO partner with an in-country office able to receive funds from the US) and has a budget for support staff, as necessary, and coordination activities. Regular meetings of the CORE PEI national secretariat are held with NGO partners sending appropriate representatives for planning activities and updating.

Each CORE PEI national secretariat is a member of the Interagency Coordinating Committee (ICC), which coordinates all polio eradication and Expanded Program for Immunization (EPI) policies and activities in the affected region. Through its membership in the ICC, each CORE PEI secretariat works in close collaboration with the World Health Organization (WHO), UNICEF, Rotary International, the U.S. Agency for International Development (USAID), the national EPI program and the Ministry of Health (MOH) to develop, implement or support vaccination coverage surveys, campaign monitoring, workshops, meetings, mapping, micro-planning, training, and other critical national polio eradication activities.

[8] Note that the ICC ceased to exist in India shortly after PEI began, and there, the CORE PEI Team works with UNICEF, through the Social Mobilization Network that CORE PEI India co-established with UNICEF and Rotary.

Activities may be the same across all CORE PEI partnership organizations or vary depending on the country's needs or geographical areas.
CORE PEI national secretariats are functionally accountable to the CORE Group Polio Project Team office in Washington DC (located in the health technical unit of World Vision, Inc, the USAID grantee) and administratively accountable to World Vision. They are housed in a "host PVO", (a US based international development PVO which has legal status to operate in country.) The CORE PEI voluntary host differs in each country, according to the PVO's experience and capacity to link well with partners and other stakeholders in country, their location (e.g. capital city), and available office space and equipment for the partnership's Secretariat Director.

Initially, each implementing NGO partner was expected to submit a concept paper before developing a more detailed action plan with well-defined roles and responsibilities for PEI activities in the NGO's identified polio project communities or districts. Next, each implementing partner prepared a planning document of approximately 13 pages, detailing activities, roles, responsibilities, and budget for its work to stop local transmission of WPV in its high risk project area.

Over time this process has been streamlined and simplified so that the partners now submit budgets, budget narratives and work plans prior to the beginning of each fiscal year. (In some countries, these individual PVO plans are "bundled" into one integrated plan, timeline, and budget.) In each country the secretariats convene planning meetings (collectively and individually) with the CORE partners to discuss strategic goals for the coming year, geographic ant technical priorities, available funding, unmet needs and proposed work plan and budget. The secretariats must approve the country partner's budgets and work plans before they are sent to the CORE PEI Team in DC for final review. Once approved by the CORE PEI Team, these form the substance of the sub-grant award or sub-grant modification. At the time of the Final Review, this revised process required the CORE PEI Team to review annual budgets and work plans from 16 sub-grantees, 3 country secretariats, plus those from the CARE HQ, CORE and JHU partners. Just approving these plans represents a significant time commitment for the CORE PEI Team at the Washington DC offices at World Vision.

Although the specific emphases and activities of the national secretariats differ according to country need, in general, the national secretariat carries out the following functions:

- ✓ Provides management support to the partnership
  - Schedules and convenes meetings for preparing work plans, budgets and reports
  - Analyzes gaps, overlaps, in service delivery and maximizes efficient sharing of resources to reach objectives with high-risk populations.
  - May 'bundle' proposals, work plans and budgets of partner NGOs, while in some countries, each NGO partner submits its own work plan and budget for PEI activities in the communities or districts where it work.

- ✓ Develops a common vision among all partners in the CORE polio eradication initiative
  - Fosters an overall vision of partnership action, including how the CORE PEI collaboration provides strategic advantages, shared objectives and indicators, a common monitoring and evaluation plan, and a set of similar general interventions.
  - Keeps the partner NGOs informed of international and governmental plans, policies, and recent decisions by the ICC, Ministry of Health, and the national EPI programme that will affect polio eradication field operations.

- ✓ Coordinates with internal and external partners the planning and support of training, implementation, and analysis of polio eradication activities
  - Prevents duplication of effort
  - Unites the community-level expertise of the NGOs with the national and international expertise of the UN agencies

- ✓ Strengthens the quality of community-based services

- Trains community volunteers and CHWs with accurate, up-to-date materials and methods to improve their basic epidemiological skills of careful risk analysis, and targeted actions to stop local transmission of WPV
- Assures uniform appropriate messages and improves communication/listening skills for social mobilization efforts
- Facilitates technical support to strengthen M&E skills, weak across most NGOs
- Addresses immediate problems in facilitating community-based polio eradication.

✓ Facilitates flow of information between the ICC and the CORE PEI partners
- Provides national and international partners with up-to-date information on the functioning of the polio programme at the provincial, district, and community level.
- Promotes on-going communication among NGOs, the MOH and UN agencies.

✓ Advocates for polio eradication
- Provides information to public, the media, and other health professionals about the conditions on the ground, the need to protect children from polio, and changes seen in polio transmission by the PVO/NGOs working in the high-risk areas.
- Keeps alive the/NGO partners' commitment to addressing polio eradication along with the organizations' other priorities
- Is alert to additional resources and prepares proposals to intensify eradication efforts

✓ Conducts operational research with higher education partnerships in country or region

C. Achievements of the National Secretariats

The polio secretariats in Angola, Ethiopia, India and Nepal have been functional for almost a decade. The CORE Group held a meeting of members in 2008 to discuss the direction and legal status of the partnerships. A document prepared for that meeting noted that the CORE secretariats are well-known in their respective countries. While focusing almost exclusively on polio and immunization activities, each secretariat has taken on additional global health activities, and has built up a seasoned staff of well-respected professionals. Each secretariat has increased the depth of its activities in country and its connections to the global health community. All of them have expressed interest in becoming a separate legal entity.

Dr. Roma Solomon, National and Regional Director, India has drawn together a list of most important achievements and lessons learned for a successful Secretariat. Her compilation is based on the experience with CORE Group PEI India, but the international relevance of the list has been substantiated by interviews with key informants in other PEI countries. She lists the achievements in perceived order of importance:

- *Attained membership of the Immunization Coordinating Committee at the national level and currently working along with the MOH and other major stakeholders such as WHO, UNICEF, Rotary, USAID, etc.*
- *Built capacity in partners as well as in field level NGOs to support a global disease eradication program through social mobilization in areas considered 'hard-to-reach or 'forgotten'.*
- *Identified local NGO networks and brought them into the larger PEI coalition as well as into the national polio eradication campaign.*
- *Facilitated linkages between the government staff and NGO partners at National, State and district levels for smooth implementation of the program.*

The CORE Group PEI has detailed the achievements of the national secretariats in each of the four CORE PEI countries in the Final Review. From the description can be seen their individual differences in emphases, activities and achievements.

ANGOLA. In Angola, the Secretariat has built the capacity of local government to manage a community-based disease surveillance system, provided logistics, conducted social mobilization campaigns and supported children disabled from polio. The Secretariat Director sits on the Interagency Coordination Committee. CORE Angola responded to a cholera emergency by using its network to do a massive education campaign. Secretariat personnel have trained government officials in the use of Lot Quality Assurance Sampling to monitor insecticide bednet utilization following an integrated Vitamin A and bednet campaign. The early achievements of CORE Angola are documented in a CORE field study, "Drop by Drop: The NGO Contribution to the Polio Eradication Initiative in Angola", available on CORE Group's website.

ETHIOPIA. The Ethiopian Secretariat is the recognized organization for information on NGOs and polio activities, immunization and surveillance. CORE Ethiopia has developed a community based disease surveillance model that has been replicated across the country, working in "silent" or hard to reach nomadic or cross border areas, and contributing to improvements in these areas' surveillance reporting. WHO has requested CORE to replicate this model in eastern Sudan on the common border, and other organizations (e.g. the Japanese Development Agency, JICA) are replicating this model for their surveillance work. The Secretariat Director and the CGPP Deputy Director sit on the GAVI CSO provisional board. Under the leadership of the CORE Secretariat, a Civil Society Proposal was submitted and accepted by GAVI. CORE brought together several local and international NGOs to implement immunization activities for approx. $2.8 million. With the assistance of the CORE Malaria Working Group, the Ethiopia Secretariat held a Fresh Air Malaria workshop which resulted in a successful proposal to Global fund for a 2 year pilot project with CORE NGOs and local partners, and a funded position that sits at the CORE Ethiopia office.

INDIA. The CORE India Secretariat has grown into an internationally recognized organization that works in partnership with UNICEF in the Social Mobilization Network (SMNet) in Uttar Pradesh state. The SMNet provides uniformity in activities, salary structure and nomenclature in the fast paced polio eradication work in Uttar Pradesh. The India Secretariat and partners provide social mobilization activities in support of frequent polio campaigns (8-10 per year); registers and maps all under five year olds and pregnant women in project areas to ensure that all are vaccinated; and provides strong supportive supervision and leadership to the partnership. The Secretariat receives the majority of its funds from the USAID mission and anticipates receiving Gates Foundation funding in the future. Dr. Roma Solomon has provided consistent leadership for CORE India, including provision of technical assistance to other countries.

NEPAL. In Nepal, the Secretariat sits within the Ministry of Health and has trained government counterparts in the use of geographic information systems for immunization monitoring. CORE Nepal has engaged several local partners in immunization strengthening, reporting and surveillance. In 2004, the Secretariat served as an NGO representative for Community Integrated Management of Childhood Illness activities with the government, supporting an effort of functional collaboration between CORE member organizations in various districts.

D. Secretariat's 'value added' for donor, state, and partners: Program efficiency and support

CORE PEI operates in country through small national secretariats responsible for coordinating the activities of the partners, communicating with project headquarters staff in the US, representing the partners (and the communities they serve) at local, national and international polio stakeholder meetings, and communicating changes in national, regional or global strategies or activities to the partners for action. The rationale for choosing this management structure is as follows: A small country Secretariat to coordinate efforts of PVO/NGO partners avoids duplication of effort; increases sharing of information and resources; channels communication between donor and project and state and project; and has the potential for leveraging project growth – thereby increasing efficiency.

1) *Donor and state expectations of Secretariat to Increase and/or Improve program efficiency*
As reported to the review team, USAID and stakeholders in the host country governments anticipated that the Secretariat model or structure would be an asset as a result of its ability and commitment to:

- Coordinate polio eradication activities of PVO/NGO partners
- Avoid duplication of effort
- Simplify and channel communication between donor & project and state & project
- Facilitate project growth by being able to leverage funding from other donors

The review indicated that there is positive evidence of

- Coordination that was successful at increasing efficiency.
- Success in avoiding duplication of effort and increasing efficiency
- Adequacy of communication, resulting in less confusion, and increased efficiency
- The Secretariat's capacity to leverage other donor funding for project growth (at least in some countries)

The review also indicated evidence of lingering problem areas where there seems to have been a lack of efficiency.
(Source – stakeholder interviews)

2) *Secretariat's value added for PVO/NGO partners: Increased support*
Representatives of the CORE partner PVOs engaged in PEI activities also indicated that they had certain common expectations regarding the nature of the support they would receive from the secretariat (at in-country levels), including expectations that the Secretariat model/structure would:

- Increase sharing of information and resources among participating PVO/NGOs,
- Provide TA when needed to increase partner(s)' knowledge of how to carry out polio eradication efforts in immunization and AFP surveillance
- Build morale among PVO/NGOs working in challenging situations
- Provide a forum for family and community-centered issues and represent the united view of partners at regional and national polio policy and planning meetings
- Facilitate micro-planning at community level, rather than leaving the polio eradication effort as an entirely a top-down process

Evidence from the review in the four countries indicates that:

- The CORE PEI Secretariats increased sharing of information and resources
- Secretariat staff built PVO morale and PVOs were satisfied with social support received from Secretariat
- The National Secretariat(s) served as effective spokespersons for community views at regional and national polio policy and planning meetings
- Micro-planning occurred at community level
- An increased sense of local ownership of efforts to increase polio immunization awareness and coverage was achieved

The evidence was, however, inconsistent as there were some reports of instances where the partners found that there was:

- A lack of sharing of resources and information among partners.
- A lack of focus on empowering local community to take ownership of polio efforts, articulate needs, and take action

(Source of above information- Partner and Secretariat interviews)

E. Important lessons learned about the management structure and process for a successful NGO partnership to stop local WPV transmission

Eight years of a focused health program, is as long as most initiatives get. It's important to review what has been learned by CORE PEI about structure and processes necessary for stopping polio transmission under quite different geographic, political, and cultural conditions, and consider the value of the PEI mechanism and approach, beyond polio itself, for controlling disease in areas or pockets where health services are weakest. The "good practices" learned in this evaluation are:

Strong personal leadership is vital for all programs, and polio eradication is no exception. Successful CORE PEI National Secretariats have strong, dynamic leadership. A few country programs were moving slowly, but revitalized under new leadership, and are attracting funding for expanded activities.

Partner commitment must be of the highest level and a continuous process. The commitment must evolve into a sense of 'ownership' of the network. All partners must follow standard program guidelines, these being included in their memorandum of understanding.

The initial requirement that each PVO partner submit a concept paper before developing a proposed action plan ensured *clarity of vision and agreement on goal and objectives at the beginning* of the project in countries. The revised process retains that assurance, with the secretariats convening individual and collective planning meetings before the end of the fiscal year to discuss needs, resources, strategic goals and priorities for the coming year.

The CORE Secretariat must be *democratic in functioning* with all partners being on an equal footing and equally accountable. This is different from a Prime and Subs model.

The Secretariats and implementing partners must learn and consistently maintain a *Disease eradication mode* – that is, they must share a vision and strategize actions consistent with stopping polio *transmission within a specific local area of responsibility.*

District health service data is useful for understanding which local areas need more intensive social mobilization. Together, government health staff, the implementing NGO field staff and community volunteers review with local or district level health staffs the district's data on reported polio cases, and immunizations completed, by age and gender. Partners can then plan evidence-based strategies for community health volunteer contact and follow-up at every household with an unimmunized child less than five years.

The CORE PEI point person from each implementing PVO/NGO must be in a position to take decisions on the ground and change course rapidly, if required. Community health volunteers 'see' the program operating as the people perceive it, not just as the health services intend. CHV's hear what people are saying about the programme, what mothers believe about polio and about immunizing their children, and whether the community trusts the immunizers or understands the polio-related messages of the health volunteer. They know whether community members feel respected and safe at the health facility. The CORE PEI point person for the implementing PVO must have a rapport with the field staff and PEI volunteers, listen, and act on what is happening.

Learning new skills invigorates field workers and has a positive impact on programmes. For example, CARE Bangladesh conducted an aggressive active and passive search for AFP and for polio cases though their road and agriculture projects. CORE PEI paid those field workers 1% per month to conduct surveillance activities the first year of operation. By the second year the agriculture and road projects refused the PEI funds and paid the field workers out of their funds because they recognized that their field workers were so motivated by the new surveillance skills that their projects flourished. Another example occurred in CORE PEI/India, where repeated polio campaigns have worn on the motivation of health workers and community members. In an attempt to re-engage volunteers, the PEI implementing partners taught them key maternal child health messages and skills to add to the polio information. The field workers gained new enthusiasm and drive to continue their PEI work.

F. Barriers to the functioning of a successful partnership mechanism

"Identity" has been an issue for the polio secretariats. There really is no vertical structure linking CORE Group and the country secretariats. This issue has not been a barrier to actions in country; the secretariats operate well with their partners and other stakeholders in country. But, the issue has affected morale of staff of the secretariats and the team who has provided technical and management back-up to them. Basically, they are disquieted by the grant's financial and administrative arrangement which suspends the country secretariats between two entities, -- a large international NGO (World Vision), and a membership organization (CORE Group)—each with their own mission and priorities. One informant explained "World Vision provides the money, but has other priorities than polio eradication. We carry the name of the CORE Group but the organization doesn't have legal status in this country... We are not part of World Vision, and CORE Group doesn't recognize us. There is nothing personal. Members of the CORE Group have been helpful and collaborative to the polio projects. But the relationship between the partnership mechanisms and the CORE Group looks stronger than it is."

The problem is recognized by both CORE Group and World Vision, and they try to do what they can to minimize any sense of alienation on the part of the leadership and members of the country secretariats. The Board of CORE Group has had discussions about how best to structure their partnership grants (polio, malaria, and PanFlu), and have a committee dedicated to partnership coordination. The question of legal status was discussed also at a meeting of the membership. However, to date the CORE Group has not arrived at a decision, and so the problem that existed in CORE PEI continues in the new CGPP grant.

The issue of competing priorities also can be a barrier to the success of a voluntary country partnership that plans, trains, implements and analyzes its activities. The members have formed a group to more effectively and efficiently assist the national polio eradication programme to accomplish its goal of stopping local transmission of the wild polio virus, but each member organization also has its unique mission and priorities, which sometimes dilutes the energy and attention individual representatives of partner organizations can give to the coalition's polio work. As one informant said, "The success of a coalition depends on its ability to energize spontaneous voluntary action at the grassroots level." However the informant noted that at times the goals and structure of the partner's own organizations override and swamps all program activities, "til vision becomes clouded by infrastructure and routine tasks." The problem of competing priorities seems built into a voluntary partnership that is organized around implementation of some specific, vertical health activities by organizations engaged in broader community development assistance. The Secretariat Directors have found that it's critical to keep advocating for polio eradication, even with the secretariat's members, so members stay enthusiastic and focused on the goal.

G. Contributions of CORE PEI to national capacity building

The evaluation revealed an unusual feature of the partnership networks: their sense of country "ownership". The evaluation did not uncover a brand or identity of one PVO or NGO associated with the NGO PEI partnership. There was no idea imparted that CORE PEI's activities are determined by one leader PVO, or a particular donor, or even by an office in another country – the PEI NGO focus seems entirely on the national polio eradication programme strategy, filling service gaps in the country, and meeting the objectives of the national polio eradication programme.

This sense of country ownership could be attributed to the several factors observed in CORE PEI: a shared vision congruent with the national eradication programme; the democratic functioning of CORE PEI meetings; and each partner contributes to the country-scale enterprise by implementing PEI activities in its project areas that fall in pockets at high risk for transmission of the wild polio virus. Whatever the origin of this country identity, it is vital to success of capacity building. That is because growing capacity is more than training others in skills or giving new knowledge. In order for new information to be absorbed and used, messages must be uniform and reinforced from multiple directions, especially from others in one's social network, and from those who are trusted or revered leaders by one's social network.

Other ways in which good practices of CORE PEI has improved capacity in country are:

- ❖ The secretariats do not stress outside solutions but respect and support adoption of local strategies devised by individual NGOs and community partners to increase local immunization coverage, detect AFP cases, and mobilize participation in hard-to-reach areas.
- ❖ The secretariats link communities to national programs, adding local presence and increasing community trust in programs, and the partners supervise planned actions of volunteers in cooperation with local/district health services;
- ❖ The secretariats focus on high-risk, underserved areas where the virus is more likely to emerge or be imported, and where governments have few health resources in place to address the task, but where trained community workers can fill gaps in a program led by the government.
- ❖ The secretariats are flexible to move field operations when the virus moves location, and engage, orient, and train a local NGO operating in the new area to work as a partner in stopping local transmission of polio. This grows capacity of local organizations.

H. Country and international "spin-offs"

In its nine years, CORE PEI has resulted in several "spin-offs", or outcomes that were neither planned for nor anticipated, but are welcome results for the host country, PVO country partners, and for CORE Group itself. These include:

- The social mobilization work of CORE PEI India led to partnership with UNICEF in building the Social Mobilization Network (SMNet) in Uttar Pradesh state, India.
- The Ethiopia Secretariat held a Fresh Air Malaria workshop which resulted in a successful proposal to Global fund for a 2 year pilot project with CORE NGOs
- The effectiveness of CORE PEI in reaching the hard-to-reach encouraged subsequent donor funding of a Pan-Flu partnership project at the CORE Group.
- Three partner PVOs stated that their participation in CORE PEI has enlarged the technical scope of their health programming; improved the HQ and field commitment to data use; and led to other partnerships, in addition to polio, in their field operations. They report that the reputation they gained for being part of a successful country partnership has brought them new monies for health-related programs.

I. Issues to consider in replication of polio partnerships with country secretariats

There are plans now to develop CORE PEI coalitions in a few additional high-priority countries in Africa. Information provided by Dr. Solomon will be useful to the PVO/NGOs that are embarking on this development. From her years of experience, here are a few issues that need to be considered when establishing a PVO/NGO coordinating mechanism in country:

- *How much participatory planning (At the HQ & Country level) is needed for the design of an in-country NGO coordinating mechanism?*
- *What features are needed to promote equal sharing of responsibility between Secretariat and PVO/NGO partners, while supporting respect for individual identities?*
- *Is there a process for new issues to be initiated by the Secretariat, by the partners, and/or by the field? How is that recognized?*
- *How do the partners expect to sustain the capacity that will be built in each local partner, and in each high-risk or hard-to-reach area?*
- *What is the plan for sharing systems among country partners and among country secretariats to streamline our work?*

Section 6: "Surprises" About the PEI Experience

Our assumptions shape our "surprises". We all expect events to unfold the way our prior experience or our training has prepared us to expect. We have certain assumptions about how other people will behave --at home, at work, in pubic, based on what has happened before. Sometimes experience is different from what we had assumed would happen, and so, we are surprised. – Positively or negatively surprised, depending on the experience. Often, these "surprises" are the basis of our recommendations for change.

Asking informants what "surprised" about their experience with CORE PEI can result in responses that range from the most pleasant of outcomes, to those unfulfilled expectations that were frustrating and stressful. These surprises in PEI mark out the extremes of this mechanism's performance. That which is unique and positive about the PEI experience needs to be promoted and preserved; and that which is frustrating and performance-depleting needs to be changed.

Here is a compilation of unexpected elements in the CORE PEI experience of key informants selected from interviews with past and present PEI country secretariats, CORE Group Partnership Coordinating Committee members, PVO partner HQ staff, and CORE Group Polio Team members who worked out of the Washington DC office. Listening to the "surprises" people say they had with PEI provides guidance as to where change is needed in CORE PEI's structure and process, (e.g. communications, recognition, oversight, etc.) Listed first are quotes about the pleasant surprises, and then a listing of the quotes regarding unexpected elements which were frustrating and stressful.

A. Unforeseen positive outcomes

1) Surprised with extent of personal growth and professional development of participants and success of partnership

Quotes:

- *When I was hired, I had no idea or relevant experience to manage such a large project. Somehow the need kept driving us to innovate, strategize, network more and more until we raised the bar so high there is no question of lowering standards or going back. All of us have been stretched to the maximum and forced to contribute our best, drawing on all our hidden reserves of energy and experience.*

- *A positive one! I am totally taken by surprise by the caliber of CMCs in filling the registers, which, though simply designed, require complex analytical skills at places and need a degree of alertness. It has been a pleasant surprise to find increasing number of CMC registers that are so accurately and completely filled, and beautifully kept.*

- *It is not really a surprise, but, it's very good to see the partnership working out in practice*

- *It was always a nice surprise to meet the national PVO organizational staff and to be motivated at their sincere dedication and commitment.*

- *The simplicity of the global eradication plan was impressive. Challenges and challengers were matters of personality and attitude, and did not come from errors in the plan.*

- *Paralysis, "my child can't walk" --the experience was a vivid reminder of how disease occurs at the expense of a child. Also, taking part in surveillance was indispensible to seeing through the eyes of the community.*

- *It's been a wonderful experience! PEI was my first job, and profoundly shaped my professional vision. My work with PEI has definitely been instructive and intellectually challenging. I learned so much from the partnership meetings.*

2) Surprised with success of the PEI partnership in changing perceptions of NGO country partners and NGO practices

Quotes:

- *None of us in the beginning anticipated how much the COPE PEI partnership would change the perception other organizations in country have of the value of engaging the community in health.*

- *The project opened doors to the leading PVOs, who had to make changes in their systems also, since this kind of work required a real 'hands on' approach, monitored by the whole global community, it did not have the luxury of a 7 or14 year's pre-determined life span. It was either 'fall in-line or leave'.*

- *We did not envision, when we started, that through CORE PEI we would build strong operational linkages to local NGOs and adapt their approaches to engage communities in ridding children of polio.*

- *PEI field activities are data driven and partner driven. Surprised at the understanding and use of data by the PVO polio volunteers and paid workers, and capacity to respond as planned. I think I underestimated the perception of community volunteers.*

- *Surprised at the way our PVO's polio programming has incorporated a pretty vertical intervention, into its overall health development programming, and used indicators and conducted social mobilization. It's not the usual way.*

- *Project staff found it remarkably powerful to have data. It is very energizing; gets the field staff fired up. Remarkable power in*

3) Surprised that PEI partnership has led to increased recognition and new program funding for PVO

Quotes:

- *Our CORE Group country secretariat will be receiving a 1.3 million dollar grant for 3 years from GAVI. I never anticipated this outcome. I never expected when I began PEI that we would receive such recognition from the outside for the value added by engaging communities, or the value of PEI as a mechanism to achieve engagement of hard-to-reach communities in global health initiatives.*

- *PEI has really made a difference to our organization. Participating in PEI has brought us exposure, credibility, increased our communication with other organizations, and opened opportunities for funding and for new countries.*

- *PEI has been very helpful for our small PVO, and allows us to interact with other stakeholders in a way we would not have done earlier. Collaboration enables us to participate on a much larger scale. We have benefited by being a peer with other PVO/NGO, and we've tried to be responsive partners.*
- *CORE Group PEI has taken PVO/NGO partnerships onto the next level. It is essential to retaining technical expertise among the NGOs working in child health. Real difference is made right in countries with technical support across all partners and levels. Benefits exceed expectations.*

- *One consequence is that [our PVO] is now helping to manage the H2P collaborative project. We don't use the Secretariat model, but we do work alongside our partners.*

- *Our organization obtained HIV/AIDS partnership funding because of our experience with partnership in PEI.*

- *The experience of working with PEI has been a great professional opportunity. The experience organizing programming was very valuable. It yielded results in terms of partnership and opened up additional funding possibilities.*

B. Unanticipated problems, stresses

1) Gap larger than expected between country organizations and community

Quote:

- *I never, never understood there was such a big gap between organizations and the community, especially in these hard-to-reach areas. The intent was there to work with communities, but there was no mechanism. Until we started working with community volunteers, and engaging local NGOs in operational issues did communities become receptive and real social mobilization take place. Health promotion and prevention activities were taking place at the clinics, but seldom were reaching the communities overall. In these hard-to-reach areas, even clinics were not operating. So there was no source of health information, or promotion of preventive actions to people living in those areas.*

2) Often experienced vaccine and management failures in polio immunization program

Quote:

- *Murphy's Law. We found that anything can and will go wrong and furthermore this will happen at the worst moment possible. We saw high rates of vaccine failures, vaccine derived polio outbreaks, data cheating, and a total lack of denominators to calculate coverage, failure to produce and distribute sufficient oral polio vaccine*

3) Found less understanding and support of technical issues at field level than expected

Quotes:

- *The lack of field understanding of basic applied epidemiology regarding polio and other communicable diseases was a major surprise. This resulted in long delays in effective national, district and community-based disease control and prolonged eradication efforts and costs.*

- *PVO partners were found to be highly deficient in technical resources to support PEI field activities. No PVO ever provided technical assistance to any PEI field staff.*

- *I was surprised by how challenging it is to stop local transmission of the polio virus. It requires a very comprehensive approach.*

- *We should have been capable of covering USAID reporting requirements and also keeping a set of measures of individual project management.*

- *We found difficulty in getting country level PVOs to focus on polio eradication versus their individual PVO priorities in their service areas.*

- *Country NGOs were weaker than expected. Formal feedback was inconsistent or missing. Not very much information about technical programming was getting back to field staff.*

4) Support for PEI was less than expected from CORE Group USA, and from USA HQs of PVO partners

Quotes:

- *One of the most surprising factors was the lack of Core Group involvement for the global eradication of polio. We couldn't get ownership at the Board of Directors level and every two years membership changed but their inability to see the need for close collaboration never occurred.*

- *The CORE Group-USAID-PEI partnership was frustrating. Efforts at polio eradication could have been expanded had we been more partners than so separate*

- *CORE Group never "owned" us and at one CORE Group meeting we were even told that there would never be a country secretariat in any of its other programs.*

- *An unpleasant surprise at the beginning of the country partnership was when it was found that most of the PVO/NGO partners in country were unaware of their links through the CORE Group. It took three weeks ... to get contact info about these partners... then they had to be briefed about The CORE Group, PEI, etc.*

- *The PVO HQs have not shown any interest in PEI, except for one Executive Director who has witnessed a SIA round in India. Most Country Directors also seem loath to visit the field even though this is one of their toughest but most well implemented programs. But, PEI is appreciated by other stakeholders at the global and national level.*

- *I wished more initial direction from the CORE Polio Project Team in Washington. No clear mandate or TOR was given to me, [when I started working], except that I was to provide support to the national polio eradication program though these partners and their NGO affiliates.*

Section 7: Challenges that Constrain the Project and Opportunities to Strengthen CORE PEI and its Outcomes

A. Challenges that constrain the CORE PEI project

1) *The nature of WPV is ambiguous and its movement unpredictable*

During most CORE PEI's project life, one of the biggest challenges has been to follow the polio virus. (This was mainly in India when there were no cases in the other CORE PEI countries.) Add-on funding to existing PVO child health programs worked where either the virus was circulating, or surveillance was very poor. However, when the virus shifted to new areas where CORE PEI's PVO/NGO partners were not working, partners with add-on funding found the funds insufficient to support shifting polio operations to the areas where the virus was then circulating. This was a learning experience, and the donor and grantees changed the mode of funding and the approach to meet this challenge. In fact, as described earlier, CORE PEI has shown great flexibility in shifting locations and adding new NGO partners to follow the virus. India did well focusing on Uttar Pradesh and approaching local NGOs in new areas. This was also Ethiopia's strength as they partnered with an organization of 145 local NGOs, keeping costs low, and often resetting areas and NGO partners each year. Still, the unpredictability of the virus and its subtypes remains a major challenge to the responsiveness of CORE PEI. There is always the possibility of importation of the virus, and outbreaks in areas with few local NGOs.

2) *CORE PEI has a resource problem; funding is not meeting growing need*

The financial systems of the USA, Europe and Asia have been under great strain. The dollar has dropped in value, and does not buy as much as previously and it is not clear if Congress will allocate additional funds for the polio eradication program. Originally the PEI was not expected to last beyond year 2000, then 2005 and now 2010. Although enormous progress has been made globally, WPV is still circulating in several areas, putting strain on the energies and morale of those who have worked so long and hard to eradicate polio. The initial four strategies the global program chose to eradicate WPV were correct and necessary, but not sufficient to eradicate the wild poliovirus. WHO and governments have recognized the need to link communities and HRAs to the national program. Now the community element is sliding into place, but the funds are nearly gone, and are insufficient for CORE PEI to add new areas within countries or adjoining countries with HRAs where the virus is now circulating. Effort is needed to develop additional donors for the project if it is to expand to areas where the virus is now circulating. However, grants development is not the expertise of the CORE Polio Project Team in Washington DC, (though it does exist in the offices of the prime grantee, World Vision.). The CORE Polio Project Team, located at World Vision in Washington DC, is responsible for grants management, and support to country partnership mechanisms, facilitated by CORE PEI national secretariats. CORE PEI has had no development strategy for seeking expansion funding, in part because no one predicted the length of the campaign, or the movement of the virus. In part also, CORE PEI is a mechanism for collaboration that was not expected to be expanded, or even, sustained. Although the DC office of CORE PEI has generated proposals for additional funding for CORE PEI country programs, grants solicitation can not be on the shoulders of one person (Director of the CORE Polio Project Team), or one office (CORE PEI Washington DC) or even the responsibility of national secretariats alone. It would appear the responsibility of the co-grantees, World Vision Inc and the CORE Group, along with CORE Polio Project Team and CORE PEI secretariats, to devise a development strategy, prioritize actions and designate who is to take what action by what time. Grants solicitation is an institutional responsibility – much as the Board of any non-profit is expected to oversee development. The resource issue goes beyond programming, and tests ultimately the commitment of the participating institutions to eradication of polio at the local level.

3) The CORE PEI Washington office does not have enough people to grow the project in way the project could grow

In 2008 the CORE Group Polio Project Team numbered 3 FT health personnel, a part-time contracts officer and a 50% FTE Control/Finance Officer in the Washington office to support PEI. There is a director

who is particularly skilled in grants management. She relates to USAID, World Vision, and CORE HQ in DC, as well as to the US-based headquarters offices of the CORE partner PVOs, and to the secretariats. There is a deputy director who fortunately has been with the project since the beginning and brings a wealth of experience to operations in support of the field projects. She backstops two country Secretariats, and the CORE PEI Technical Officer (seconded from CARE) backstops the other two countries, and has interest and experience in program assessment. There has been no position responsible for project documentation; (this may become the responsibility of the Technical Officer).

There is one position in the CORE PEI Washington office in the original project staffing design that is not currently filled or built into the yearly budget. Currently, the full obligation of funds is being budgeted, approved and used to cover project costs at the field level, so in actuality, that position can not be filled. There is a small amount of money in the budget for technical assistance to the Washington office, and it is being used to support documentation and assessment activities (including training CORE PEI field workers in data collection methods, such as LQAS) to support program quality and reporting/publication. There might be a possibility to obtain a student intern, from one or more of the public health master's training programs located in the Washington-Baltimore area. It would be excellent experience for international health students, and allow staff more time to cover current gaps in operations.

The Final Review team estimated that the staff in CORE PEI Washington are engaged 30-40% in problem-solving, and 60-70% in grants management and technical support. The staff travels frequently to the CORE PEI countries. In this past year alone, approximately 40% of the total working days of the three central team members' working days have been spent out of the USA supporting national Secretariats and partners. In the coming months, there will be increasing tension surrounding the management of personnel resources with limited funds. The leadership of CORE PEI will have to review priorities and reallocate responsibilities to fill gaps and reflect changes in priorities. The Final Review for CORE PEI has been a catalyst in that process. The worldwide economic slowdown will continue to add pressure to the situation.

4) CORE PEI needs to raise quality and consistency of documentation

CORE PEI provides a quality and consistency of training for its PVO/NGO partners and district health affiliates. This decreases variation in information/skills transfer and improves the performance of local volunteers and health staff in social mobilization and surveillance activities. What CORE PEI has done in standardizing training to raise quality and consistency, can and should be done to raise quality and consistency of documentation. Nine years into a project there would seem to be no excuse for not collecting certain indicators of achievement recognized by national and global polio authorities. For example, take the WHO (and USAID) indicator for timely identification and reporting of AFP cases. Without knowing whether and when the CORE Group partner identified and reported an AFP case, how can the partner determine from the AFP case rate whether the problem is that the NGO is not finding enough AFP cases per expected numbers? And if that answer is not clear, then how can the national Secretariat be certain that the partners have set the correct priorities for technical focus?

The PVO/NGO partners can improve documentation. These are the same projects that so carefully have mapped communities, analyzed government NID/SIA statistics and supplemented that with data from registers to develop micro plans. Many of the same projects have carried out LQAS. Hopefully as the polio programs come closer to certification, the CORE PEI partners will have mastered the skills to produce the essential standardized documentation, because without it, CORE PEI will be handicapped in seeking additional funding from foundations. CORE PEI Washington will need to prioritize the improvement of documentation, and possibly secure additional TA from IMMUNIZATIONBasics (or similar TA mechanism) to expand IMMUNIZATIONBasics work in India to all four countries, to make forms more user friendly, and systematize the reporting and presentation of data, including polio indicators specified by USAID. In addition, it would be desirable to conduct, in partnership with research groups with this expertise, a more comprehensive study of community based strategies for vaccine preventable disease.

5) Loss of health worker motivation is an underappreciated challenge, due to both burn-out, and the shift to long-term prevention of WPV emergence or importation

As countries shift into long-term prevention of re-emergence of polio, it is natural for the public to grow tired of the same polio messages, feel besieged with round after round of campaigns, and say "enough is enough". (For example, in Uttar Pradesh, the frequent campaign rounds are prompting such response.) We know that the value that the health system, the government, community leaders and others place on polio immunization campaigns has a huge impact on morale of health workers in polio eradication. Low morale leads to lose of motivation, and in turn, health worker inaction or drop-out. To date CORE PEI project morale has stayed high. Secretariats and PVO partners have been able to retain staff for the polio program, because most CORE PEI workers find the work challenging and fulfilling. Those who have moved on did so to take advantage of career opportunities. One suggestion put forth in a country review is that there be capacity building of the Secretariat staff, and in turn transferred to PVO/NGO partners, to analyze the potential for innovative approaches that could be implemented to prevent fatigue and "burn out". (As examples, it was cited in the India report, to train community committees in UNICEF's Facts for Life, and to simplify the tracking systems linked with immunization counterfoils.)

However, there are strains reported in both country programs and the CORE PEI Washington office. In part it is due to constrained resources, reduced size of staff, the volume of work, (and perhaps "over-work", and growing pressure to add more areas of CORE PEI activity. The support to Secretariats needs to be re-examined. And it is advisable to once again rethink the allocation of responsibilities and schedules in CORE PEI/Washington and in the National Secretariats and partners. In part the strains are due to near "burn-out" of health workers who have put enormous effort into eliminating polio in local areas only to have the virus shift and the need to start up and implement another focused effort elsewhere. The fight continues without respite.

6) *Recognition is overdue for the secretariat facilitators and the PVO/NGOs that are implementing the immunization and surveillance strategies*

Being recognized is necessary to maintain morale and motivation. Secretariats have organized recognition events for the community volunteers– with games, food, and music. Some have tried providing certificates for volunteers. The prime and sub-grantees need to raise the profile of the National Secretariats and PVO/NGO partners CORE PEI has been a low-key project with almost no self-promotion, or publicity. State and district authorities engaged in the polio eradication effort do recognize and praise the value added by CORE PEI and PVO/NGO partners. However, the achievements of the CORE PEI country programs have received little notice on a regional or international health level. Because of budget constraints, CORE PEI/Washington has brought the Directors of the Secretariats together only once, and has not been able to afford travel to send country representatives to present at the Global Health Council annual meeting in Washington DC, or the annual APHA meeting. The CORE PEI Washington staff itself have perhaps been closer to their host PVO, World Vision Inc, than to their founding collaborative spirit, the CORE Group. (This might be expected since CORE PEI was housed at World Vision offices.) . There are indications this sense of isolation is ending as a recent strategic planning session and the semi-annual meeting of the CORE Group took notice of its "offspring", the CORE PEI project and the national Secretariats.

Hopefully, in the coming year, CORE Group Inc will step up and use its pool of creativity to recognize the technical contributions and value added by the CORE Group Polio Partners project to global polio eradication. For example, it would be extremely motivating if the CORE Group Inc could find a way to tap vaccine manufacturers to support travel of the Directors of the CORE PEI National Secretariats to attend the Global Council meetings in late spring 2009, and there through a panel presentation, disseminate what has been learned about effective community strategies to stop transmission of vaccine-preventable disease.

7) *There is a growing tension between the secretariats' role and their authority*

As CORE PEI is a partnership mechanism, with donor support for technical operations of participating PVO/NGOs to assist national polio eradication programming in four countries. National Secretariats facilitate and administer national partnerships. As a partnership facilitator, the National Secretariat does not have much authority and little leverage. In U.P. state, India, for example, where UNICEF has program operations, UNICEF has a huge presence and a large budget. In contrast, in CORE PEI, the

PVO/NGOs partners who implement the polio strategy have considerable responsibilities for social mobilization and child tracking in a number of underserved local communities but have a small budget. (One interviewee commented that CORE PEI was like a flea in the room with an elephant.) UNICEF and CORE PEI are collaborators, but the unequal size of operations gives the Secretariats little leverage.

CORE PEI elsewhere has found it difficult to bring community concerns to the forefront because in terms of resources, the National Secretariat is such a minor player in the national polio story. For example, initially, the global agency, WHO, did not appear to note the contributions of the small CORE PEI collaboration. However, recently that perception has been changing as WHO staff are increasingly speaking out on the value of the direct linkage with communities to eradicate local poliovirus, and several WHO staff are very supportive of CORE PEI. Still, as a temporary collaborative network, the National Secretariat will probably never have a great deal of authority. The fact is that these networks do not work independently. That is why it is so important to give recognition to the Secretariat Directors, appreciate the good relationships they have built with national and international leaders, and value the wisdom they have gained in their years of facilitating linkage between communities, PVO/NGOs, and national health programming. Such partnership facilitation skills are rare, and need to be acknowledged and documented. This is not to diminish the profile of those PVO/NGOs who implement the polio immunization and surveillance strategies in each country. Both facilitators and implementers play their part, in an organization that sometimes is regarded as having a minor role in global polio eradication, much as communities themselves are sometimes regarded as being of secondary importance in the fight against disease and ill health. Acknowledging the tensions and keeping bureaucracy at a minimum will strengthen these country level partnerships.

8) *Relatively larger PVOs may see the secretariat model a threat or an opportunity.*
Time will tell whether the US based international NGOs will grasp the implications of the National Secretariat model, and aggressively move with other CORE partners to form additional, independent partnerships in countries to link communities in high risk areas to key government efforts in disease prevention. Initially, the Board of the CORE Group questioned whether CORE PEI would be competing for funding with the members of CORE, especially those larger and stronger PVOs that had obtained funding in the past to head consortia in various countries. Fortunately they moved beyond that to perceive CORE PEI as a way to draw together, temporarily, the various strengths of individual PVOs and NGOs to work in a focused way more effectively on a particular disease problem affecting local areas, within the context of a national program strategy. Actually, the grant to CORE PEI has meant more development funds flowing into community-level social mobilization and surveillance. CORE PEI has widened the possibilities for funding health interventions at the community level, and links, via PVO partners, local NGOs to national health care delivery, -- something that probably would not happen if the linkages were all to flow through one specific PVO, rather than a partnership mechanism.

It should be noted that USAID missions appear to be receptive to the idea of a CORE collaboration of PVO/NGOs to mobilize communities in high risk areas to change and monitor behaviors that result in serious health problems. It will take vision on the part of international PVOs to attend to the lessons of this extraordinary project, and require deliberate formation of temporary country level partnerships to develop quality plans and approach USAID missions with proposals for collaborative action to eliminate key local health threats, in concert with national and international partners and programs. There is room for optimism about this challenge because fundamentally, the "win-win", "united we stand" approach is the heritage of the CORE Group's heritage, and the heart of its mission.

B. Opportunities in the social-economic environment to strengthen the CORE PEI project and its outcomes

1) *The current donor environment is extremely favorable to CORE PEI's mission of collaboration*.
Donors, as well as business management schools in general, emphasize (even insist) on the value of public-private partnerships, partnerships of organizations at different administrative/political levels, and partnerships that include representatives of those most affected by services. The theme is breaking

down the isolation of "silos" of expertise which lead to duplication, wasted effort, communication snafus, and higher administrative costs. Partnerships promote coordination, sharing of information and lessons learned; standardize project goals, objectives, and strategic approach. Partnerships also reduce the cost of multiple administrative structures, and streamline communication channels. The organizational structure of CORE PEI exemplifies this thinking. Its entire reason for being is based on a collaboration of multiple "silos" in order to work more efficiently and effectively, in concert, on eradicating the poliovirus in local areas, consistent with the national polio program and norms. CORE PEI's Secretariats are, in effect, 21st century management by networks.

2) *The donor environment for health improvement has become more diverse, and capable of major transfers of money, but expects results*

In recent years the donor community for health improvement has enlarged to take in a number of private foundations and associations as well as increasing the health efforts of multi-laterals such as the World Bank. Grants have been sizeable, with little expectation for refunding. They usually fund particular inputs that are expected to have a particular result. The headquarter offices of the PVO/NGO partners in CORE PEI are adept at seeking funds from donors, but this expertise has not extended to a partnership mechanism. In order for CORE PEI to obtain additional funding to supplement its USAID grant, it probably will require the advice and efforts of a development professional with contacts with the various potential donors. Fortunately the CORE Group Polio Partners Project can take the results of the final review of CORE PEI to demonstrate in each CORE PEI country its benefits and value –added to national disease prevention and polio eradication. In addition, the CORE PEI will need information from a careful financial analysis of project costs (e.g. Washington office grants management and country support costs ; National Secretariat costs for capacity building of partners and national advocacy efforts; and implementing PVO/NGO partners' costs for social mobilization; surveillance; training of volunteers, etc.) Such a financial analysis was beyond the scope of this assessment,

3) *A decade of donor emphasis on "scale" is shifting to incorporate the additional emphasis on "specificity," potentially creating a donor environment more receptive to coalitions of smaller organizations working in smaller but harder-to-reach populations or areas.*

Not only must programs reach a wide number of people, they must also reach the right age group, reach those unreached by the usual methods and health messages, reach those with poor or no access, and reach those who are marginalized or live where health service campaigns and RIs have not yet interrupted transmission. When the objective of health programs is focused almost exclusively on "scale", health program administrators place little value on the efforts of small community-based organizations unless those organizations work at a district, province, or state level. In the past, organizations and agencies talked about "linkage to the community", but the words had little meaning in terms of local strategies for eliminating disease. When, however, the objectives shift to obtaining both *scale* and *specificity*, there is far greater appreciation of PVO/NGOs whose particular niche has been "reaching the unreached", and have a presence in high risk areas. It is becoming clear to many who are working at top, influential levels that there are huge benefits to have collaborating partners located within many small communities, a partner who is trusted, able to take the pulse of communities, learn citizen reaction to program efforts, knows the map of the community, can head off rumors and diminish resistance to vaccines or child health care services.

4) The scientific community is now more receptive to the premise that community-based organizations can be effective mechanisms to deliver community-based strategies to prevent or treat diseases in childhood and adults, even where health systems are weak.

Within the past year there have been several articles published in peer-reviewed scientific journals which add to the growing body of evidence that community engagement and changed care practices can reduce young child mortality.[9] For years there were debates about whether horizontal or vertical programs were more effective, and the question of attribution was paramount – i.e., to which approach do we attribute

[9] See "Effect of community-based behavior change management of neonatal mortality in Shivgrah, Uttar Pradesh, India: a cluster-randomized controlled trial ". V. Kumar, G.Darmstadt et al. *The Lancet* , Sept 2008

success? Scientific leadership is recognizing that a diverse partnership is more effective than one approach or one main mechanism alone. In other words, groups with different key specialties and approaches, but sharing the same goals and objectives, can be effective at improving different components of population health that lead to the desired outcome.

Evidence of the change in scientific reception, can be seen in the positive reception at the Horn of Africa TAG, and the Africa Regional TAG to the 2008 presentation by the Director of CORE PEI Ethiopia on the results of CORE's community surveillance for AFP, measles and maternal/newborn tetanus. Given greater scientific backing, major public and private organizations are far more likely now than ten years ago to collaborate with community-based organizations to test *how* best to implement certain strategies to engage communities and change family care practices. This change in receptivity is an opportunity for CORE PEI to seek research collaboration with universities or institutes in the USA or in country, and validate the value-added of community engagement in social mobilization and community surveillance to prevent polio and other vaccine preventable diseases.

5) *The CORE PEI project, after 9 years of growing the project, can be considered to be 'mature"*.

The basic coordinating infrastructure is in place; the collaborating organizations trust and respect the complementary work of CORE PEI. There is now standardization of CORE PEI goals, objectives and strategic planning among the partner PVO/NGOs; CORE PEI has accomplished considerable capacity building for district level health staff and PVO/NGO workers and/or community volunteers. The project now enables micro-planning and greater quality implementation of NIDs, SIAs, and RIs. The time is right to strengthen community surveillance of AFP cases, develop stronger, simpler record systems at community level, improve and track timeliness of reporting. Child tracking, and social mapping can be expanded, and results documented and disseminated throughout the larger PVO/NGO community. It is time to acknowledge CORE PEI's successes, and aggressively build on the Secretariat concept for forming disease fighting collaborations in the coming years. The idea has been successfully launched; the PVO community can take ownership of the organizational strategy. It does not need much nurturance from USAID, educational institutions, or technical mechanisms. CORE PEI, or the national Secretariats, can become vehicles for future work by PVO and NGO partners. It will take vision and aggressive in-country action to take advantage of the partnerships now in place, or to develop similar temporary partnerships in other regions to address other health problems. The proof it can be done lies in the PVO community's own legacy of establishing CORE. It took similar vision and aggressive, persistent, positive action on the part of many to build CORE's collaborative platform to share lessons learned and best practices for advancing maternal and child health in communities around the world.

6) *Paradoxically, the winding down of campaigns can be an opportunity for PVO/NGOs to strengthen technical capacity of health volunteers and deepen child care knowledge and practices of families and communities*

The Country Review team found that in areas with frequent campaigns, people appreciated that CORE PEI was willing to link complementary disease prevention interventions with messages about eradicating polio. They were hungry for additional information about how to protect their children. Because PVO/NGOs aren't disease-specific organizations, it is possible for them to integrate other complementary health interventions, such as improving community water and sanitation, into their health messages and education of child caretakers. It is also possible for the partner organizations to continue to stress routine polio immunization in mother education and health communications as part of on-going child survival programming. As the polio program moves toward certification in more countries, there is opportunity for CORE PEI to use the community development strengths of its partners to build volunteer capacity in other child health interventions, broaden health communications to community members, and motivate and re-energize community volunteers.

7) *There is an opportunity to improve CORE PEI's documentation by linking it to the global health initiative to strengthen the framework for improved national health information systems and build country capacity to produce and use quality health and population data, including at local levels.*.

Many countries continue to be weak in their capacity to aggregate, tabulate, analyze, or use health data. There is an absence of standards and indicators of performance. Medical records are largely incomplete or irrelevant for system decision-making (in contrast to decision-making about patients.) For many years ministries of health have worked on strengthening the health information system used in government clinics and hospitals. However, a number of recent changes have accelerated the pressure at lower levels on the performance of local HIS. More countries have decentralized health planning and management. Costs for HIS equipment have decreased, but the HIS technical capacity of district and local health staff to productively use the equipment is very weak. Consequently, there is new donor emphasis on working with national academic institutions to strengthen HIS training of existing staff and establish new post-graduate programs to train graduates to collect and share health information and use HIS data in program management decisions. These new training programs call for better knowledge of epidemiology, health metrics, and program management decision making. The basic point is to strengthen the uses of information – the capacity of individuals to analyze data, and to communicate statistics via policy papers, or public reports, or use in micro-planning for field operations.

How is this an opportunity for the CORE PEI project? It is because CORE PEI has successfully improved the quality of polio eradication efforts and immunization systems in local program areas by using available HIS data as a catalyst for improvement efforts. Examples include:

- A number have initiated use of community pregnancy or child registers for volunteers to track children.
- CORE PEI has made a substantial contribution to establishing community surveillance, and is working on measures of timely reporting.
- The national Secretariats have learned what it requires to produce users of health and population data a community levels.
- The Secretariats have knowledge about what incentives work with volunteers or how accountability is best built in at community level.
- CORE Group Polio Partners are "demand-driven", as they assist community volunteers to draw from population data and NIDs and SIA statistics the kind of information community volunteers understand, can analyze and use to canvas X houses, track defaulter children from clinics or campaigns, or increase zero dose coverage.

This accumulated field-based HIS "user" knowledge as well as the collaborative mechanism that CORE PEI represents, has much to bring to a potential M&E strengthening partnership with Measures, IMMUNIZATIONBasics, or CDC, or the Rhino network, or possibly WHO's strong Health Metrics program.

C. Restrictions observed in country reviews regarding CORE PEI's ability to ensure continuity

1) Poor documentation and uneven use of existing information and skills training

- Poor documentation and use of information is the most serious challenge, and is evident almost in all places visited. *(Ethiopia)*
- The visibility of CORE PEI's work , -notably with partners at national level - is limited due to its small staffing and lack of synthesized project data that highlight CORE PEI's specific contribution and value-added. *(Nepal)*
- Although comprehensive polio and immunization data are available through the linked government and WHO systems, CORE PEI results are not differentiated or sufficiently presented by the project to be able to demonstrate its specific value-added contribution. *(Nepal)*
- Many partners and *woreda* health staff were trained on the LQAS technique, but most of them have not used the knowledge to evaluate the performance of their immunization and surveillance program. They were trained also on HMIS, but utilization of data has been unsatisfactory. *(Ethiopia)*
- Field staffs of PVO/NGO partners interviewed in 2 CORE PEI-supported areas were lacking ability to provide quality TA to area health staff on PEI, RI and surveillance of AFP and other vaccine preventable diseases. A few were unaware if the *woreda* has a micro-plan for routine immunization. *(Ethiopia)*

- Despite a high turnover among field staff in partner organizations, CORE PEI lacks a system and orientation package to give to newly recruited staff. *(Ethiopia)*

2) *Situational challenges to maintaining support and transferring capacity*

- Security is a concern, notably in Dhanusha, which results in episodic or sometimes limited access to communities. *(Nepal)*
- Almost all field service areas of PVO/NGOs are located in geographically hard to reach, especially during rainy season. *(Ethiopia)*
- PVO/NGO partners in CORE PEI are working in 53 districts, in seven regions – field visits to all of them by the small staff of the Secretariat is a challenge. *(Ethiopia)*
- CORE PEI has provided and designed innovative tools, and conducted training and follow-up in the use of these tools in the past (e.g. LQAS, updating of software, follow-up from HQ) but has not been able to sustain this level of support due to limited staff and funding. *(Nepal)*
- High turnover among government staff in partner organizations service areas (harsh environment) – investment on capacity building, sometimes has no impact on the improvement of the quality of immunization services. *(Ethiopia)*
- It is a challenge to maintain the involvement of the best-performing Family and Community Health Volunteers, particularly when they are also committed to other programs (e.g. ARI management). *(Nepal)*
- Lack of district level partners (e.g. local NGOs) to assist with polio. *(Ethiopia)*

3) *Funding restrictions*

- Funding restrictions, particularly with the cuts in 2007-2008, are one of the largest constraints for CORE PEI's work. The project has a good relationship with the government, but annual funding cycles make it difficult to plan future and long-term activities and to keep the government informed of budget in advance. *(Nepal))*
- CORE PEI has had to focus its limited resources on basic operational maintenance and has not been able to support additional staff, which are needed for program activities and to assist with program design, implementation, and monitoring. *(Nepal)*
- Most of the partner organizations staff interviewed stated that CORE PEI Group Ethiopia has provided small funds for PEI mobilization, routine immunization and surveillance and expect/demand more work to be done than the budget allows. *(Ethiopia)*
- In the field, districts are requesting assistance for supplementary immunization activity costs – e.g. paying for transportation, logistics, and supervision - which CORE PEI had been able to assist with in the past but can no longer fund. *(Nepal)*
- Review meetings were not held for four months due to the Alemtena Catholic Church partner lack of funding. This is a sustainability issue. *(Ethiopia)*
- When PVOs have dropped out in some areas, the polio partnership notices less community-focused activities in these areas. *(Ethiopia)*
- CORE PEI has less money to finance the costs involved in training volunteers and supporting their work with surveillance and NIDs/SNIDs. PVOs have funded some of the polio work themselves, but this causes internal audit issues because they must justify why funds have been shifted between programs. *(Nepal)*
- Limited funds have hampered CORE PEI's ability to move into areas that should perhaps be targeted for polio support. *(Nepal)*
- Routine immunization coverage is very low in some of the regions supported by CORE partners. National program and border district governments would like continuing support from CORE PIE to strengthen routine immunization, including training the Family and Community Health Volunteers to mobilize the routine immunization of more children. However, the CORE' Group's polio mandate means that it is concerned more with surveillance and SIAs. *(Ethiopia)*
- Medical districts and local NGOs are requesting additional assistance for polio mop-ups and special outreach to low coverage areas, but CORE PEI's funds are too constrained to provide support for additional activities. *(Nepal)*

D. Recommendations made in country reviews to focus and accelerate PVO efforts in polio eradication

1) Intensify collaboration

- Secretariat to ensure more discussion with PVO partners on overall program management and decisions to enable better brainstorming on program direction, information sharing, and possibilities for addressing funding gaps and additional resources. *(India)*
- CORE PEI National Secretariat and UNICEF should meet and discuss stronger linkages & potentials for cooperation. *(Ethiopia)*
- The partnership between UNICEF and the CORE PEI Group should continue to be strengthened in order to advocate for more visible communication programming. A stronger partnership would enable CORE PEI to have a more pro-active role in future polio strategic planning, to mobilize additional resources and to identify and address additional "at risk" areas. *(India)*
- More direct linkage with the MOHFW at national and state levels could potentially assist in pulling in the IEC unit. *(India)*
- Establish stronger linkages with U.P. state and India national level government counterparts by regularly communicating CORE PEI's contributions in campaigns and RI. *(India)*
- CORE Secretariat should be involved in State-level planning. Ensure that the PVOs/NGOs are represented on the state and RI task force. *(India)*
- Share reports and program information with USAID Ethiopia Mission including annual work plans. It will also be useful if the mission staff will be invited to participate in monitoring and joint supportive supervision activities. The mission could also discuss with the Secretariat the possibility of providing logistical support, e.g. vehicle. *(Ethiopia)*
- Report on what CORE PEI Secretariat and CORE PEI/Washington are doing for leveraging other government and human resources, additional financing, and involvement in district micro-planning. *(India)*
- Assist with linking other PVO partners (like WV, Plan), USAID partners – e.g. NFHP – and other projects and initiatives to build cross-learning with polio and with other initiatives. This could be done with possible CORE PEI/Washington technical support. *(Nepal)*
- Continue to emphasize and support activities that will sustain and increase collaboration with local influencers (e.g. involvement of private doctors, sensitization of ration dealers and ward leaders, coordination with local government and religious leaders). *(India)*
- Organize periodic inter-face meetings of CMC, ASHA and ANM at community and block levels for increasing collaboration and coordination. *(India)*

2) Intensify use of data to improve quality and consistency of field work

- Streamline the M&E strategy to focus on key indicators to be tracked and a standardized reporting format for each PVO partner. Utilize PVO M&E staff to assist in developing this as needed. Include guidance from CORE PEI Secretariat on trend analysis and how to make field level data more user-friendly (with graphical analysis like coverage monitoring charts) and action oriented. To ensure maintenance and effective use of the MIS, capacity building in computer skills is needed at all levels. CORE PEI could also assist better use of technology to simplify the process (e.g. transferring key indicators via text messaging.) *(India)*
- Explore further technical discussion with National Polio Surveillance Program (NPSP) on how to use the data being collected by CORE PEI at the household level more effectively/concisely and link with polio and RI data. *(India)*
- Adapt RCS with RI sessions and do trend analysis – discuss with CORE PEI and PVO partner M&E staff to look at data trends for RI and SIAs. *(Nepal)*
- CORE PEI Secretariat and WHO surveillance team should have regular information sessions to compare the community-based surveillance system reports with WHO surveillance reports

- to identify strength and weaknesses in the system (document and follow-up all suspected AFP, measles and maternal/neonatal tetanus (MNT) cases reported by CVSFP) – provide feedback in their monthly review meetings. This might be a huge task but good to document the work of these volunteers .*(Ethiopia)*

- CORE PEI Secretariat organized over 30 training & capacity building sessions, trained over 600 health staff in 6 different topics (LQAS, IIP, HMIS, EPIInfo, etc). Partner organizations trainers also trained many other field staff (government & partners) – this is a huge investment. A system has to be in place to monitor the use of knowledge gained during these training exercises. *(Ethiopia)*
- CORE PEI Secretariat could organize review meetings and supervisory visits that assist with on-the-job-use of data as well as presentation and analysis of consolidated findings from RCS, LQAS, and DQSA. . *(Nepal)*
- CORE PEI Secretariat could support improvement of the sensitivity of the HMIS to better differentiate whether Nepalese children are being vaccinated and address issues of coverage above 100% (due to Indian children being immunized in Nepal during RI). *(Nepal)* .
- CORE PEI Secretariat should provide written feedback to partner organizations (periodic reports, field visits) to improve the quality of their work. *(Ethiopia)*
- Request TA (in biostatistics, demography, or epidemiology) to address the denominator problems that have been identified through tracking. *(Nepal)*
- CORE PEI National Secretariats should do a financial sustainability analysis that looks at predictability of funding and calculations (e.g. based on cost per small local unit) to maintain program activities and staffing, possibly looking at different staffing configurations. This could include a cost analysis of the minimum amount of funding needed to maintain social mobilization in a district, including number of volunteers, costs for meetings and other activities and implementation costs. This should also consider possibilities for sharing operational costs fir add-ons, health camps, RI-related support. *(India)*

3) Advocate for addressing areas with low RI coverage

- CORE PEI Secretariat and partners should work with other stakeholders to re-define strategies to target low coverage areas. *(Ethiopia, see Annex 5)*
- Use the CORE Group's community mobilization experience and coordination skills to liaise with government and partners for state and district-level advocacy for combining services – e.g. NRHM link with polio, advocating for ANM postings and function, further linking CMCs and Auxiliary Nurse Midwives (ANMs), ensuring that RI sessions planned are held, and exploring possible additional cadres of vaccinators and ASHAs to support immunization. *(India)*
- Use the CORE Group's expertise in networking, partnership and participation in ICC meetings for advocacy to raise the profile of routine immunization in areas with very low coverage. These areas need support of all stakeholders and partners, to ensure detailed micro-plans are being developed and all other resources are in place to implement them. . *(Ethiopia)*
- Strengthen the National Secretariat's advocacy role on immunization at higher levels to improve the routine immunization coverage in areas with poor access. *(Ethiopia)*

Section 8: The Validity of Assumptions about What PVO/NGOs Can Bring to Polio Eradication, and Implications for CORE PEI Replication

The intent of this project was to set up a coordinating mechanism to bring PVO/NGOs into existing national partnerships to interrupt polio virus transmission. What are the possibilities for replication of CORE PEI? It depends on how well CORE PEI is perceived to do its job, as well as whether there are other health programs that need the same or similar functions that CORE PEI performs in these four countries. Below are listed the major functions that CORE PEI was to fulfill in the CORE PEI countries, and the expectation for the results of that work.

A. Functions CORE PEI is to fulfill in national polio eradication programs and results expected of CORE PEI's work

1) CORE PEI country program

Its major functions are to recruit, fund, and train local PVOs/NGOs to join a coordinated eradication effort in polio-endemic areas and areas with limited service access, and low <5 immunization coverage.

> *Expectation: This activity will increase local capacity to interrupt transmission of the poliovirus, especially in high-risk areas, and achieve greater scale of PVO/NGO cooperation with the national polio eradication program.*

2) CORE PEI national secretariat

Its major functions are to advocate for polio eradication with the PVO/NGO partners; provide the link with national immunization coordinating committees; facilitate collaboration at district and local levels; standardize strategic approaches; and assure uniform quality and consistency of training of local health workers and volunteers.

> *Expectation: This activity will result in more efficiency, and improve quality and consistency of local immunization administration and reporting, especially in geographic areas where the population has limited or no access to health services, peri-urban areas with poor access, border areas, and migratory groups.*

3) PVO/NGO implementing partners

The PVO/NGO field staff and volunteers carry out social mobilization and, where needed, aid in community AFP surveillance,

SOCIAL MOBILIZATION

The main social mobilization functions of the implementing partners are to train field staff and volunteers to Increase community awareness of threat of polio and benefit of immunizations, especially in families with young children; increase community knowledge of where and when to get polio immunizations, and number of doses required; mobilize communities to participate in and support NIDs, SIAs, and routine immunization care; and dispel rumors and antagonisms before they undermine campaigns.

> *Expectation: Social mobilization will engage hard-to reach communities, and migratory groups in support of the national polio eradication program, and increase local polio immunization coverage, especially among in areas that are most at risk.*

COMMUNITY SURVEILLANCE

The main surveillance functions of the implementing partners are to engage communities in support of AFP surveillance; train volunteers to make household visits and report AFP cases; build community

health volunteer capacity to providing timely accurate reporting of cases; and facilitate timely collection of stool samples from the child affected with AFP.

> *Expectation: Coordinated PVO/NGO participation will Increase timeliness of AFP surveillance and reporting, especially in geographic areas with limited or no access to health services, peri-urban areas with poor access, migratory groups, and border areas.*

As the preceding sections of this report have shown, the Final Review Team found that the country participants in CORE PEI did carry out their functions as specified, and they did increase local capacity to stop local transmission of the poliovirus; achieve greater efficiency in strategic approach and training; greater scale of cooperation with government health programs; engaged and trained community volunteers; increased polio immunization awareness and coverage in high-risk areas; and enabled surveillance of AFP in difficult and hard to reach areas. . There were shortcomings in documentation but good use of district data for planning purposes. Overall the Final Review team perceived CORE PEI as having done an excellent job in the four countries under review, and would provide a good model for replication if those same or similar functions are needed in other country polio eradication programs.

The potential for replication of CORE PEI is also dependent on the assumptions one can make about the strengths that a coordinated set of PVO/NGOs can bring to national programs. As part of the final evaluation, there was a check on whether certain assumptions about PVO/NGOs and coordination were valid in the experience of the four CORE PEI country programs working with existing government partnerships to interrupt polio virus transmission. The data used in this validation come from the country review reports and stakeholder interviews. Table 6 shows the results of the check on assumptions.

B. Validity of assumptions about benefits of coordinated PVO/NGOs to national polio eradication programs

TABLE 6: Assumptions and Findings of the PEI Review

Assumptions	Final Review Team Found Valid	Weak	Not Enough Information to Determine
Assumptions about what PVO/NGO partners bring that is critical to raise coverage			
Have presence and trust of local communities in areas with poor or no access	X		
Have presence and trust of local communities in polio-endemic areas	X		
Have credibility with local leaders	X		
Have credibility with child caretakers	X		
Have linkage and credibility with local health services staff	X		
Reputation of being politically neutral and safe *(no information available)*			X
Have pulse of community; know what is happening	X		
Understand and work with community power structure	X		
Know and work with marginalized groups in community *(no specific documentation*			X
Understand concerns of community, and can adjust operations to reality	X		
Capacity to deal with rumors and antagonisms that could undermine health care campaigns	X		

Assumptions	Final Review Team Found Valid	Weak	Not Enough Information to Determine
Transport capacity, can reach out	X		
Communications capacity to local, district authorities	X		
Communications capacity to CORE PEI Secretariat, and PVO/NGO partners	X		
Able to meet reporting requirements *(depends on project location)*		X	
Capacity to make household visits and talk with child caretaker	X		
Capacity to engage and educate mothers and record activities			
Presence of trained mobilizers with knowledge and skills to motivate communities *(No documentation of pre- and post- training knowledge and skills)*			X
After standardized PEI training by CORE PEI Secretariat, PVO/NGO partners			
Understand essential practices to interrupt polio virus transmission, and partner's role	X		
Support local health services in special and routine immunization activities	X		
Support national government in NIDs and SIDS	X		
Enroll/train community volunteers to mobilize communities to participate in campaigns √Tailor communications to various population segments (age, gender, ethnic, and religious) about polio threat, and benefits of immunization	X		
Implement social mobilization campaigns in local area	X		
Develop and use data from child tracking system (e.g., registers)	X		
Implement or use existing system to record Immunizations of eligible children	X		
Identify and trace RI defaulters at health clinic	X		
Identify and trace defaulters at NIDs	X		
Identify X households and conduct follow-up	X		
Use data to develop micro-plans for mobilization and home visits	X		
Transmit quality reporting skills to mobilizers and immunizers	X		
Track progress in immunization coverage *(NOTE: depends on service location)*		X	
Document social mobilization efforts and track progress in community participation		X	
Assumptions about what PVO/NGO partners bring that is critical for success of community surveillance			
Ability to enroll/train staff and local volunteers in the AFP case surveillance	X		
Capacity to build community awareness of need to	X		

Assumptions	Final Review Team Found Valid	Weak	Not Enough Information to Determine
report AFP cases			
Rapid communications capacity to medical surveillance officer	X		
Transport capacity to transmit stool samples, if needed by medical surveillance officer	X		
Have presence and trust of local communities in areas with poor or no access	X		
Have presence and trust of local communities in polio-endemic areas	X		
Have credibility with local leaders	X		
Have credibility with child caretakers	X		
Have linkage and credibility with local health services staff	X		
Reputation of being politically neutral and safe *(no information available)*			X
Have pulse of community; know what is happening,	X		
Understand and work with community power structure	X		
Know and work with marginalized groups in community *(no specific documentation)*			X
Understand concerns of community, and can adjust operations to reality	X		
Capacity to deal with rumors and antagonisms that could undermine surveillance	X		
Communications capacity to CORE PEI Secretariat, and PVO/NGO partners	X		
Able to meet reporting requirements *(NOTE: depends on project location)*		X	
Capacity to make household visits and talk with child caretaker	X		
Capacity to engage and educate mothers and record activities	X		
After Surveillance Training by COREPEI the PVO/NGO partners have capacity to			
Understand district surveillance reports and WHO standards for AFP cases	X		
Transmit knowledge/skills to CHVs to provide timely, accurate reporting of AFP cases	X		
Facilitate timely collection of stool samples from the affected child	X		
Implement AFP case reporting system, track timeliness of reports, give CHV feedback		X	
Staff capacity to track USAID indicator for timely reporting of AFP cases		X	

Conclusion: The majority of assumptions about PVO/NGOs and CORE PEI Secretariat training are valid. About 10% are weak, and another 10% have insufficient documentation to judge.

C. Implications for end of CORE PEI project and potential replication

Many functions that PVO/NGOs do to support national polio eradication programs are dependent on good communication skills. Do staff and volunteers have the ability to speak with community members without hectoring or lecturing them? Are they able to deliver accurate, culturally appropriate, and relevant educational messages in entertaining, appealing ways? Do the communications emphasize actions to take, where and when? Are staff and volunteers trained in social skills? That is, can they listen to community and individual caretaker concerns, answer questions, solicit views of community leaders and members, diminish fears, and dispel rumors without being defensive, or disparaging of others? These are questions that go beyond the scope of this review, but have to be considered if considering replication elsewhere, and strengthened, if necessary, in any participating organizations.

Another implication of Table 6 is that more needs to be done by the CORE PEI Group to diminish obstacles to adequate documentation. A few country reviews pointed out that volunteers engaged in surveillance needed more feedback. Documentation is a problem across countries for many PVOs and most local NGOs, and it is not unique to the polio eradication program. This is a factor that could hinder replication of CORE PEI, unless everyone concerned pulls together to diminish obstacles, institute incentives, and arrange for field staff and volunteers to receive feedback on efforts in collection of social mobilization and surveillance data. Fortunately, the National Secretariats and partners will be continuing their efforts to improve the reporting forms and other processes supporting sustained high immunization coverage. Possibly the Secretariats could hold workshops too, on ways to improve feedback on reporting of AFP cases as countries near certification. And CORE Group might gather a group together to brainstorm ways to foster better documentation and feedback at field level.

Once CORE PEI ends, it will leave a network of trained, concerned community members and NGOs to continue surveillance, social mobilization for continued campaigns, and support of routine immunizations. This network could be mobilized for other national (and perhaps even regional) programs against other childhood diseases. However, the contributions of trained volunteers are dependent on having in place a local infrastructure that coordinates efforts, links to national partners, and standardizes the quality and consistency of training, and empowers communities to take organize planned action. This requires:

- Government mandate
- A coordinating body with local presence and trust of PVO/NGO partners
- PVO/NGOs with local presence and trust of communities and their leaders
- Linkage with local/district health authorities
- Linkage with national, district and regional partners power groups
- An agreed upon strategy and supervised, planned actions
- Transport capacity
- Communication capacity
- Sufficient numbers of trained volunteers willing to participate
- Training that is practical, of quality, appropriate for level of literacy, and consistent across NGOs
- Recognition for work of volunteers and feedback
- Accountability for any funding

D. Summary

The final review found that the majority of assumptions about what coordinated PVO/NGOs can bring to a national health program did, in fact, hold true across different cultures, geographic locations and peoples. The functions the coordinated PVO/NGOs perform in the national polio eradication programs of four different countries are being fulfilled by CORE PEI and, those functions have been shown to meet expectations for success. To the extent that future national programs need similar functions performed, there is reasonable assurance that the CORE PEI benefits could be replicated by constructing other temporary PVO/NGO country coordinating mechanisms, as long as there is existing local infrastructure (e.g. international PVOs and local NGO partners), and agreement to come together for a common purpose, allied with national health goals and objectives.

Section 9: THINKING AHEAD TO CERTIFICATION AND END OF PROJECT

During certification, governments will conduct concurrent activities to support high population immunity and sustain surveillance at very high levels. The implications of CORE PEI's participation in certification are two-fold. First, CORE PEI will be conducting mobilization and support of those continuing immunization campaigns. Secondly, CORE PEI will be assisting governments to carry out active surveillance for cases, check rumors of cases, and track contacts of cases. This expected high level of activity calls for careful advance planning. CORE PEI/Washington and the National Secretariats are encouraged to set aside some time to jointly review progress toward certification and what might be expected of them during that time. (For example, Angola could take on increased surveillance responsibility and include detailed monitoring of follow-up on AFP cases within the project area.

The expected process is that national advisory groups will decide the number of rounds; and the likelihood is that mop up will be low. Secretariat then takes that information and makes its work plan. The budget does not increase, so if there if more rounds are required, then the NGO partners will have to scale back to do more mobilization. With fewer rounds required, the partner organizations can take on additional activities.

Given that the funds are established before the advisory groups take decisions on the number of campaigns for the year, CORE PEI is wise to develop a better and worse case scenario for the coming year. That is, using a planning session to think through what it means for the Secretariat and partner organizations in the coming year if the Advisory group decides on two rounds, versus four rounds.

The national secretariats will close when the CORE PEI project funding ends. USAID, the donor for the polio eradication program never intended the national secretariat coordinating mechanism for PVO/NGOs to be in place beyond polio. Sustainability of CORE Group national secretariats was not one of CORE PEI's goals. Left in each CORE PEI country will be a cadre of trained people who have worked at the local level within a national partnership network, and experienced directors of such a network. Other sources of funding could tap this reservoir of knowledge and skills in mobilizing communities for prevention of childhood disease. CORE PEI has developed and tested methodologies at the community level that other programs may wish to adapt. Neonate-tracking for example, is so useful it is hard to see how government or other partners would let it go. Community surveillance is another such innovation. There are community people trained in case detection and timely reporting. The linkages and processes are in place to bring cases to the attention of surveillance officers; that is of value. There is an opportunity for the government and NGO community to build on the closer linkage CORE PEI established between WHO and NGOs. Given a national health framework, communities could continue to bring cases of other child health diseases to district and local medical officers.

Finally, the many country partners (government, WHO, UNICEF, Rotary and NGOs) will have learned some valuable lessons through partnering with CORE PEI. If they regard them as important principles, they will want to see them in other programs where conditions would call for similar approaches. These key principles, or lessons learned, are summarized well by the CORE/Nepal Country Review team:

- Periodic joint assessment is valuable (e.g. through LQAS, RCS and review meetings) to determine program impact and identify gaps at community level.
- Home visits are useful for active surveillance and timely reporting.
- Involvement of local leaders, CBOs, and NGOs is critical for maintaining program activities and involvement.
- Social Mapping and GIS are beneficial tools to sensitize and encourage volunteers and the community to participate in NIDs/SNIDs.
- Use of data is essential to identify and target high-risk communities and houses missed in densely populated urban areas.
- Strengthened coordination between the development committee, DPHO, municipality and agencies ensures continuity and transparency.

- Trained and supervised family and child health volunteers are successful in social mobilization for NIDs/SNIDs, RI, and with community VPD surveillance.

The usefulness of these key lessons will not go away; but the opportunity for their utilization is dependent on leadership

- Recognizing the value of having local presence and community input to national health programs, and mobilizing the linkages and processes that are now in place.
- Having a vision for a different future in population health and knowing what has to be done to make partnerships to mobilize community knowledge and skills around health development, a reality
- Creating a framework in which communities linked via civil society mechanisms to government and other country partners can continue coordination with medical officers, development officers, etc, and build on the reservoir of trained people now in many communities.

The challenge to PVOs, NGOs and other community-oriented health advocates is to document and disseminate information on CORE PEI project benefits and value-added to catch the imagination of a new generation of public health leaders, government authorities and research scientists. This new generation is engaged even now, somewhere, someplace, in designing future programs to improve population health. From the CORE PEI project they can learn about achievements and gaps found in management by networks, decentralized decision-making, bottom up change, and a uniform quality and consistency of training and micro-planning. CORE PEI has been a visionary project, building on past success and strengths, attempting new ways of working and creating sustainable innovation. It has not been a large, trumpeted project; it's been a small, modest one which has brought the power of dedicated non-profits and mobilized communities to interrupt transmission of the polio virus. Its achievements have far outstripped its funding. CORE PEI has added value to national polio eradication programs that could not have come from another source, and in the process, communities have gained, and national polio programs have gained. Most of all, at-risk children living in hard-to-reach areas with few or no health services, have gained – they are protected from polio.

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