
Evaluation of the Red Cross and Red Crescent contribution to the 2009 Africa polio outbreak response

Final report, January 2010



International Federation
of Red Cross and Red Crescent Societies

strategy2020

Strategy 2020 voices the collective determination of the International Federation of Red Cross and Red Crescent Societies (IFRC) to move forward in tackling the major challenges that confront humanity in the next decade. Informed by the needs and vulnerabilities of the diverse communities with whom we work, as well as the basic rights and freedoms to which all are entitled, this strategy seeks to benefit all who look to Red Cross Red Crescent to help build a more humane, dignified and peaceful world.

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- 1. Save lives, protect livelihoods and strengthen recovery from disasters and crises**
 - 2. Enable healthy and safe living**
 - 3. Promote social inclusion and a culture of non-violence and peace**
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International Federation of Red Cross
and Red Crescent Societies, Geneva, 2010

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List of acronyms and abbreviations

CDC	US Center for Disease Control and Prevention
CRBF	Burkinabe Red Cross Society (Croix-Rouge Burkinabe)
CRCI	Red Cross Society of Côte d'Ivoire (Croix-Rouge de Côte d'Ivoire)
EPI	Expanded Programme on Immunization
GOSS	Government of South Sudan
GPEI	Global Polio Eradication Initiative
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
MoH	Ministry of Health
NID	National Immunization Day
OPV	Oral polio vaccine
SIA	Supplementary immunization activity
SNID	Sub-National Immunization Day
SRCS	The Sudanese Red Crescent Society
UNICEF	United Nations Children's Fund
URCS	The Uganda Red Cross Society
WHO	World Health Organization
WPV	Wild poliovirus

Acknowledgements

The evaluation was conducted by a team of two consultants who visited the four countries and undertook all interviews.

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1.

Executive summary

While the polio eradication effort has made significant progress since 1988, the recent spread of polio in late 2008 and throughout 2009, particularly in Africa, has caused some African countries that had been polio-free for a number of years to become reinfected. The Global Polio Eradication Initiative (GPEI) is a broad partnership of organizations committed to global eradication of polio. The role of the International Federation of Red Cross and Red Crescent Societies and its member National Societies in this partnership has historically been concerned with social mobilization around supplementary immunization activities. To undertake social mobilization, each National Society mobilizes and trains its network of volunteers.

Because of the acknowledgement that the Africa polio outbreak was a public health emergency and threatened the eradication goal, the International Federation launched a special appeal for funding in 2009 so that National Societies in the renewed outbreak countries could assist the GPEI and other partners to respond to the emergency and support the vaccination against polio of approximately 25 million children under five years of age. A sum of CHF 1.7 million (over US\$ 1.6) was raised, allowing the Red Cross Red Crescent to mobilize over 30,000 volunteers.

An independent evaluation of the role of the Red Cross Red Crescent was commissioned, with a remit to assess the added value of the activities undertaken with the emergency appeal funding. Of the 15 countries funded, the evaluation team visited four of the countries to interview stakeholders and in some cases to visit households and observe activities undertaken by the National Society. The stakeholders interviewed were all asked the same series of questions which had been developed earlier by the evaluation team. The team also studied reports from the other 11 countries. It was in general found that the experiences of all the countries funded were very similar.

The four countries visited were Uganda, Sudan, Côte d'Ivoire and Burkina Faso. In all but Sudan, funds were used for social mobilization activities, which included pre-campaign activities, house-to-house visits, during-campaign activities and, in some cases, post-campaign reviews. Some volunteers also acted as vaccinators following training. The situation in Sudan was complicated by delays in delivery of funding for the activity in South Sudan, and thus the consultants were unable to evaluate the activity.

Findings for the four countries are similar. In each case, the potential for utilization of the National Society volunteer network in future polio rounds was

emphasized, largely because volunteers are able to reach communities that may be less accessible to government or other agencies. In general, Red Cross Red Crescent volunteers are welcomed into homes, and play a valuable role in “selling” the need for immunization. The use of the network is also very cost-effective. In general, the consultants noted the need to raise the visibility of the National Society, both with partners and other major stakeholders, so that they are aware of the broad mandate to work in health and disasters, and include the National Society in national plans. In addition, to help raise the profile of the National Society in high level planning meetings of all the partners, the attendance of very senior National Society staff is recommended.

In most cases, while GPEI partners respect the talent of the Red Cross Red Crescent for social mobilization, the consultants also found a need to work more closely in cooperation with all the partners, in order to avoid duplication of effort and to work more effectively with the funds available. In general, it was found that the National Society network of volunteers did give added value, both at district and at national level, although often there is less awareness of the role of the National Society by government and other stakeholders at national level than at branch level.

Recommendations for the four countries are also similar, concentrating on the need for National Society capacity-building, timely funding and systematic evaluation of contribution. Some of the issues highlighted include sometimes poor communications and poor record-keeping, meaning that results cannot be quantified and assessed accurately.

The final recommendation is that GPEI partner organizations should realize the potential of the Red Cross Red Crescent and the role it can play in polio eradication, particularly through social mobilization activities and post-campaign monitoring.

2.

Introduction

Over the past 21 years polio eradication has made significant progress. In 1988 more than 125 countries were considered polio-endemic, with the disease paralyzing more than 1,000 children every day. By 2001 only ten countries remained endemic, and by 2006 this number had reached a historic low of four endemic countries.

Since 1988, more than two billion children around the world have been immunized against polio thanks to the unprecedented cooperation of approximately 200 countries and 20 million volunteers. The founding members of the Global Polio Eradication Initiative (GPEI), WHO, UNICEF, Rotary International and the US Center for Disease Control and Prevention (CDC), have encouraged a broad partnership to help achieve the goal of a polio-free world. This partnership includes the International Federation of Red Cross and Red Crescent Societies and its member National Societies, as well as other health-related organizations.

Polio, however, remains a threat. In spite of the successes of the Initiative, global eradication has still to be achieved. A resurgence of polio cases across 20 African nations in late 2008 and throughout 2009 has caused countries to become re-infected after a number of polio-free years. By mid-October 2009, the total global number of infected countries rose steeply to 23, the highest since 2000¹.

The International Federation of Red Cross and Red Crescent Societies has historically been a key partner in providing social mobilization around supplementary immunization activities (SIAs), particularly during polio and measles vaccination campaigns. Provision of this support primarily comes through the activation of local Red Cross and Red Crescent National Societies, using their networks of community-based volunteers. As a long-standing partner of the GPEI, National Societies support polio campaigns by mobilizing volunteers to promote vaccination through household visits and community sensitization activities, providing logistics support, including use of vehicle fleets, storage areas, support to cold chain, assisting at fixed-post vaccination sites through crowd control and data recording, serving as vaccinators (when duly trained), and sometimes supporting campaign evaluations and surveillance activities.

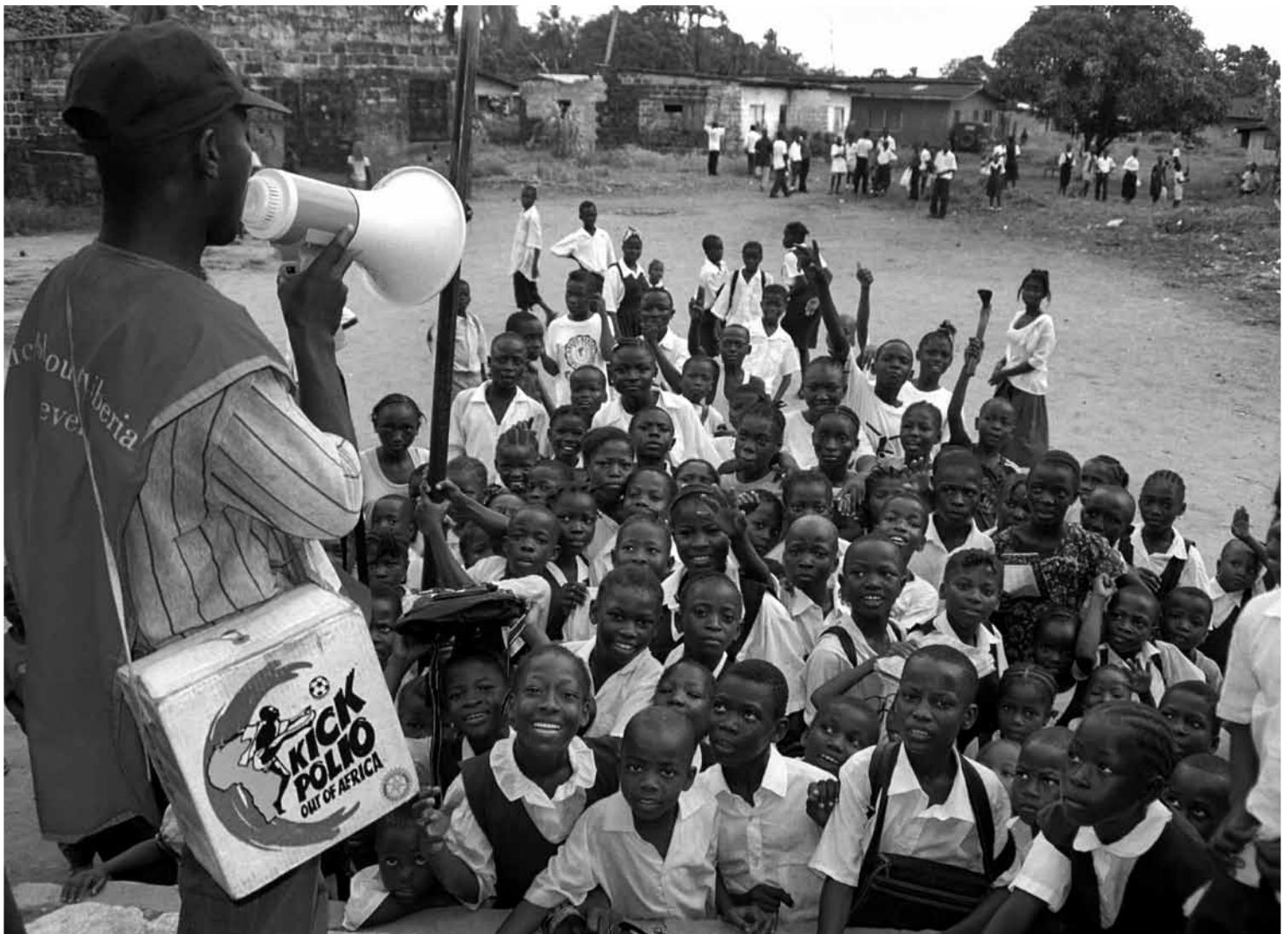
The support provided by National Societies to polio National Immunization Days (NIDs) and Sub-National Immunization Days (SNIDs) has come to be seen as an important civil society contribution to national vaccination efforts and child survival goals. Effective communication activities, known widely

1. As of 1 December 2009 there were 1,457 wild poliovirus (WPV) cases reported by the GPEI. Of these, 629 cases were in African countries. For the most up-to-date information on global case count, please see: www.polioeradication.org/casecount.asp.

2. *The 2009 International Federation Global Measles and Polio Initiative budget is CHF 1,052,406 (approx US\$ 1,025,646). Approximately CHF 9 million (US\$ 8,770,066) has been raised for measles and polio SIA social mobilization activities since 2001. The Initiative is managed by the International Federation's Health and Social Services Department, and annual appeals can be viewed at: www.ifrc.org/where/global.asp.*

as “social mobilization” are increasingly recognized as a critical component of successful campaigns. Evidence for this is the development of polio and routine immunization communication indicators, the advent of polio-specific country communication strategies, commissioning of polio communications surveys, and organization of annual polio communication reviews for the endemic countries. UNICEF, with the mandate for communications, takes the lead within the GPEI for country-level communications and social mobilization around NIDs/SNIDs.

To support the involvement of Red Cross and Red Crescent National Societies in their national polio eradication efforts, the International Federation maintains a small budget of flexible social mobilization funds raised through the annual Global Measles and Polio Initiative (the Initiative)². This funding, which is allocated to individual National Societies via proposals to the International Federation in Geneva, enables National Societies to be key partners in their NIDs/SNIDs and to respond to requests for social mobilization support from their ministries of health and other polio eradication partners.



3.

Background to the evaluation

With the re-infection of countries across Africa, and the corresponding increase in planned emergency response measures, the International Federation Initiative saw a significantly amplified demand for social mobilization funds beginning in early 2009. As the scale of the outbreak grew, and mass synchronized NIDs were planned for regional blocks in West, Central and the Horn of Africa, the full extent of the polio outbreak was realized.

At the request of WHO, and acknowledging that the Africa outbreak was a public health emergency and threatened progress towards the eradication goal, the International Federation launched the Africa polio outbreak emergency appeal (the appeal) for CHF 2.4 million (US\$ 2.3) in April 2009³. The tri-zonal appeal to cover the three International Federation Africa zones, West and Central, East and Southern Africa, initially included emergency response activities in 14 countries across Africa from February to the end of July 2009.

The 14 countries originally covered in the appeal were:

- Central Africa: Angola, Central African Republic, Democratic Republic of Congo
- West Africa: Benin, Burkina Faso, Côte d'Ivoire, Ghana, Mali, Niger, Togo
- Horn of Africa: Ethiopia, Kenya, Uganda, Sudan (North and South)

The appeal aimed to raise funds to enable Red Cross and Red Crescent National Societies to support the vaccination against polio of approximately 25 million children under five years of age.

As the polio outbreak spread throughout West Africa, additional countries were included in emergency response measures. In the first International Federation emergency appeal operations update published in May 2009 three countries, Guinea, Liberia and Sierra Leone, were added to the appeal. A subsequent operations update in August 2009 requested the extension of the appeal timeframe to the end of November to encompass activities where funds had already been secured but not yet received. The last activities supported with funds generated by the emergency appeal were conducted in South Sudan from 5–7 December 2009.

3. The emergency appeal can be viewed at: www.ifrc.org/cgi/pdf_appeals.pl?09/MDR61004-65005-63002.pdf.

In October 2009, the International Federation initiated an evaluation of the emergency appeal polio immunization activities, the results of which are reported below. Country visits (four in total), in-depth partner interviews and secondary data analysis form the basis of the report findings. This report should serve as an advocacy tool for strengthening both global and national partnerships concerned with polio eradication, utilizing the role of the Red Cross Red Crescent and its network of volunteers.

4.

Aim of the evaluation

The overall aim of the evaluation is to provide an independent assessment of the Red Cross Red Crescent added value, as financed through the emergency appeal, to the 2009 polio outbreak response across the African continent.

Specific objectives of the evaluation are:

- > to evaluate at district (or state/province) and national level the added value of four National Societies: Uganda, Sudan, Côte d'Ivoire and Burkina Faso, in their 2009 polio outbreak response
- > to assess the perceived added value of the Red Cross Red Crescent in overall social mobilization efforts and activities for polio eradication
- > to outline how the International Federation and National Societies might improve their contribution to broader polio eradication efforts
- > to propose actions to GPEI partners for improving coordination with the Red Cross Red Crescent

5.

Evaluation methodology

The evaluation team consisted of two consultants, with a lead consultant who visited all four of the countries chosen for evaluation, compiled the data, analysed findings, wrote two of the country reports (Côte d'Ivoire and Burkina Faso) and this overall report. The other consultant participated in all of the above, but visited Uganda and the Sudan only; this consultant also took the lead in writing the Uganda and Sudan country reports.

Primary data collection methods included desk review of activity reports, key informant interviews with representatives from polio stakeholders at the district, national and global level, such as WHO, UNICEF, Rotary and CDC, country-level working meetings and household monitoring visits (in South Sudan, Côte d'Ivoire and Burkina Faso). Review of administrative campaign coverage, as well as independent monitoring data were included, where available.

In order to obtain comparable data the consultants developed a series of questions which were asked of all stakeholders interviewed during the course of the evaluation. This questionnaire is reproduced as Annex 5.

In between the East and West Africa country visits, the lead consultant spent one week in Geneva for debriefing purposes and to adjust, where necessary, some of the evaluation methods. During this period, the consultant decided it would be valuable to meet with and interview more households while visiting districts, in order to gain a better understanding of the local population's perception of the Red Cross Red Crescent volunteers' work and involvement in polio eradication in their community. The consultant also prepared, with the assistance of the respective National Society, WHO and UNICEF country offices, to have campaign coverage and monitoring data available at the time of the country visits.

6.

Scope of the evaluation

Out of the 15 countries that received funding through the 2009 Africa polio outbreak emergency appeal, four were visited during the evaluation:

- Uganda: 15—21 October 2009
- Sudan: 22 October—3 November 2009
- Côte d'Ivoire: 10—16 November 2009
- Burkina Faso: 16—24 November 2009

The four countries chosen for evaluation visits serve as good indicators of what happened in all of the countries undertaking activities funded by the appeal. The situation in three of the countries visited was found to be quite similar, and reports received from the National Societies in the other eleven countries demonstrated further similarities. The exception was Sudan, as can be seen in the country report found in Annex 2. Annexes 1, 3 and 4 consist of full reports for the other three visited countries.

In each of the four countries visited, the consultant team interviewed National Society staff and volunteers, WHO and UNICEF staff and ministry of health Expanded Programme on Immunization (EPI) staff. In select countries the team met with other polio partners, such as Rotary and United Nations representatives, and visited households (Sudan, Côte d'Ivoire and Burkina Faso). Discussions with International Federation representatives were also held in Sudan, Côte d'Ivoire and Burkina Faso. Interviewees included both technical programme officers and management or government level stakeholders. At the global level, GPEI partners from WHO and UNICEF provided invaluable guidance and background information. In total 217 people were interviewed during the course of the evaluation.

7. Findings

7.1 Uganda

The first country visited was Uganda, where the consultants interviewed a total of 35 persons. With all interviewees, the team discussed the involvement of the Uganda Red Cross Society (URCS) in polio rounds, using the list of questions found in Annex 5 as a baseline. Those interviewed included:

At URCS national offices:

- > Secretary-General
- > Deputy Secretary-General
- > Head of the Health and Care Department
- > URCS special consultant on polio and measles campaigns

At branch offices Kampala West, Kampala South, Masindi and Lira:

- > the branch coordinators and several volunteers

From international organizations:

- > UNICEF representative
- > several UNICEF Kampala-based health programme staff
- > one member of staff from the UNICEF Lira Office
- > WHO team leader
- > several WHO health staff in Kampala
- > head of WHO sub-office in Lira

From the Ministry of Health:

- > Programme Manager, UNEPI
- > District Health Officers of Masindi and Lira Districts and several of their staff

Most of the URCS funding raised by the International Federation emergency appeal was spent during the April polio round. Funds were also received from the American Red Cross for the June integrated measles and polio round. Funds for both the April and June polio activities were spent on social mobilization activities. These consisted of participation in planning meetings, training of volunteers and four days of pre-campaign activities, followed by during-campaign activities, including house-to-house visits, assisting at fixed sites and searching for missed children during mop-ups. There was also one day of post-campaign review during the April round, with lessons learnt to strengthen the performance in June.

URCS activities were guided by the national communication and mobilization strategy developed by the MoH, WHO and UNICEF, and then incorpo-

rated into district level micro-plans. This strategy translated into door-to-door mobilization, use of radio talk shows and radio announcements, mobilizing schools and schoolchildren, delivering flyers, as well as cooperation with faith-based organizations, Rotarians, village health teams and local councils.

In the course of the team's evaluation visit, it became clear that URCS at the branch level is known to stakeholders as an implementing agency, with particular talent in social mobilization, and is well respected for its performance in polio and measles rounds. The majority of partners with whom the consultants spoke, both governmental and non-governmental, believed that the URCS interventions were effective and made a difference in the districts where they worked. At the national level, however, there is much less awareness of the URCS role and less understanding of how URCS works.

Since Uganda has had no wild poliovirus cases for almost ten years, until the renewed outbreak in February 2009, it became clear in the course of the visit that all stakeholders, including the URCS had become "rusty" when it came to preparing for and implementing NIDs. But as lessons learnt were applied from one round to the next, overall coverage results, as well as public awareness, increased.

Main findings of the country visit included:

- > the need to raise the visibility of the Uganda Red Cross Society nationally, both with partners and other major stakeholders
- > the need to expand on the great potential for utilization of the URCS volunteer network in future polio rounds and for post-campaign monitoring
- > the need for an improved flow of information and more transparency, from the International Federation Zonal Office in Nairobi to the URCS, as well as from International Federation headquarters in Geneva to the Zonal Office, concerning available funds for polio campaigns

7.2 Sudan

In Sudan, the consultants interviewed a total of 54 persons. These included:

In Khartoum:

- > International Federation Sudan country representative, Head of Programmes and Chief of Finance
- > Head of International Federation in Juba (newly appointed and not yet at duty station)
- > Sudanese Red Crescent Society (SRCS) Director of International Cooperation
- > SRCS Head of Health Department
- > WHO polio team leader for Sudan

- > several health staff from UNICEF Sudan
- > President of Rotary in Sudan

In Juba:

- > SRCS Director and Deputy Director
- > Head of Health of SRCS Southern Secretariat
- > SRCS Juba Branch Director
- > Health Delegate of the Netherlands Red Cross Society
- > officers and members of the newly formed Juba Rotary Club
- > Director of EPI for the Government of South Sudan (GOSS)
- > WHO polio team leader for South Sudan
- > Director General for Health and the EPI Operations Manager for the State of Central Equatoria
- > Chief of Operations, the Head of Health, and the social mobilization consultant of UNICEF South Sudan
- > Deputy Director and the Head of Volunteer Programmes of ICRC South Sudan
- > Head of the UN system in South Sudan
- > the visiting International Federation East Africa Zonal Programme Officer from Nairobi
- > a Programme Officer from USAID Juba

In the field in South Sudan (Wau and Aweil):

- > Branch Director and other staff of SRCS Wau Branch
- > Head of UNICEF in Wau
- > WHO Medical Officer for Bahr El Ghazal (BEG) States, and staff of the State EPI Office
- > UNICEF programme officer for BEG
- > Director-General of Health for Western BEG
- > staff of the SRCS Aweil Branch
- > Director-General of Health and staff of Northern BEG State
- > WHO and UNICEF staff based in Aweil, and an international STOP team member based in Aweil

The majority of the country visit was spent in South Sudan and coincided with the October 2009 NID. As there were delays in the delivery of the International Federation's emergency appeal funding for South Sudan, the consultants were unable to evaluate the value-added of SRCS and its volunteer network there. They therefore concentrated on the partnership effort as a whole in South Sudan, and on analysing the underlying causes of the delay of arrival of funding, as well as IEC materials which had been printed in Nairobi. The consultants also took the opportunity to assist the SRCS Southern Secretariat to plan for the upcoming December round. Furthermore, during the country visit, the consultants had the opportunity to monitor the October 2009 NID and observe the very limited SRCS social mobilization role in Wau and Aweil.

An amount of CHF 52,250 (US\$ 50,900) emergency appeal funding was, however, received by the SRCS in Khartoum for the April 2009 NID. The bulk of this was allocated to the northern states, with only a very small amount spent in South Sudan, spread over two states (Bentiu and Malakal). A second round of funding was intended for South Sudan for the October campaign, but was late arriving, causing the difficulty in evaluating the activity. This funding, both in the north and the south, was spent for incentives for the Red Crescent volunteers, who worked as social mobilizers and, when properly trained, as additional vaccinators, as well as on social mobilization materials and transport.

It should be remembered that international and national organizations (UN agencies, SRCS, International Federation, Rotary and others), work under the necessity to conform to a “one government, two systems” concept. While there is a government of Sudan as a whole, existing in Khartoum, there is also a government of South Sudan (GOSS). Khartoum services the 15 northern states, while GOSS services the ten southern states. There is often insufficient sharing of information, and poor coordination between North and South Sudan. There is one national Sudanese Red Crescent Society with headquarters in Khartoum, and a SRCS Southern Secretariat Branch office in Juba which services South Sudan. In this difficult programmatic environment, the GPEI is attempting to re-eradicate polio for the third time from South Sudan. With further support, the SRCS in South Sudan could, for instance, be given responsibility for geographically-isolated or hard-to-reach areas that would otherwise receive inadequate polio vaccination services. The capacity of the GOSS to drive this effort, however, is limited.

Main findings of the country visit included:

- > weakness in the coordination of the GPEI partnership, resulting in partners not achieving their potential
- > the need for ownership of the GPEI, and thus the NIDs, on behalf of the GOSS and its health officials
- > the need to raise the visibility of the Sudanese Red Crescent Society nationally, both with partners and other major stakeholders
- > the need for extensive capacity building of the SRCS in South Sudan, which could be achieved with the help of partner Red Cross Red Crescent National Societies, already present in the South, acting as mentors
- > the need to address the serious funding issue of the SRCS in South Sudan. With very few financial and logistical resources it is difficult for the SRCS Southern Secretariat to perform its mandate

7.3 Côte d'Ivoire

In Côte d'Ivoire, the consultant interviewed a total of 51 persons. These included:

In Abidjan:

- > Secretary-General of the Red Cross Society of Côte d'Ivoire (CRCI) and his Assistant
- > CRCI National Coordinator for Community Health
- > CRCI National Coordinator for STI/HIV/AIDS
- > International Federation Regional Health Coordinator from the Office in Abuja
- > President and Vice-President of Côte d'Ivoire Rotary
- > Head of the WHO Country Office Vaccinations Programme and four of his team members
- > a representative from the Health Department of the UNICEF Country Office
- > the Côte d'Ivoire Ministry of Health/EPI Director, Deputy-Director, EPI/Head of Communications and six other EPI staff

In Tiassale and Divo districts:

- > Directors of Health
- > representatives and volunteers from the local CRCI branches

In Divo, the consultant also conducted a brief interview with the Regional Director for Health and Public Hygiene. In both districts visited, the consultant, accompanied by staff from the CRCI headquarters office, went to various households and interviewed parents or caretakers in order to assess the performance of Red Cross volunteers during the NIDs.

All the International Federation emergency appeal funding received by the CRCI was spent during four NIDs out of a total of six held in Côte d'Ivoire up to mid-November 2009. These were held in February, March, June and August 2009. The choice of districts and their respective Red Cross branches receiving support (ten for the first three rounds and six districts for the August round) was based on a combination of number of wild poliovirus cases identified, district vaccination coverage levels and capacity of the district Red Cross branch. Most of the CRCI funding, in all four rounds, was spent on social mobilization activities. These consisted of participation in planning meetings, training of volunteers, and during-campaign activities for the four days of the NID, including house-to-house visits, assisting at fixed sites like markets, railroad and bus stations, and searching for missed children during mop-ups. It should be noted that there were no pre-campaign house-to-house social mobilization visits conducted by Red Cross volunteers in Côte d'Ivoire. All activities conducted by the CRCI were guided by the national communication and social mobilization strategy that had been developed by the Ministry of Health, WHO, UNICEF and Rotary International, and then incorporated into district level micro-plans.

At the national level there is very good awareness of the CRCI role and how it works. United Nations agency partners, as well as the MoH/EPI staff were well aware that the CRCI had participated significantly in four of the NIDs held in 2009. The majority of partners, both governmental and non-governmental, believed that the CRCI interventions were effective and made a difference in the districts where performed. According to the National Director of EPI, the CRCI has helped “sell” immunization to the population through social mobilization and communication and not only advised, but also convinced people about immunization in general and the polio programme in particular. In cases of vaccination resistance or refusal, CRCI volunteers have been able to resolve non-compliance and produce higher vaccination coverage levels.

All partners believed that coordination had improved because of the polio eradication activities, and was growing stronger as a result of lessons learnt during each round.

Main findings of the country visit included:

- the need for CRCI volunteers to deliver their social mobilization messages house-to-house prior to the NIDs, rather than during NIDs only, in order for campaigns to be more effective
- the need for incentives for Red Cross volunteers and government mobilizers to be equalized, as in some districts, there is a difference in per diem rates
- the requirement for CRCI to reinforce the community angle of the NIDs and continue to carry out social mobilization activities in the areas and villages of origin of the volunteers
- the need for CRCI to reinforce community awareness and involvement during a polio round and focus on isolated and distant communities, where, through local volunteers, they can reach more of the population than government agents
- the need to avoid duplication of effort and to maximize communications capacities, by sharing information with partners, particularly with UNICEF, about districts where Red Cross volunteers will operate
- the potential of channelling GPEI funding support for social mobilization for NIDs through CRCI directly, at least in part, to be more effective
- the need to expand on the great potential of the CRCI volunteer network in future polio rounds and for post-campaign monitoring
- the need to raise the visibility of the Red Cross Society of Côte d’Ivoire nationally, both with partners and other major stakeholders

7.4 Burkina Faso

The last country to be visited during the evaluation was Burkina Faso, where the consultant interviewed a total of 62 people. These included:

In Ouagadougou:

- > Burkinabe Red Cross Society (CRBF) Acting Secretary-General and Head of the Health Programmes
- > International Federation Sahel Region Health Manager from the West and Central Africa Zone Office in Dakar
- > Manager of the Health and Nutrition Department and Health and Immunization Project Officer from the UNICEF country office
- > WHO EPI Inter-country epidemiologist, and two WHO EPI/Health staff
- > Acting EPI Director and the Finance Officer from the Ministry of Health

In Boromo, Dedougou, Solenzo and Bobo Dioulasso districts:

- > representatives from the local CRBF branches and volunteers
- > CRBF District Health Officers and several of their staff

A visit was also scheduled to Tionkuy village where the consultant met with health staff. In all four districts visited, the consultant met with various households and interviewed parents in order to assess the performance of CRBF volunteers during the NIDs.

The International Federation emergency appeal funding received by the CRBF was spent during two polio rounds, in March and May/June 2009. As the budget for transport was very limited, selection of districts for social mobilization support prioritized those districts where polio campaigns were not usually undertaken, and which were easily reachable by volunteers. CRBF headquarters also wished to test the capacity of particular local Red Cross branches. All activities by the CRBF volunteers in the districts were carried out in collaboration with the district MoH, with the latter providing training. Most of the CRBF funding, in both rounds, was spent on social mobilization activities, including the production of IEC materials such as T-shirts, as well as some leaflets in local languages. Other activities included participation in planning meetings, training of volunteers and three days of pre-campaign activities, followed by during-campaign activities for the four days of the NIDs in most of the country's districts. During campaign days, activities included house-to-house visits, assisting at bus stations and markets and searching for missed children during the last NID day, as well as during mop-ups. Focus group discussions were also held in public places.

There is no clear national communication and mobilization strategy in Burkina Faso. As a consequence, districts are mostly left to their own devices, resulting in often different approaches and micro-plans. Resources for social mobilization are limited at the district level, but the house-to-house approach of the CRBF volunteers had a great impact and was much appreciated, not only by the local health authorities, but also by the people in the communities, as was witnessed by the consultant while visiting households in some districts.

CRBF branch offices at the district level are known to stakeholders as an implementing agency with particular talent in social mobilization. The National Society is well respected for its performance in polio, meningitis and measles campaigns. All partners, including governmental (at district level) and non-governmental, believed that the CRBF interventions were effective and made a difference in the districts where they were performed. At the national level, however, there is much less awareness of the CRBF role and even less understanding of how the CRBF works. UN agency partners, in contrast, were well informed and aware of CRBF involvement in the NIDs and very much welcomed the Society's support.

Suggestions to enhance this support in future rounds included expansion of number of days of social mobilization by CRBF volunteers to cover at least four days prior to the NID and focusing on intensified pre-campaign social mobilization. At the community level, in almost all places visited, the CRBF was perceived to be trusted by the community, especially when the volunteers were wearing some form of Red Cross identification. People were always willing to allow these volunteers into their homes and listen to their explanations about polio campaigns.

Main findings of the country visit included:

- the need to raise the visibility of the Burkinabe Red Cross Society nationally, particularly with the government, but also with other partners
- the need for a higher level (at the management hierarchy) representation of the CRBF at partner and government level meetings, as at these coordination meetings policies and capacities of CRBF can be explained and fund-raising advocated
- the need for CRBF national head office to work to increase the visibility of local branches and their members, particularly in those districts and sub-districts where the leadership is weak
- the need to expand on the great potential for utilization of the Burkinabe Red Cross Society volunteer network in future polio rounds and for post-campaign monitoring

7.5 Other countries receiving appeal funding

Information and reports written by the respective National Societies are available at the International Federation in Geneva for the remaining 11 countries in receipt of appeal funding. It appears that emergency appeal funding was mainly spent on social mobilization activities in all countries concerned. In some cases, Red Cross Red Crescent volunteers performed their social mobilization activities prior to the polio campaign, and in some during the NID. In general, it was a combination of both. It also appears that lessons learnt from a previous round were almost always applied for the next NID.

Information-sharing and collaboration with the central and local health authorities varied from country to country, although some evidence shows that there was far better cooperation and mutual understanding at the district or local level than at the central level. Most National Societies also worked together with other GPEI partners like WHO and UNICEF, although the extent of this collaboration needs some clarification. Furthermore, it is obvious that the overall impact and success of Red Cross Red Crescent involvement in polio campaigns greatly depend on the strength of the National Society and its level of coordination with other polio stakeholders.

Recommendations and lessons learnt from these 11 countries can be summed up as follows:

1.

Increased support from partner National Societies acting as mentors to help build the capacity of National Societies is required, particularly at the branch level, so that Red Cross Red Crescent volunteers are better prepared and equipped to assist during national vaccination campaigns.

2.

In almost all countries there is a need to put in place or to improve joint micro-planning to avoid duplication of effort, have a more streamlined coordination of social mobilization activities, and thus maximize the overall results and coverage levels of polio campaigns.

3.

At the branch level the National Societies are advised to undertake proper mapping of all communities where their volunteers will be active during NIDs, particularly since volunteers should be working in the communities in which they live. This information should be shared with other GPEI partners and stakeholders.

4.

There is a need for enhanced visibility and advocacy with the respective ministry of health EPI sections, as well as with other GPEI partners, in order to facilitate a more integrated approach and streamlined collaboration.

5.

There is a need for early planning of polio campaigns, in order to secure funds and agreements, and allow for timely and focused participation in NIDs.

8.

Conclusions

Country-specific conclusions can be drawn from the results summarized above, as well as from the separate country reports found in the annexes. At the global level, conclusions can be summarized as follows:

1. There is **great potential for using the Red Cross Red Crescent volunteer network** in social mobilization efforts for polio rounds, particularly for pre-NID social mobilization, but also for post-campaign monitoring.
2. **Sufficient funding and other resources to cover the various social mobilization activity requirements must be available** in good time before a campaign. Currently, all social mobilization activities that are carried out by National Societies are funded through the International Federation, and there is no coordination of budgets with the other GPEI partners. Joint mobilization and communication budgets would make social mobilization activities more effective.
3. **Sufficient time** is necessary to prepare Red Cross Red Crescent volunteers for a specific task, such as carrying out social mobilization activities before a NID. Sufficient lead time is also needed for training and proper planning in order to have optimal volunteer performance.
4. Most National Societies have **branches or sub-branches in every district or state** in the country, with a network of volunteers in each branch. Volunteer networks are extensive and can be quickly mobilized, relative to other social mobilization strategies.
5. The type of social mobilization carried out by Red Cross Red Crescent volunteers is particularly effective. With the **extensive network of volunteers who live within communities**, there is a depth of reach. Volunteers can also make contact with community members, such as those living remotely, or the illiterate, who may not otherwise be reached with other social mobilization methods.
6. The network of volunteers is very **cost-effective**, with incentives usually between two to four US dollars per day per volunteer.
7. **Partners often do not fully understand the work of the Red Cross Red Crescent** in health activities, particularly for hard-to-reach, vulnerable sectors of the population.
8. **National Societies are generally under-resourced** when it comes to human resources and also do not have sufficient staff with technical polio expertise.
9. Often, the **poor communication** between polio partners may result in duplication of effort or unclear roles and tasks.

9.

Recommendations

GPEI partners and stakeholders are recommended to consider the following:

1. Knowledge and understanding of how the International Federation and National Societies function should be further developed in order to improve incorporation of the Red Cross Red Crescent value in polio eradication efforts.
2. The Red Cross Red Crescent network of volunteers should be used much more extensively by GPEI partners, particularly taking into consideration its effectiveness in reaching a large proportion of the population, and its cost-effectiveness.
3. The role of the Red Cross Red Crescent National Society in national communications and social mobilization strategies should be enhanced and written into the overall global eradication plans of action. Ensuring that national polio communications strategies outline the role of every partner, including the International Federation and the National Society, will improve coherence of campaigns and maximize success. Joint mobilization and communication budgets would make social mobilization activities more effective.
4. UNICEF should provide social mobilization funds not solely through the respective governments via the health ministry, but directly to the Red Cross Red Crescent, using its volunteer network as social mobilizers and communicators. UNICEF has already shown some interest in exploring this possibility further.
5. GPEI agencies should consider supporting National Societies with technical assistance in order to enable them to be a more effective partner. Alternatively, the National Society should look for additional human resource support in their national health ministry.
6. Other funders like Rotary or the Gates Foundation should consider National Societies as funding recipients for social mobilization and communication activities for polio campaigns.
7. Where appropriate and assuming adequate capacity of the National Society, WHO and the national health/EPI Department should task the Red Cross Red Crescent with reaching geographically isolated or hard-to-reach areas that would otherwise receive inadequate polio vaccination services.
8. Red Cross Red Crescent contribution to NIDs should be systematically evaluated as part of the overall campaign's social mobilization and communications activities. This can be done through inclusion of Red Cross Red Crescent specific questions on independent monitoring forms (see Annex 7 for an example) as well as in larger evaluations.

The International Federation and Red Cross Red Crescent National Societies are recommended to consider the following:

1. The Red Cross and Red Crescent Movement should enhance their institutional capacity-building effort in order to strengthen the National Societies in many of the African countries. The International Federation should take the lead in this, building upon existing efforts by supporting National Societies and the ICRC, where appropriate.
2. The International Federation should facilitate exchanges on lessons learnt after each NID between National Societies. The Federation should also encourage strong National Societies to act as mentors to improve and increase capacity building in those less strong.
3. The International Federation should seek funding at the global level for specific countries, seeking for the donor to fund a National Society directly or through UNICEF. The Federation should also support local fund-raising efforts.
4. Funding should arrive at the appropriate time at National Society level, not only for future polio rounds but for all other programmes, in order to allow for adequate planning. Late arrival of funds complicates relationships with partners, in terms of sharing information, or deciding who will be able to contribute to social mobilization efforts. In turn, timely financial feedback reporting from the National Society to the International Federation should also be provided, in order not to jeopardize future funding. The International Federation should improve its financial management system, not only within the Federation itself, but also when dealing with National Societies.
5. National Societies should enhance capacity building in branches in order that Red Cross Red Crescent members and volunteers should become more valuable partners in the GPEI. Greater consideration should be given to other roles that the International Federation and National Societies could play in supporting polio eradication.
6. National Societies should work with other civil society partners, such as Rotary International, for joint fund-raising and advocacy for their social mobilization and communications efforts for NIDs.
7. Most National Societies need to raise their visibility nationally, with partners and other stakeholders. There should be a higher level representation of the National Societies at partner meetings on any given subject, not just polio.

Overall, the evaluation team encourages GPEI partner organizations to realize the potential of the Red Cross Red Crescent, and the role it can play in polio eradication. It is only with cooperation and collaboration of all GPEI partners that polio can be successfully eradicated from these re-infected African countries. If National Societies are regularly and systematically invited to take part in all planning, preparatory and decision-making meetings related to polio eradication rounds, and therefore given an opportunity to provide

social mobilization activities, their strengths and capacities will be further realized. ■



Annex 1

Uganda country visit

Following consultations with staff from the International Federation of Red Cross and Red Crescent Societies in Geneva, WHO and UNICEF Global Polio Eradication Initiative (GPEI) staff in Geneva, and Nairobi Zonal-based American Red Cross staff, the consultancy team visited Uganda from 15—21 October 2009. Usually accompanied by Daniel Musoke, Immunization Programme Officer of the Uganda Red Cross Society (URCS), the team held an extensive series of interviews with various stakeholders in Kampala, Masindi, Lira and Entebbe.

At the URCS national offices these meetings included the Secretary-General and the Deputy Secretary-General, the head of the Health and Care Department, and the URCS special consultant on polio and measles campaigns. Meetings were also held with the Branch Coordinators and several volunteers in each of four URCS branches, Kampala West, Kampala South, Masindi and Lira. Meetings with representatives from international organizations included the UNICEF Representative, several UNICEF Kampala-based health programme staff and one member of staff from the UNICEF Lira office, the WHO Team Leader, and several WHO health staff in Kampala, as well as the head of their sub-office in Lira. From the Ministry of Health, the Programme Manager, UNEPI, the District Health Officers of Masindi and Lira Districts and several of their staff were interviewed. For a full list of interviewees, see Annex 6.

From the funds raised by the International Federation Africa polio outbreak emergency appeal, the sum of CHF 240,024 (US\$ 234,000) was allocated to Uganda. However, according to Mr Musoke only US\$⁴ 391,855,876 (equivalent to US\$176,115, or CHF 201,828, at the then exchange rates) was received by the URCS for programme activities. This emergency appeal money was all spent on the April 2009 polio immunization round.

For the June round, an integrated polio/measles round, a sum of approximately US\$ 245,000 was received directly from the American Red Cross for implementation of activities.

This review and its conclusions stem mainly from URCS activities in these two rounds, April and June. However, it should be noted that URCS also participated in the January, March, August (SNID) and October rounds. Participation in these latter rounds was significantly reduced in size and scope since there were no extra financial resources available to provide incentives and mobilize the volunteer structure.

4. US\$ = Uganda shilling

Almost all of the URCS funding (both April and June) was spent on social mobilization activities, beginning with participation in planning meetings, training of volunteers, and then four days of pre-campaign activities. These were followed by during-campaign activities for the three to four days of the campaign, including house-to-house visits, assisting at fixed sites, searching for missed children, and so on. Finally, there was one day of post-campaign review in the April round, with lessons learnt to strengthen performance in June. In the April round it was estimated that 3,500 volunteers were mobilized in 15 branches covering 11 districts of Uganda. During the June round there were 4,200 volunteers selected and trained in 15 districts.

These activities by the URCS were guided by the national communication and mobilization strategy developed in collaboration with the MoH, WHO and UNICEF, and incorporated into district level micro-plans. This strategy called for door-to-door mobilization, use of radio talk shows and radio announcements, mobilizing schools and schoolchildren, delivering flyers, and cooperation with faith-based organizations, Rotarians, village health teams and local councils.

In addition to social mobilization activities, volunteers also gave some support for poorly performing government efforts, on an ad hoc basis, particularly in Kampala urban districts.

URCS at the branch level is known to stakeholders as an implementing agency, with particular talent in social mobilization, and is well respected for its performance in polio and measles rounds, as well as in other health activities. Virtually all partners, both governmental and non-governmental, believed that the URCS interventions were effective and made a difference in the districts where they worked. At the community level, in at least some communities, the URCS is more trusted by the community than government agents are.

Using the data available and information gathered in the field as a guide, it is the opinion of the consultants that coverage was almost certainly higher in districts where URCS volunteers were mobilized. It is not, however, possible to provide hard data to support this opinion. There was no specific independent post-campaign coverage monitoring. Published coverage data rely on out-of-date census figures, and data for the different districts may not be reliable. For example, reported coverage figures range from 78 per cent to 161 per cent for the June round. The chart below shows the data that were reported for the districts supported by URCS (11 in April and 15 in June), but consideration of the figures must bear in mind the limitations of inadequate post-campaign independent monitoring.

Figure 1: March, April and June polio immunization rounds in Uganda

	March	April	June
District			
	%	%	%
Kampala	64.8	77.4	78
Lira	109.6	111	111
Dokolo	104	104	
Amolator	124	124	
Apac	107	104	121
Oyam	112	119	
Kotido	105	96.6	
Kaabong	89	101.6	
Moroto	65	89	
Nakapiripirit	98	106	
Abim	81	96	
Bushenyi			100
Iganga			110
Kamuli			105
Kanungu			125
Kisoro			127
Masindi			98
Masaka			93
Mbarara			104
Mukono			104
Nebbi			161
Pallisa			133
Soroti			114

Source: UNEPI

Notes:

- > All figures are percentages of children under the age of five years covered in the round, based on Uganda census data.
- > In the March round, there was no URCS activity. In the April round, URCS activity took place in 11 districts with emergency appeal funding. In the June round, there was URCS activity in 15 districts in an integrated polio/measles round, with American Red Cross funding.

The national level

While the role of URCS is well understood at branch level, at the national level there is much less awareness and less understanding of how URCS works. The UNEPI Programme Manager was only vaguely aware that URCS participated to a great extent in the April round, though he had a good and positive memory of the June round and other activities that URCS carries out for routine immunization. United Nations agency partners exhibited some ignorance of the standard operating procedures of URCS, indicating that they had not been adequately briefed.

It is clear that URCS plays a negligible advocacy role at the national level with the government, although its role is more significant at the branch/district level.

The consultants questioned the choice of branches selected for support in the April round with the emergency appeal money. In response, the URCS explained that the 11 districts (15 branches) chosen for support were indeed low performing ones in terms of immunization coverage, but that since they did not receive the notice of firm funding availability until about seven to ten days before the round began, they necessarily had to go to branches which had other ongoing health programmes being implemented by URCS volunteers. In short, there simply was no time to mobilize volunteer networks in other, probably higher risk, districts.

WHO and other partners believed that coordination was stronger because of the polio rounds, and was specifically stronger in the June round as a result of lessons learnt in April. The UNEPI Programme Manager reactivated the National Coordinating Committee (NCC) forum specifically for coordination purposes and this seemed to work well. The URCS played a significant role on the social mobilization subcommittee. However, except for the presence of their consultant John Barenzi (former head of UNEPI), the URCS representation at the NCC was at too low a hierarchical level to have much influence. It is suggested that if the Director of UNEPI chairs a NCC meeting, then URCS needs to reciprocate with the attendance of a URCS member at an equal level of hierarchy. In the opinion of the consultants, this means that either the Head of the Health and Care Department, or the Deputy Secretary-General needs to attend NCC meetings. This level of attendance highlights to other partners attending NCC meetings that the URCS is a serious actor in polio eradication.

While many things went well in the campaigns, there were many other things that were not so successful. Very often the effective social mobilization efforts created demand at fixed sites that could not be met because of late arrival of vaccines or immunization workers, and communities were therefore frustrated. This damaged the credibility of both the programme and the URCS. Evidence for this can be seen in the transcripts of meetings held during the field visits made by the consultants.

Furthermore, in the June round in many immunization posts, markers dried up, complicating coverage reporting by external monitors. Tally sheets were often not correctly filled out. In addition, frequently there was too little, or no, participation or support from the local councils.

It does appear that the April and June rounds combined enhanced the visibility of URCS at the community levels where they worked, as well as strengthening their partnership with global partners of GPEI, especially UNICEF, although there is still much work to be done to achieve an optimal partnership and mutual understanding. The participation of URCS volunteers was indeed cost-effective. The cost-effectiveness of URCS in social mobilization for GPEI is further explained in the section below.

The URCS volunteer network clearly offers a significant opportunity to the Government of Uganda and to GPEI partners nationally to be used in a variety of ways. Volunteers can be used for social mobilization, for supporting the logistical movement of vaccines, and, most importantly, for post-campaign monitoring of coverage, an area of universal weakness in Uganda. With six to eight weeks advance notice, and with funding available for volunteer incentives, the URCS can mobilize their network in virtually any district of the country. It simply takes planning to identify where they should be used, and relatively minimal amounts of money to support the implementation. At present this capacity represents a significant missed opportunity for GPEI.

Overall findings

Three major conclusions were presented at the closing meeting with the URCS Secretary-General and his senior management team, as follows:

1. There is indeed added value to URCS activities on social mobilization for polio. URCS can perform this function effectively, efficiently and well because of its extensive and mobilized volunteer network. In the case of the IFRC Africa polio outbreak emergency appeal funds, in Uganda these funds were all spent in the April round. However, because the funding from IFRC was not received in Uganda until approximately seven days before the round began, it was necessarily programmed in some 15 URCS branches in Uganda where there were already ongoing, strong, mobilized volunteers for other health sector programmes. In short URCS decided to go to districts, admittedly low performing ones in terms of immunization coverage, where it already had capacity, rather than attempt to go to new ones where it would have to mobilize its volunteer network. There simply was no time for the latter. This late⁵ arrival of funds also complicated relationships with partners, in terms of sharing information; for example, some partners expected URCS, having received International Federation funds, to donate to the common donor pool of financial support (usually channelled through government) to the polio rounds.

5. *It must be noted that the funds were not really "late". The appeal was launched in early April, money raised quickly and activities were front-loaded so the April round could be supported. It was the pressure to spend money quickly that really caused the problems.*

2. There is great potential for utilization of the URCS network of volunteers in future social mobilization efforts for polio rounds, for post-campaign monitoring of polio rounds, or indeed, for other kinds of health activities. The URCS has branches or sub-branches in every district in the country, and has networks of volunteers in each branch. However, to activate them in a given branch for a specific objective, such as social mobilization for a polio round, two things are required: first sufficient lead time (three to four weeks) for the activation, and for any training necessary, and second, funding to cover the costs of the volunteers (incentives for lunch costs, or costs for transportation) and other costs (fuel, vehicle rental, etc.) necessary for the effort. The fact that such incentives are in the range of two to three US dollars per day per volunteer makes the network very cost-effective. It can and should be used much more extensively by partners.
3. There is a need to raise the visibility of the Red Cross Society nationally, with partners and other major stakeholders. Often the Red Cross is thought of as just a group of dedicated volunteers who respond in times of emergencies, particularly public health emergencies. Frequently partners do not understand the commitment of the Red Cross to work in health and other areas, both in emergency and development, particularly for hard-to-reach, vulnerable sectors of the population. Two ways this heightened visibility might be achieved are suggested below.
 - a) First, there needs to be higher level management hierarchy representation from URCS at partner meetings on any given subject. It is at such coordination meetings that policies and capacities of the Red Cross Red Crescent and the URCS in particular can be explained, and fund-raising can be advocated.
 - b) Second, URCS management needs to recognize that effective “partnering” requires time to collaborate with partners, negotiate with them, advocate with them, explain roles and working procedures, etc. At present, it appears that virtually all the URCS staff are overstretched, and subsequently little attention can be paid to such partnering techniques, with negative consequences for URCS both in terms of ongoing operations and in terms of raising additional funding for new operations where there is such great potential, as described above.

Annex 2

Sudan country visit

Following consultations with staff from the International Federation of Red Cross and Red Crescent Societies in Geneva, WHO and UNICEF Global Polio Eradication (GPEI) staff in Geneva, and (by telephone) with the programme officer from the Nairobi Zonal office who was responsible for technical support to the programme, the consultancy team visited Sudan from 22 October to 2 November 2009. The team held an extensive series of interviews with stakeholders in Khartoum, Juba, Wau and Aweil, often accompanied by staff from the Sudanese Red Crescent Society (SRCS).

Stakeholders interviewed included, in Khartoum, the International Federation Sudan Country Representative, Head of Programmes and Chief of Finance, the newly appointed Head of the International Federation in Juba, and the SRCS Director of International Cooperation and Head of Health Department. Interviews were also held with the WHO polio team leader for Sudan, several health staff from UNICEF Sudan and the President of Rotary in Sudan.

In Juba, stakeholder interviews included the Director, Deputy Director and Head of Health of SRCS Southern Secretariat, the SRCS Juba Branch Director, the Health Delegate of the Netherlands Red Cross Society, officers and members of the newly formed Juba Rotary Club, the Director of EPI for the Government of South Sudan (GOSS), the WHO polio team leader for South Sudan, the Director General for Health and the EPI Operations Manager for the state of Central Equatoria, the Chief of Operations, the head of health and the social mobilization consultant of UNICEF South Sudan, the Deputy Director and the head of volunteer programmes of ICRC South Sudan, the head of the UN system in South Sudan, the visiting International Federation zonal programme officer from Nairobi, and a programme officer from USAID Juba.

In the field in South Sudan, interviewees included the Branch Director and other staff of SRCS Wau Branch, the Head of UNICEF in Wau, the WHO Medical Officer for Bahr el Ghazal (BEG) states, and staff of the state EPI office, the UNICEF programme officer for BEG, the Director General of Health for Western BEG, staff of the SRCS Aweil Branch, the Director General of Health and staff of Northern BEG State, WHO and UNICEF staff based in Aweil, and an international STOP team member based in Aweil. A full list of those interviewed can be found in Annex 6.

Having already reinfected both Kenya and Uganda, the polio outbreak in Sudan is a threat to the Horn of Africa, as well as to the global polio eradication programme. Inside Sudan the outbreak is overwhelmingly in the south, with only four cases reported in the north as at the end of November 2009 (the last

one being 15 March) and 41 cases in the south. In spite of the last case in the south being reported in June 2009, the consultants believe that the outbreak continues there, given sub-quality Acute Flaccid Paralysis (AFP) surveillance, and sub-quality immunization rounds.

It is important to note that government structures in Sudan, as well as international and national organizations, such as United Nations agencies, the International Federation, SRCS and Rotary conform to a “one government, two systems” concept. That is, there is a Government of Sudan as a whole in Khartoum, but in reality it only services the 15 northern states, while the Government of South Sudan services the ten southern states. There is one national Sudanese Red Crescent Society, with national headquarters in Khartoum, but there is a SRCS Southern Secretariat Branch office in Juba which services South Sudan. Similar structures exist for United Nations agencies.

When analysing Sudan, it must be remembered that the political situation is complex. The GOSS is operating in an unstable political environment, with North Sudan failing to recognize the moves for independence by South Sudan. Security is unpredictable, with many believing that a resumption of active conflict is a real possibility. This political overlay consumes the attention of all actors, to the detriment of humanitarian as well as developmental programmes in South Sudan.

As a consequence of the political situation, there is a fundamental distrust between the two parts of the country, which affects government structures, agencies and national organizations and their staff. As a result, there is often insufficient sharing of information, and/or poor coordination, between North and South Sudan.

In this difficult programmatic environment, the GPEI is attempting to re-eradicate polio for the second (or third, depending on how one counts) time from South Sudan. The capacity of the GOSS to drive this effort does not exist. The capacity of the humanitarian organizations, collectively, is lower than during the war years (up to 2005), the conclusion of which saw the disbanding of Operation Lifeline Sudan.⁶ Thus the challenges facing the International Federation and the SRCS to assist in the polio eradication effort in South Sudan are indeed daunting.

For reasons explained below, there were serious delays as well as faulty programmatic judgements in the delivery of International Federation emergency programme assistance for the eradication of polio in South Sudan. This assistance was funded by two contributions. The first, from the British Red Cross (BRC), totalled CHF 52,250 (US\$ 50,900) in April 2009, but the bulk of this was allocated to the northern states, with only CHF 4,400 (US\$ 4,288) allocated to South Sudan, spread over two states. There was little or no accountability for the expenditures in these two states, and in fact the Southern Secretariat of the SRCS was not even aware that these expenditures had taken place.

6. *Operation Lifeline Sudan, set up in 1989, was a consortium of agencies (e.g. UNICEF, World Food Programme) and NGOs operating in South Sudan to provide humanitarian assistance throughout the civil war-induced famine and the drought.*

The second contribution was from the American Red Cross (ARC), with a sum of CHF 204,196 (US\$ 199,000) pledged in August 2009. At the time of the consultancy visit in October, only CHF 4,400 (US\$ 4,288) had been expended in the South, mainly due to funds not arriving in the field in time for the polio immunization rounds in July, August, September and October.

The terms of reference of the evaluation included the evaluation of the International Federation contribution to the global 2009 outbreak response. There was, in fact, little to be evaluated, at least in South Sudan where the polio outbreak exists. As these facts were gradually realized during the consultancy visit to the Sudan, they were documented and communicated back to the International Federation headquarters in Geneva. The consultants therefore concentrated on an analysis of underlying causes of the delays, as well as on the partnership effort as a whole in South Sudan, as described below.

While in South Sudan the consultants took the opportunity to assist the SRCS Southern Secretariat to plan for the upcoming December immunization round. This planning was undertaken with the express understanding that before SRCS could participate in the 5–7 December 2009 round, agreement for an additional funding extension would have to be approved by the donor, the American Red Cross. Furthermore, the consultants had the opportunity to monitor the October NID and observe the limited SRCS social mobilization role in Wau and Aweil during the country visit.

Internal International Federation organizational issues

Analysis of the BRC donation calls into question the allocation of the CHF 52,250 between northern states (eight received funding) and southern states (two received funding of CHF 2,200 each). When this programmatic decision was made by the staff of SRCS in Khartoum in early April 2009, the polio outbreak was only two cases in North Sudan as compared to 23 cases in South Sudan. The outbreak in North Sudan had been dealt with well. In South Sudan, however, the outbreak was continuing unabated, and had already reinfected both Kenya and Uganda.

No information was given to the SRCS Southern Secretariat that allocations were being made to two of their states, and the relevant staff in Juba were unaware of these allocations. Finally, there was limited accountability for the expenditure of these funds, with only a brief report received from SRCS Khartoum. Despite this imperfect reporting, however, it can be confirmed that the BRC funds were spent on polio eradication activities in both North and South Sudan as per the donor requirements.

With regard to the ARC donation, there were huge delays in the transfer of funds from International Federation East Africa Zone Office to the SRCS South

Sudan. Some three months after receipt of the pledge for this contribution, less than four per cent of the sum allocated had been received in South Sudan.

There were at least three issues to explain the delay. Restrictions placed on the donation as a result of US government sanctions on the authorities in Khartoum was the first issue. Sanctions required that no ARC funds could flow through Khartoum or be used to procure commodities from vendors in North Sudan. This restriction meant lengthy negotiations between ARC and the International Federation, and resulted in the Federation having to transfer funds in entirely new ways that were outside standard operating procedures, with resultant delays.

Secondly, there were serious International Federation staffing problems in Sudan. During the five months starting in May 2009 when initial discussions on a possible ARC pledge to the emergency appeal took place, there were lengthy vacancies in the posts of International Federation Country Representative in Khartoum, programme coordinator post in Khartoum and health delegate in Juba. The normal support and follow-up available to SRCS and required for transferring funds was therefore missing within the International Federation organizational structure.

Thirdly, there was insufficient International Federation appreciation of the complexities of working in South Sudan, or of the difficulties of shipping supplies to South Sudan.

The result was that the significant ARC donation went unspent during the August and October polio rounds in South Sudan.

Polio partnership issues

The Sudanese Red Crescent Society is only one actor in the range of agencies attempting to assist with polio eradication in the South. The consultancy review of programme implementation during the October polio round, in the states of Central Equatoria, Western Bahr el Ghazal and Northern Bahr el Ghazal revealed some weaknesses on the part of some of the other players as well.

Of the four core partners in the GPEI, Rotary is just being established in Juba and therefore understandably is feeling its way on polio eradication. CDC has a permanent presence in Juba, to assist GOSS, but does not have permanent polio eradication staff there. The CDC visiting staff are highly qualified and competent, but the consultants consider that a longer term presence is required to ensure continuity and effectiveness.

WHO is in the process of reorganization in South Sudan, filling vacancies at the state level in all of the ten states, and greatly increasing its logistical capacity. At the time of the consultancy visit in October the new WHO polio team leader had been in post for less than two months, and the reorganization process was not yet complete.

Finally, UNICEF, while the best organized of the four core partners, and the best staffed to perform its mandate, mainly vaccine procurement and social mobilization, also displayed minor weaknesses in letting standard operating procedures related to cash advances overcome priority programmatic decisions.

Given the weak capacity of the GOSS, the presence and the effective performance of the core GPEI agencies, as well as other supporters, is critical to mission accomplishment in South Sudan. Individually, all agencies were concerned with the polio outbreak in South Sudan, and are committed to eradication, but more needs to be done to encourage a coordinated partnership between them. The coordination role is normally played by WHO, or WHO and UNICEF together, but it clearly requires more attention in the current situation.

Finally, it is clear that polio will not be eradicated from South Sudan by having operations well carried out in Juba alone. There is a need for a strong GPEI partnership presence in state capitals, in order to oversee implementation across the ten states of South Sudan. The GOSS has extremely limited capacity to take this on at the state level, and therefore the core agencies need to have staff posted appropriately. Their staffing levels currently appear to be insufficient.

It must also be recognized that there is insufficient ownership of the programme by the GOSS, as well as by the state governments. Addressing this issue, while simultaneously strengthening the international presence because government capacity is so limited, is indeed difficult.

International Federation programme performance and implementation issues

Given the political and financial situation described above, there was clearly little emergency appeal funded programme performance by the International Federation and SRCS to evaluate at the time of the consultancy visit in October/November. With prior knowledge of this, the consultants would have changed the brief and spent more time evaluating how the BRC funds were expended on polio eradication efforts in both North Sudan and two states in South Sudan earlier in the year.

Taking into account the challenges facing the programme and its key implementing partners as described above, it is the opinion of the consultants that there can and should be a significant role in the eradication of polio for SRCS Southern Secretariat and its branch offices across the ten states. The fulfilment of that potential will, however, require building the capacity of the SRCS in South Sudan.

Currently, SRCS in South Sudan is fundamentally weak. It has a history of operating (during the war) in government garrison towns, not in the broader South Sudan which was controlled by the Sudan Peoples' Liberation Move-

ment (SPLM). After the Southern Secretariat was formally organized in 2006, it became responsible for operating across all South Sudan, from branch offices in the ten states. SRCS Southern Secretariat now has four “strong” branches in Juba, Wau, Malakal and Bentiu. In three other state capitals (with branches), and in other locations, it is rather weaker, with fewer staff and lower capacity. Even in the four relatively stronger branches, the capacity is exceedingly weak, at least in comparison to other countries in Africa.

SRCS in South Sudan faces serious challenges. It must deal not only with the challenges that everyone faces in South Sudan, those of a weak government, lack of infrastructure and security, intertribal conflict, seasonal flooding, and so on, but also with a serious shortage of financial and logistical resources. Funding is required not only to pay staff to organize volunteers in the branches in the state capitals, but also for the central secretariat in Juba, and funding is in short supply. Without the resources needed, it is very difficult for SRCS to perform its mandate.

While there are a number of partnering Red Cross National Societies (Netherlands, Denmark, Switzerland and Germany) providing assistance to specific branches of SRCS in South Sudan, they are primarily advising on specific programmes. They are not tasked with helping to build the capacity of the SRCS Southern Secretariat and its branches. This means that SRCS volunteers are trained for specific programmes and are not easily mobilized to work on different programmes.

The consultants advise that an institutional capacity-building effort is required by the Red Cross Red Crescent Movement, to strengthen SRCS in South Sudan. This is a major task that requires the International Federation to take the lead, building upon small existing efforts that have already been started by the Federation and a few of the National Societies, like Denmark and the Netherlands. The strengthening is required not just in the central office in Juba but in each of the ten state branches.

If this institutional capacity could be built, and indeed while the building process is going on, SRCS in South Sudan can play a major role in polio eradication. All partners agree that the volunteers have tremendous potential to mobilize communities, just as they are doing in North Sudan. With proper funding for the activity, good organization and management, and an intensive programme of training, SRCS volunteers in all ten states would be able to play a critical role in social mobilization. In addition, the consultants believe that the SRCS volunteers should be given responsibility for certain geographically isolated or hard-to-reach areas that would otherwise receive inadequate polio vaccination services. When raising this conclusion, the consultants found that WHO Headquarters staff supported further discussion of this approach.

UNICEF, WHO or USAID, as well as the traditional sources of National Societies in developed countries all have an interest in, and mandate for, social mobilization for polio, and are potential sources of funding.

Conclusions

Bearing in mind that the original period for the Africa outbreak polio emergency appeal issued on 7 April 2009 called for the conclusion of activities within four months, the fact that most of the money from the ARC donation was unspent by the end of October certainly indicates less than optimal performance. The programming environment in South Sudan is one of the most difficult in the world, and it takes extraordinary efforts by extraordinary staff to accomplish anything in the humanitarian or development arena of South Sudan. It is, however, not impossible to do.

Polio has been eradicated before in South Sudan and it can and will be again. To be part of that effort, the Sudanese Red Crescent Society must build sufficient internal capacity, and raise sufficient funding both for institutional capacity building and for polio eradication activities, as well as for all the other important areas in which they work.

The role of the International Federation is critical in supporting these endeavours by SRCS. The newly strengthened staffing of the International Federation in Khartoum and in Juba should assist such developments to occur. The consultants advise that senior International Federation management in both Geneva and Nairobi should undertake to support such an effort, both financially and with appropriate attention by staff.

Partner organizations should realize the potential of the SRCS and the role it can play in polio eradication. It is only with cooperation and collaboration of all GPEI partner organizations that polio can be successfully eradicated from Sudan once again.

Annex 3

Côte d'Ivoire country visit

As the third country to be visited, the consultant went to Côte d'Ivoire from 10–16 November 2009. At all times accompanied by staff from the Red Cross Society of Côte d'Ivoire (CRCI), including Dr Alexis Konoumi, National Coordinator in charge of Community Health, and Dr Marcel Yapi, Health Coordinator and National Coordinator for STI/HIV/AIDS and by Dr Philip Bassey, International Federation Regional Health Coordinator, West Coast Regional Office in Abuja, Nigeria, the consultant held an extensive series of interviews with various stakeholders in Abidjan, Tiassale and Divo.

These stakeholders included, in Abidjan, the Secretary-General of the CRCI, the President and the Vice-President of Côte d'Ivoire Rotary, the Head of the WHO Country Office Vaccinations Programme and four of his team members, a representative of the Health Department of the UNICEF Country Office, and the Côte d'Ivoire Ministry of Health/EPI Director, Deputy-Director, EPI/Head of Communications and six other EPI staff. In Tiassale and Divo, stakeholder interviews included representatives of the local CRCI branches and volunteers, as well as the Directors of Health of both districts. In Divo district, the consultant also had the opportunity to meet with the Regional Director for Health and Public Hygiene, as well as with two members of the District Health Office. The consultant also visited some households in Divo district and talked to the local population about polio and the NIDs.

From the funds raised by the International Federation Africa Polio Outbreak emergency appeal, an allocation of approximately CHF 145,297 (US\$ 141,500) was awarded to Côte d'Ivoire. According to Dr Konoumi, the sum was received in four instalments and was spent on the February (27 February–2 March 2009), March (27–30 March 2009), June (26–29 June 2009) and August (14–17 August 2009) NIDs. During the early June (29 May–1 June 2009) and October (2–5 October 2009) NIDs, although there were no additional financial resources available for incentives to mobilize the volunteer structure for those rounds, some of the local Red Cross branches still contributed through their volunteers undertaking social mobilization.

With these emergency appeal funds, the CRCI was able to support Red Cross branches in 10 districts for the first three rounds and six districts for the fifth (August) round. A total of 300 volunteers and 30 supervisors were mobilized during the first three rounds and 180 volunteers and 18 supervisors during the fifth round. The choice of districts was based on a combination of number of wild poliovirus (WPV) cases identified, district vaccination coverage levels and capacity of the district Red Cross branch.

Almost all of the CRCI funding, in all four rounds, was spent on social mobilization activities, beginning with participation in planning meetings, training of volunteers, followed by during-campaign activities for the four days of the campaign, including house-to-house visits, assisting at fixed sites like markets, railroad and bus stations, searching for missed children, etc. No pre-campaign house-to-house social mobilization visits were conducted by Red Cross volunteers in Côte d'Ivoire.

The emergency appeal funds also permitted the CRCI to equip the volunteers with megaphones (some bought, some rented), produce T-shirts, hats, and posters. Some transport money was also provided to enable volunteers to get to hard-to-reach areas and in some districts money was also provided for radio messages in local languages. Although the main task of volunteers during the NIDs was social mobilization, in certain districts the volunteers were also asked by the local government health department to help with the distribution of vaccines and occasionally to administer oral polio vaccine (OPV) to missed children during mop-up activities. Training for this was always provided beforehand by the local government.

All activities conducted by the CRCI were guided by the national communication and social mobilization strategy developed by the EPI Department of the health ministry, WHO, UNICEF and Rotary International, and then incorporated into district level micro-plans. This strategy called for house-to-house mobilization, use of radio and television talk shows, radio announcements, and the printing of IEC materials like T-shirts, banners and posters.

At the national as well as district levels the CRCI is known to stakeholders as an implementing agency, with particular talent in social mobilization, and is well respected for its performance in polio and measles rounds. CRCI is also known for support to nutritional programmes. Virtually all partners, both governmental and non-governmental, believed that the CRCI interventions were effective and made a difference in the districts where performed. According to the National EPI Programme Coordinator, the CRCI has helped "sell" immunization to the population through social mobilization and communication and not only advised, but also convinced people about immunization in general and the polio programme in particular. In cases of vaccination resistance or refusal, CRCI volunteers have been able to resolve non-compliance and produce higher vaccination coverage levels. At the community level, based on the consultant's field missions and visits to households, the CRCI is known and trusted by the local population, particularly when the Red Cross volunteers carry clear identification. Most feedback was very positive.

It was not possible to demonstrate the effectiveness of social mobilization efforts carried out by the CRCI volunteers in quantitative terms. The lack of baseline data (the last population census having been held in 1998), and unreliable immunization coverage data provided by the government meant that quantitative analysis was challenging. Fortunately, independent post-

campaign coverage monitoring was done (organized by the MoH and WHO) in each of Côte d'Ivoire's districts, using two monitors per district, during the four campaign days and for three days after the campaign. This was carried out for each of the six polio rounds held in 2009 at the time of the country visit. By using the data provided to the polio evaluation team by the WHO Country Office, it can be noted that in those districts supported by International Federation emergency appeal funding the coverage rates during the six polio rounds vary between 96.1 per cent and 97.2 per cent. In districts not supported by the Red Cross, figures vary between 92.5 per cent and 97.8 per cent. It is the opinion of the consultant that coverage was somewhat higher in districts where CRCI volunteers were mobilized, using available data and information gathered in the field as a guide. Table 1 shows data reported for districts where there was CRCI intervention. Table 2 gives data for those districts where there was no CRCI intervention. Both tables cover five NIDs.

Table 1

Coverage rates in districts supported by CRCI with International Federation emergency funding during the 2009 NIDs

District	March 2009 NID round			May 2009 NID round			June 2009 NID round			August 2009 NID round			October 2009 NID round		
	Vaccination coverage %	Soc. mob. coverage %	Radio coverage %	Vaccination coverage %	Soc. mob. coverage %	Radio coverage %	Vaccination coverage %	Soc. mob. coverage %	Radio coverage %	Vaccination coverage %	Soc. mob. coverage %	Radio coverage %	Vaccination coverage %	Soc. mob. coverage %	Radio coverage %
Basassandra	79	14	74	94	16	76	97.2	20.8	73.2	94.3	8.6	80.4	95.1	23.4	79.1
Fromagan	100	17	49	100	51	35	98.9	46.3	56.8	96.9	14.2	56.9	95.7	20.8	37.3
Haut-Sassandra	100	7	23	95	0	33	97.9	1.3	36.5	96.1	0.8	40.9	94.7	11.1	37.1
Lacs	96	1	56	96	4	26	95.1	3.4	36.5	97.2	2.9	44.1	96.5	0.5	47
Lagunes 1	98	21	79	97	21	74	95.7	12.3	78.2	94.3	20.2	84.9	93.4	9	83.5
Lagunes 2	100	8	80	100	4	81	98.6	16	92.7	97.9	11.5	90.4	96.8	12.4	93
Moyen Cavally	100	23	46	99	27	59	100	40.1	54.4	99.3	46.6	70.5	99.2	34.6	55.3
Moyen Comoé	100	7	64	99	37	33	99.6	2.4	67.5	99.7	7.8	37.2	99.2	2.3	68.1
NziComoé	97	11	46	96	23	40	98.5	19.4	4.7	99	4.4	34.7	97.5	1.3	38.8
Savanes	97	3	28	99	5	47	94	5.2	58.9	96.2	2	38.4	97.2	6.3	37.2
Sud Bandama	88	14	75	90	11	57	87.1	9.5	57.3	94.7	22	65.5	91	9.3	82.8
Sud Comoé	100	20	73	100	12	77	96	8	86.1	95.2	5.4	91	97	7.2	88.8
Vallée du Bandama	99	11	29	98	7	31	94.5	8.9	32.2	96.2	2.5	32.1	96.2	3.9	31.3
Average vaccination coverage %		96.5			97.2			96.4			96.7			96.1	

Source: WHO Côte d'Ivoire. NID coverage and social mobilization data 2009

Table 1 shows the immunization coverage data for the 13 regions where the CRCI carried out social mobilization activities during the four polio immunization rounds that were supported through the emergency appeal funding. Table 2 shows the coverage data for the regions not covered by CRCI. When the average immunization coverage rates for the two groups are compared, however, it is noted that the percentage coverage rates in the regions where CRCI carried out social mobilization activities are slightly higher than those in which the CRCI did not carry out social mobilization activities during the March, May, June and October rounds, but NOT during the August round. For instance in the March round, the average immunization coverage in the districts with CRCI activities was 96.5 per cent while it was 93 per cent in the non-CRCI regions. In the month of October, when CRCI was not involved in the campaign, there was a drop in the average coverage in those regions that had been supported by the CRCI in previous rounds.

In conclusion, from Table 1, a cursory look at the data on social mobilization methods shows that radio announcements were generally the more available source of information. According to WHO, 80 per cent of the population in Côte d'Ivoire has access to radio and television. It cannot be deduced from the tables that there is any direct correlation between coverage and the social mobilization method used.

The national level

At the national level there is very good awareness of the CRCI role and how it is carried out. The MoH/EPI Director and his staff were well aware that the CRCI had participated significantly in four of the 2009 NIDs. United Nations agency partners equally showed good awareness of CRCI and its involvement in the GPEI.

However, the CRCI plays too limited an advocacy role at the national level with the government, whereas district level CRCI advocacy activities are often more significant. WHO believed that at central level, the presence of the CRCI is felt and that they are always present at Inter-Agency Committee meetings. Additionally, WHO staff noted that they have often observed Red Cross volunteers in the field carrying out social mobilization and using megaphones. Occasionally, WHO recruits Red Cross volunteers as independent monitors. Furthermore, WHO believes that the CRCI should 1) reinforce the community angle of the NIDs and 2) go to hard-to-reach and far away areas where they can do a better job than the government through their local volunteers.

The consultant was also informed by WHO that there are still many problems with social mobilization in Côte d'Ivoire, as there is not sufficient funding per health centre nor sufficient human resources. With additional funding, CRCI volunteers could possibly support health centre activities during polio campaigns.

UNICEF believed that the outreach social mobilization work done by CRCI volunteers is the Red Cross's greatest strength, but in future rounds would like to be informed in which districts the Red Cross volunteers will be operating in order to reduce duplication and maximize communications capacities. UNICEF also believed that it is unfortunate that support for social mobilization for NIDs has to go through the MoH/EPI, as per the national communication and mobilization strategy, and not directly through the Red Cross. During our discussions with UNICEF, it was also suggested that CRCI looks at how to increase its support to routine immunization through its local community networks.

Rotary in Côte d'Ivoire considered the CRCI an effective partner in many of its programmes, particularly in hard-to-reach and isolated areas. The President of Rotary recommended that the CRCI take over these areas, as well as the islands (where boats are needed for access). He also suggested that NIDs in these places should be entirely handed over to the CRCI who have a strong volunteer network almost everywhere, and that the government should support the CRCI in this initiative.

All partners believed that coordination was stronger because of the polio eradication activities, and was growing stronger as a result of lessons learnt during each round. Although the CRCI played a significant role on the social mobilization sub-committee, its presence at the Inter-Agency Coordinating Committee (IACC) was at too low a hierarchical level to be influential. If the MoH/EPI Director is chairing an IACC meeting, then the CRCI needs to reciprocate with the attendance of a staff member at an equal level of hierarchy. In the opinion of the consultant, this means that the Secretary-General himself needs to attend these meetings. This level of attendance highlights to other partners attending the IACC meetings that the CRCI is a serious actor in polio eradication.

While many things went well in the campaigns, it is important to note those that were weaker. There was some confusion, for instance, about which districts the CRCI volunteers worked in during each polio round, since they changed depending on the round. This led to inefficiency and lack of effectiveness in certain districts. It would also be much more effective if the CRCI volunteers delivered their social mobilization messages house-to-house a few days prior to the NIDs, rather than during NIDs only.

It does appear that the four rounds combined, during which the CRCI actively participated in the NIDs, enhanced the visibility of the Red Cross at the community levels where they worked. Partnership was also strengthened with GPEI partners at the country level, although there is still work to be done for true partnership building and mutual understanding. It is certainly true that the network of volunteers provides a cost-effective method of social mobilization.

It is also believed that the CRCI volunteer network offers a good opportunity to the Government of Côte d'Ivoire and to GPEI partners nationally, particularly WHO, UNICEF and Rotary, to use the Red Cross network in a variety of ways. Volunteers can be used mainly and most effectively for social mobiliza-

tion, but also for post-campaign monitoring of coverage, for giving additional support by filling vaccinator gaps and helping with logistical movement of vaccines, as well as for covering isolated and hard-to-reach areas. With a minimum of one month's notice, and with funding available for incentives for volunteers, the CRCI can mobilize its network in most districts of the country. It simply takes planning to identify where volunteers should be used, and fairly small amounts of funding to support programme implementation. At present, and like in the three other countries visited during this evaluation, this capacity represents a significant missed opportunity for the GPEI.

Overall findings

At the closing meeting with the evaluation team, the consultant presented the following conclusions:

1. As found in the other three countries visited during this polio evaluation, it is imperative that funding, whether for future polio rounds or for other programmes, arrives on time or at least that timely notification is provided in writing so that the CRCI can show this to their partners. In turn, timely financial feedback reporting from the CRCI to the International Federation should also be respected, as late arrival may jeopardize future funding.
2. The International Federation funds for the emergency appeal were, in the case of Côte d'Ivoire, all spent during four out of the six polio rounds held in 2009. The CRCI has branches, and sometimes even sub-branches, in virtually every district of the country, and each branch and sub-branch has a network of volunteers. However, activating these volunteers in any given branch for a specific objective, like social mobilization before a NID, requires sufficient lead time (preferably one month) for the activation and for any training necessary, and also sufficient funding to cover the costs of the volunteers (incentives for lunch, costs for transportation, etc.) and costs like buying or rental of megaphones, vehicles, telephone, etc. necessary for the effort. These incentives are relatively low in Côte d'Ivoire at approximately US\$ 2.5 per volunteer per day, and make the voluntary network very cost-effective. It is therefore strongly recommended, as also indicated by WHO, UNICEF, and Rotary that partners use the CRCI volunteer network much more extensively, particularly for social mobilization during polio campaigns.
3. There is indeed added value of the CRCI social mobilization activities to polio rounds, not only during-NID social mobilization, but also for pre-NID mobilization, for post-campaign monitoring, or, in the longer run, for other kinds of health programmes. The CRCI can perform these functions effectively, efficiently and well because of its extensive and mobilized volunteer network.
4. Like in the other countries visited during this polio evaluation, there is a need to raise the visibility of the Red Cross Society nationally, not only with

partners, but also with other stakeholders. First of all, there needs to be a higher level management representation of the Red Cross at partner meetings on any given subject. It is at such coordination meetings that policies and capacities of the Red Cross Red Crescent and CRCI in particular can be explained, and fund-raising can be advocated. Furthermore, as was also discussed with the CRCI Secretary-General during the briefing meeting, the CRCI management needs to recognize that effective advocacy and partnering is at present not very efficient, as it takes time to collaborate, negotiate and advocate with partners, explain roles and working procedures, and maintain a continuous flow of information and experience exchanges. At present, little attention is paid to partnering techniques, which has negative consequences for the CRCI both in terms of ongoing operations and in terms of raising additional funding for new operations.

As a final note to this country report, the consultant found that of the four countries visited the Côte d'Ivoire Red Cross Society had best dealt with the International Federation-generated emergency appeal funding for polio support in Africa. Funding had been secured for four out of the six rounds, contact with partners and stakeholders had been continuous throughout these rounds, with a fairly good exchange of information, and detailed reports on each round had been sent to International Federation headquarters in Geneva. Although there is still room for improvement, as outlined in this report, the CRCI is to be applauded for their efforts in the GPEI made thus far.

Annex 4

Burkina Faso country visit

The last of the four countries visited for the evaluation of the International Federation Africa polio outbreak emergency appeal was Burkina Faso, where the consultant visited from 16–24 November 2009. At all times accompanied by Dr Maxime Yaméogo, Head of the Health Programme of the Croix-Rouge Burkinabe (CRBF) and by Dr Aissa Fall Gueye, Health Manager Sahel region of the International Federation West and Central Africa Zone Office, based in Dakar, Senegal, the consultant held an extensive series of interviews with various stakeholders in Ouagadougou, Boromo, Dedougou, Tionkuy, Solenzo and Bobo Dioulasso.

These stakeholders included, in Ouagadougou, the CRBF Acting Secretary-General, the Manager of the Health and Nutrition Department, and the Health and Immunization Project Officer from UNICEF, the WHO EPI Inter-country (IST) Epidemiologist, and two WHO EPI/Health staff in Ouagadougou, Ministry of Health Acting Director EPI, as well as the Finance Officer at central level. In the four districts of Boromo, Dedougou, Solenzo and Bobo Dioulasso, meetings occurred with the CRBF Branch Coordinators and volunteers, and the MoH District Health Officers and several of their staff.

From the funds raised by the International Federation Africa polio outbreak emergency appeal, an approximate allocation of CHF 76,000 (US\$ 74,000) was made for Burkina Faso. According to Dr Yaméogo, a total of CHF 71,608 (US\$ 69,790) was received in two instalments: CHF 35,345 (US\$ 34,449) which was spent on the March NID (second round) and another CHF 36,263 (US\$ 35,344) which was spent on the May/June NID (third round). No additional funding was received during this period, either through the emergency appeal or from other sources.

With these emergency appeal funds, the CRBF was able to support Red Cross branches in 28 districts during the second NID, with 500 volunteers and 50 supervisors, and during the third NID in 29 districts with 520 volunteers and 52 supervisors. It should be noted, however, that in certain districts, like Boromo and Bobo Dioulasso, volunteers continued to work during subsequent polio rounds, despite the fact that there were no additional financial resources available to mobilize and provide incentives for the volunteer network for those rounds.

Almost all of the CRBF funding, in both rounds, was spent on social mobilization activities, including the production of IEC materials. T-shirts and leaflets in local languages were produced, with 80 per cent of the funds being spent on per diems and materials for the volunteers. Any remaining funding was spent on supervisory and communication costs, such as telephone and mail. Social mobilization activities for the volunteers included participation in

planning meetings, training and three days of pre-campaign activities. These activities were often followed by during-campaign activities for the four days of the campaign, at least in most of the districts in the country, including house-to-house visits, assisting at bus stations and markets and searching for missed children. Focus group discussions were also held in public places.

The districts where CRBF social mobilization activities were undertaken were selected by the National Society in order to give priority to those that did not usually undertake polio campaigns. These districts had to be reachable for volunteers because the budget for transport and fuel was very limited. The CRBF headquarters office reported that it also used the emergency campaigns as a way to test the local branches' capacities.

The activities carried out by the CRBF were always done in collaboration with the district MoH, with training provided by the MoH as well. Since there is, unfortunately, no clear national communication and mobilization strategy, due to weak central level government planning and implementation, the districts are mostly left to their own devices, resulting in often different approaches and micro-plans. As very limited resources are available for social mobilization at the district level (some local radio announcements, a "crieur" or public announcer here and there and a few megaphones), the house-to-house social mobilization approach of CRBF has a significant impact. The involvement of CRBF is much appreciated not only by the local health authorities, but also by the community. This appreciation was reported to the consultant by the district health officers in Boromo and Bobo Dioulasso, and later witnessed first hand while visiting households in both these districts.

In addition to social mobilization activities, in certain districts CRBF volunteers were also asked by the local health authorities to supplement capacities by serving as vaccinators when there was a shortage of staff. Training for this was always provided beforehand by the local government.

CRBF branch offices at the district level are known to stakeholders as an implementing agency with particular talent in social mobilization. The National Society is well respected for its performance in polio, meningitis and measles rounds, as well as in other health activities. Virtually all partners, including district-level governmental and non-governmental, believed that the CRBF interventions were effective and made a difference in the districts where they were performed. At the community level, in almost all places visited, the CRBF was perceived to be trusted by the community, especially when the volunteers were wearing some form of Red Cross identification. Community members were always willing to allow these volunteers into their homes and to listen to their explanations about polio campaigns. CRBF volunteers are often more welcomed than the government health workers, who are mostly unknown to the local population and therefore less trusted.

Despite all this positive feedback, it was not possible to demonstrate the effectiveness of the social mobilization efforts carried out by the CRBF volunteers

in hard quantitative terms because of lack of baseline data, and because administrative immunization coverage data were highly unrealistic for all rounds, and reported to be well above 100 per cent (government data). This is due to a denominator problem where the published coverage data rely on out-of-date census figures. Although independent monitoring is done in Burkina Faso after each round, it is organized by the districts themselves on instructions from central level. With a few exceptions these districts use the same supervisors and vaccinators that work during the NIDs. This monitoring method makes it virtually impossible to do a proper assessment after each polio round, most importantly in determining underperforming districts for additional support in subsequent rounds. WHO does not use percentage coverage rates after each round, but looks at numbers of children immunized, comparing these to the previous NIDs. Using the data available (provided courtesy of WHO Burkina Faso Office) and information gathered in the field as a guide, in the opinion of the consultant, coverage almost certainly was higher in the districts and during the rounds where CRBF volunteers were mobilized. The table on the following page shows the data that were reported for the districts supported by the CRBF (28 in March round and 29 in May/June round), bearing in mind the limitations of inadequate post-campaign independent monitoring.

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Social mobilization indicators for 2009 polio immunization rounds in Burkina Faso, by districts involved in CRBF activities

Social mobilization indicators	1st NID 27/02/09-02/03/09 No EA funding		2nd NID 27/03/09-30/03/09 CRBF EA funding		3rd NID 29/05/09-01/06/09 CRBF EA funding		4th NID 24/07/09-27/07/09 No EA funding		5th NID 02/10/09-05/10/09 No EA funding	
	CRBF- supported district	Non CRBF- supported district	CRBF- supported district	Non CRBF- supported district	CRBF- supported district	Non CRBF- supported district	CRBF- supported district	Non CRBF- supported district	CRBF- supported district	Non CRBF- supported district
% of parents informed about polio round prior to NID	86.38	94.62	93.1	91.9	93.84	92.96	N. A.	N. A.	94.53	96.07
How did parent/caretaker know about the polio campaign?	25.07	28.93	17.92	8.68	17.76	7.44	N. A.	N. A.	94.53	96.07
Public announcer (megaphones)	68.08	51.12	69.78	62.22	67.42	66.18	N. A.	N. A.	76.53	64.68
Religious leaders	8.71	7.09	8.4	8.4	6.27	6.13	N. A.	N. A.	8.37	13.03
Are parents informed about next NID?	23.79	25.81	30.39	26.81	37.37	34.63	N. A.	N. A.	36.26	34.74
Social mobilizers	0	0	0	0	0	0	N. A.	N. A.	0	0
Other	0	0	0	0	0	0	N. A.	N. A.	0	0
% of parents knowing which disease their children are being immunized against	77.14	81.86	80.8	84.2	88.33	83.47			90.33	79.48

Source: Compiled by Croix-Rouge Burkinabe from independent monitoring data, MoH

Notes (for table on page 51)

Social mobilization indicators

- > The chart (see previous page) compares the first five polio campaigns held in Burkina Faso in 2009, as the last round (4–7 December 2009) had not yet taken place at the time of the consultant's visit.
- > Emergency appeal money was spent during the second and the third NIDs, i.e. the March and the May/June 2009 rounds, for a total of 28 districts in the second polio campaign and 29 districts in the third campaign, out of a total of 63 districts nation-wide. This difference is referred to in the chart as CRBF-supported districts versus non CRBF-supported districts.
- > In order to be able to make a comparison between the various rounds, these two columns, CRBF-supported and non CRBF-supported, are noted even for those rounds where no emergency appeal funding was used.
- > Prior to being supported through the emergency appeal funding, the overall awareness of the local population about NIDs and polio appears to be lower, particularly in terms of awareness of parents regarding which disease their child is being immunized against.

Percentage of parents/caretakers who were informed about the polio campaign prior to the NID

- > There is an increase in the number of parents who are informed about the campaign prior to the NID during the second and third round in the CRBF-supported districts.
- > During the fifth round, when there was no CRBF additional funding, the percentage of parents who have been informed about the campaign beforehand is actually lower in CRBF-supported districts.

How did parents receive the information regarding polio and the next NID?

- > The main source of information was via public announcers (known as "crieurs" in Burkina Faso). These are community health workers or Red Cross volunteers who go around villages using a megaphone announcing information about polio vaccination and the NIDs.
- > All local CRBF branches that supported the various polio rounds were equipped with a megaphone and thus able to supply a crieur for villages and public areas.
- > It appears as though no parents were aware of the polio campaigns via social mobilizers. One possible explanation is that the concept of "social mobilizers" is not adequately described in the monitoring forms. Furthermore, the monitoring form does not explicitly ask whether information was received via the local Red Cross volunteer.

Were parents informed about the next polio round?

- > No parent had received any information or was aware about the next NID. This is not unexpected. District health officers and thus the CRBF volunteers do not have this kind of information until a few weeks prior to the next round, as was discovered during the evaluation mission.

Parents' awareness about poliomyelitis and why their children are being immunized against this disease

- > Generally speaking, parents' and caretakers' awareness is increased after each NID.

The national level

As mentioned briefly before, at the national level there is much less awareness of the CRBF role and even less understanding of how the CRBF works. The Acting EPI Director had not been properly briefed about the CRBF's significant participation in the March and May/June rounds. The Acting Director was not given a copy of the letter that the CRBF sent to the Ministry of Health informing them about the emergency appeal funding and their planned activities. This led the consultant to the hypothesis that it is possibly a lack of communication and vertical sharing of information within the MoH which led to this lack of information. Only two Inter-Agency Coordination meetings were held in 2009, but the planned NIDs were not on the agenda and thus not discussed. The Acting EPI Director also conveyed his belief that his government was already spending a significant amount of money on social mobilization for each NID. There was an apparent lack of understanding as to the value-added of the CRBF involvement in social mobilization activities. The consultant furthermore observed that there was a misunderstanding or miscommunication with the MoH/EPI Department, as the Acting Director expressed lack of interest in NIDs, believing that they were of little use in the fight for polio eradication. The Acting Director believed that all focus should be on routine immunization. Although this does not directly reflect on the CRBF participation in polio activities, it does contextualise the situation in which the CRBF is working. They not only have to sensitize people to their role as social mobilizers, but also to the importance of NIDs as a tool against the spread of polio in Burkina Faso.

United Nations agency partners, in contrast, were better informed and aware of CRBF involvement in the NIDs and very much welcomed its support. Various suggestions were provided to enhance this support in future rounds, such as expanding the number of days of pre-campaign social mobilization carried out by CRBF volunteers to a minimum of four. A second area where collaboration between organizations could be strengthened was through partner agencies suggesting that CRBF volunteers work in those areas that are geographically isolated and hard-to-reach. It was recognized by polio eradication partners interviewed that these areas are often not reached through the normal social mobilization channels. Both WHO and UNICEF noted challenges in collaboration and exchange of information with the MoH, which makes the planning and execution of each NID increasingly complicated.

The CRBF plays a negligible advocacy role at the national level with the government, although its role is more significant at the branch level.

As for CRBF representation at the National Coordinating Committee (NCC) forum (the Comité Inter-Agences), as reported in the other countries visited, representation is at too low a hierarchical level to be influential, even if the NCC met only twice in 2009. If the Director of EPI is chairing an NCC meeting, with the WHO Director and UNICEF Representative in attendance, then CRBF needs to reciprocate with the attendance of a CRBF member

at an equal level of hierarchy. In the opinion of the consultant, this means that the Secretary-General himself needs to attend these NCC meetings. This level of attendance highlights to other partners that the CRBF is a serious actor in polio eradication.

While many things went well during the polio campaigns, there were also a few shortcomings. There was some duplication of work where government mobilizers were working in the same areas as CRBF volunteers. Some CRBF volunteers received a greater sum for the per diem than the government mobilizers, as they were engaged for a longer period of time. This created friction in certain places. For further details see the field visit meeting transcripts, available from the International Federation.

It does appear that the March and May/June rounds enhanced the visibility of the CRBF in the communities where they worked, as well as strengthened their partnership with the district health authorities. The consultant can also report that the social mobilization activities of the CRBF were found to be as equally cost-effective as those undertaken in Uganda and Côte d'Ivoire.

The CRBF volunteer network offers an excellent opportunity to the government of Burkina Faso and to GPEI partners nationally. In particular, UNICEF has the opportunity to utilize the CRBF network in a variety of ways. The CRBF volunteer network can be utilized most effectively for social mobilization, but it can also be utilized for post-campaign monitoring of vaccination coverage, an area of enormous weakness in Burkina Faso. With one month's notice, and with funding available as incentives for volunteers, the CRBF can mobilize its network in virtually any district of the country. It only takes planning to identify where volunteer efforts would best be used, and relatively small amounts of funding to support implementation of activities. At present, this capacity represents a significant missed opportunity for the GPEI.

Overall findings

At the closing meeting with the Acting Secretary-General of the Burkinabe Red Cross Society, the consultant presented the following conclusions:

1. There is a need to raise the visibility of the CRBF nationally, particularly with the government, but also with other partners. Often, the Red Cross is thought of as just a group of hard-working volunteers who respond in times of emergencies, whether natural disasters or public health emergencies. Furthermore, it was found that partners did not fully comprehend the commitment of the CRBF to work in areas such as health and disasters, particularly when it comes to reaching the most vulnerable areas of the country. In order to achieve a heightened visibility, the CRBF needs to recognize that the current engagement with polio eradication partners, particularly the MoH/EPI, is not sufficiently coordinated. It takes time to collaborate with partners as well as with the government. CRBF needs to

advocate, negotiate, explain roles and working procedures to partners and, above all, maintain a continuous flow of information and experience exchange. At present, it seems that most of the CRBF staff, and particularly the single Health Officer, are overstretched. Subsequently little attention can be paid to such time-intensive partnering techniques. This has negative consequences for the CRBF both in terms of ongoing operations, as well as for raising additional funding for new operations. Furthermore, there also needs to be higher level (at the management hierarchy) representation of the Burkina Red Cross Society at partner and government level meetings on any given subject. It is at such coordination meetings that policies and capacities of the Red Cross Red Crescent and CRBF in particular can be explained, and fund-raising can be advocated.

The CRBF head office needs to devote more time to increasing the visibility of its local branches and members, particularly in those branches where the leadership is weak. Often, the branch leaders (in Burkina Faso called “Presidents”) are not pro-active enough, or are too occupied with their normal workload to spend sufficient time on increasing their visibility with the local government and partners. When this is the case, it immediately reflects on the work of the volunteers and often results in the work of the Red Cross and its volunteers not being known among the local population. Capacity-building and increased visibility are the only means for a Red Cross branch to be fully operational with a minimum of funding.

2. There is great potential for using the CRBF volunteer network in future social mobilization efforts for polio rounds, particularly for pre-NID social mobilization, but also for post-campaign monitoring of polio rounds. The CRBF has branches, and sometimes even sub-branches, in every district in the country, and each branch and sub-branch has a network of volunteers. However, activating these volunteers for a specific objective, such as social mobilization before a NID, requires sufficient lead time, preferably one month, for training and other preparatory activities. Sufficient funding to cover activity costs such as volunteer incentives (lunch, costs for transportation), rental of megaphones, vehicles and communication must be available in good time before the campaign. Since volunteer incentives are very low in Burkina Faso, about three US dollars per day per volunteer, it makes the network very cost-effective. It is therefore strongly recommended that partners engage the CRBF volunteer network much more extensively. Partner organizations should recognize the important opportunity presented in Red Cross Red Crescent National Society volunteer networks, and should more actively involve the CRBF in future polio eradication efforts.
3. It is imperative that funding, whether for future polio rounds or for other programmes, arrives on time or at least that timely notification is provided in writing so that the CRBF can show this to their partners. In turn, timely financial feedback reporting from the CRBF to the International Federation should also be respected, as a delay in reporting may jeopardize future funding.

Annex 5

Questionnaire used during the course of the evaluation

Name of interviewee:

Country:

Title or role:

Organization:

Interviewed by:

Date:

Question	Response
How many volunteers participated in how many rounds in how many districts in the country and what were their roles/tasks?	Number of volunteers: Number of districts: Roles or tasks:
Were these volunteers trained and if so in which areas and by whom? What was the duration of training?	Trained? Yes/No In which areas? Who trained? Duration of training:
Was a coordinator or responsible person identified at the National Society level to streamline and coordinate the various polio-related activities for the NIDs?	Yes/No Name of coordinator:
How was the collaboration with and support from the national health authorities? Did the National Society participate in inter-agency preparatory polio meetings on a regular basis?	Describe collaboration and support: National Society participation?
Did the National Society collaborate and coordinate with the other GPEI partners, like the national and district health ministries, WHO, UNICEF, Rotary, CDC, etc. and did they provide and receive feedback after each NID?	Collaboration with other partners? Who? Feedback after each NID?
Did the National Society produce any social mobilization materials, such as caps, badges, banners, T-shirts, etc. separately, or in addition to UNICEF/Government produced materials?	List any materials produced

Which social mobilization/communication activities were supported by the National Society? Did those activities achieve their objectives (number of people targeted, geographic scope, etc.)?	Activities? Objectives achieved?
Have different areas or populations been reached by the National Society that would otherwise not have been? (i.e. did the National Society “take over” certain difficult or far-to-reach areas during NIDs)?	Reach of National Society?
Did campaign activities raise the visibility of the National Society as an immunization partner? Did relationships with key agencies change as a result of the emergency appeal-funded activity?	Visibility of National Society? Relationships with key agencies?
How did campaign activities build the capacity of the National Society, from the volunteer management perspective, reporting and monitoring capacities, etc.?	Capacity building?
Are there any future implications to National Society polio involvement as a result of this emergency appeal-funded activity?	Implications?

Annex 6

Full list of all interviewees

Uganda

Dr Andrew Bakinaga	WHO Surveillance Officer, Kampala
Mr Andrew Odongo	URCS Coordinator, Lira Branch
Dr Bildard Baguma	URCS Deputy Secretary-General, Kampala
Dr Bob Davis	American Red Cross Measles Delegate, East Africa Zone Office, Nairobi
Mr Daniel Musoke	URCS Programme Officer, Kampala
Dr Emmanuel Kiboko	WHO HAC National Profile Officer, Lira
Dr Eva Kabwongera	UNICEF, Kampala
Dr Fiona Baraka	WHO, Kampala
Mr George William Barigye	URCS Coordinator, Masindi Branch
Mr John	District Health Officer, Government District Health offices
Mr John Barenzi	URCS EPI Consultant, Kampala
Mr Nataka Michael Richard	URCS Secretary-General, Kampala
Dr Peter Kosolo	District Health Officer, Lira
Dr Posse Mugenyi	UNEPI Director of Immunisation for MoH, Kampala
Mr Richard Walimbwa	URCS Head, Kampala South Branch
Mr Robert Odongo	UNICEF, Lira
Dr Sarah Musisi	URCS Head of Health and Social Services Department, Kampala
Mr Sharad Sapra	UNICEF Representative, Uganda
Ms Susan Busulwa	URCS Coordinator, Kampala West Branch
Dr William Mbabazi	WHO Surveillance, Kampala
URCS volunteers	Lira, Masindi, Kampala Branches

Sudan

Dr Abdelrahman Hamid Ahmed	SRCS Health Director, Khartoum
Dr Abdi Mohamed	WHO Special Representative, South Sudan
Mr Abraham Yel	SRCS Field Officer, Aweil Branch
Mr Abu Baker El Tigani Mahmoud	SRCS Director for International Coordination, Khartoum
Mr Agyeman Opuku	STOP team / WHO, Northern Bahr El Ghazal

Mr Akuoc Atak Santino	SRCS Field Officer, Aweil Branch
Ms Amna Ibrahim	IFRC Finance Controller, Khartoum
Ms Ann-Marie Ask	IFRC Head of Southern Office, Juba
Dr Anthony Laku	EPI Director, Government of South Sudan
Mr Arkanjelo Leon	SRCS Administrator, Wau Branch
Mr Arthur Poole	SRCS Southern Secretariat Director General, Juba
Ms Bettina Scholdan	ICRC Deputy Head of Mission, South Sudan
Ms Betty Dhyco	UNICEF, Wau
Mr Bill Kosar	Rotary Club, Juba
Ms Carmen Garrigos	UNICEF Head of Field Office, Wau
Mrs Cesarina Ayo Ngalamu	IFRC Liaison/Admin Officer, Juba
Dr Damtew W. Dagoye	WHO, Western and Northern Bahr El Ghazal
Mr David Schroder	USAID Programme Officer, Juba
Dr Debek Atak	EPI Manager, Northern Bahr El Ghazal
Dr Dietrich Fischer	IFRC Country Representative, Khartoum
Dr Dominique Athian	MoH, Northern Bahr El Ghazal
Dr Edward Ayong	MoH, Northern Bahr El Ghazal
Dr Eugenio Longar	WHO EPI Director, Western Bahr El Ghazal
Mr Fiorino Abwal	SRCS Branch Director, Wau Branch
Mr George Awuzenio	EPI Operations Manager, State Government of Central Equatoria
Dr Hassan Sugullie	UNICEF, Khartoum
Dr Hillary Owotomoi Okanyi	MoH Director General, State Government of Central Equatoria
H.E. Isahaq Elias Ibrahim	Minister of Health, Western Bahr El Ghazal
Ms Jane Amal	SRCS Health Coordinator, Juba
Mr John Lobor	SRCS Southern Secretariat Deputy Director General, Juba
Mr Joseph Lukak	SRCS Programme Officer, Wau Branch
Ms Joy Sentuke	WHO, Wau
Mr Kwami Asamani-Darko	Netherlands Red Cross Health Delegate, Juba
Ms Letitia Kleij	IFRC Programme Delegate, Khartoum
Ms Lise Grande	UN Deputy Resident and Humanitarian Coordinator, South Sudan
Dr Maha Mehanni	UNICEF, Khartoum
H.E. Mark Nipouch Obagi	Deputy Governor, Western Bahr El Ghazal State
Mr Martin Mbaka	IFRC East Africa Zone Office, Nairobi
Dr Martin Mayen	MoH Director General, Western Bahr El Ghazal
Mr Michael Muki Gordon	SRCS CES Branch Director, Juba
Dr Michael Nyang	UNICEF Health/Nutrition Officer,

	Greater Bahr El Ghazal
Dr Mohammed Abderrub	WHO Representative for Sudan, Khartoum
Ms Natalia Zeberino	SRCS Tracing/Dissemination Officer, Wau Branch
Dr Norbert Rakiro	IFRC Public Health Programmes Senior Officer, East Africa Zone Office, Nairobi
Mr Peter Crowley	UNICEF Chief of Operations and Head of Office for South Sudan, Juba
Ms Rahel Gezai	UNICEF Social Mobilisation Consultant for South Sudan, Juba
Dr Romanus Mkerenga	UNICEF Chief of Health Section for South Sudan, Juba
Dr Saleh Haithemi	WHO Polio Team Leader for Sudan, Khartoum
Mr Santino Mawrut	Health Centre, Barmayen
Mr Simon	WHO Field Assistant, Mapel
Mr Sohaib Elbadawi	Rotary Head for Sudan, Khartoum
Mr Stephen McDowell	IFRC Food Security Delegate, East Africa Zone Office, Nairobi
Ms Susan Lillicrap	UNICEF, Khartoum
Ms Susanna Fioretti	ICRC Cooperation Delegate, Juba
Mr Valentino Acuor	WHO Field Supervisor, Mapel
Mr William Bakh	WHO, Kwajok - Warrap state
Dr Yehia Moustafa	WHO Polio Team Leader for South Sudan, Juba

Côte d'Ivoire

Dr Alexis Henri Kouame Konoumi	CRCI Coordinateur santé communautaire, Abidjan
Mr Antoine Boni	CRCI Responsable secours du comité local, Tiassalé Branch
Mr Bah Paul	Tribal Leader, Daffindougou village
Dr Chouahibou N'Chamoun	UNICEF Administrateur santé, Abidjan
Mr Franck Kodjo Gaba	CRCI Assistant Opérationnel, Abidjan
Mr Guy Daipo	Vice président de la commission nationale polio plus du Rotary International, Abidjan
Dr Hilaire Bassekarou	WHO Statisticien, Abidjan
Mr Ibrahima Coulibaly	CRCI Responsable par interim du comité local, Divo Branch
Dr Joachin Achi	Directeur Départemental de la Santé, Divo
Dr Kalilou Souley	WHO Conseiller PEV, Abidjan
Dr Kofi N'zue	WHO Point Focal PEV, Abidjan
Mr Kouamé Missa	CRCI Volontaire du comité local, Divo Branch

Mr Koué Jean Wayou	CRCI Président du comité local, Tiassale Branch
Dr Leonard Zéadé Nioule	CRCI Secrétaire Général, Abidjan
Dr Marcel Yapi Gori	CRCI Coordinateur IST/VIH/SIDA, Abidjan
Mrs Marie-Irene Richmond	Présidente de la commission nationale polio plus du Rotary International, Abidjan
Dr Mathurin Kouadio	Directeur Départemental de la santé, Tiassalé
Dr Mermoz Allangba	Pharmacien du district sanitaire, Divo
Dr N'guessan Yavo	CRCI Volontaire du comité local, Divo Branch
Dr Noel Aka Brou	DCPEV Directeur coordinateur, Abidjan
Dr Philip Bassey	IFRC West Coast Region Health Manager, West Coast Regional Office, Abuja
Dr Serge Aimé Dali	DCPEV Responsable communication
Dr Yao Kossia	Directrice adjointe DCPEV, Abidjan
1 Household visit	Quartier Dialogue III, Divo town
3 Household visits	Quartier Dialogue I, Divo town
CRCI volunteers (10)	Tiassale Branch

Burkina Faso

Dr Aissa Fall Gueye	IFRC Sahel Region Health Manager, West and Central Africa Zone Office, Dakar
Mr Anatole Ouédraogo	CRBF Président, Boromo Branch
Dr Chantal Kambire	WHO/IST, Ouagadougou
Mr Dao Igrissa	CRBF Président, Dedougou Branch
Mr Denis Karaga	UNICEF Project Officer for Immunization and Health, Ouagadougou
Mr Dieni Seydou	CRBF Président, Solenzo Branch
Mr Felix Ouédraogo	CSPS Head, Boromo
Dr Ganama Seydou	Chef Médecin du District, Dedougou
Mrs Hortense Sombie	CRBF Deputy Secretary-General, Ouagadougou
Dr Kane Ibrahima	EPI Inter Country Epidemiologist, Ouagadougou
Mr Karambiri Zakaria	CRBF Treasurer, Bobo-Dioulasso Branch
Mr Ky Mamadou Korantin	EPI, Dedougou
Mr Marcel Nagana	NID Coordinator, Solenzo
Mr Maurice Hours	UNICEF Head of Health and Nutrition, Ouagadougou
Dr Maxime Yaméogo	CRBF Head of Health, Ouagadougou
Mrs Meda Kalizetou	Head of Health Centre, Tionkuy
Mr Pako Soumaila	CRBF Vice Président, Bobo-Dioulasso Branch

Mr Poda Sié Gongone	Head, Gaoua Branch
Mr Richard Traore	EPI, Solenzo
Dr Salla Mbaye	WHO/IST, Ouagadougou
Dr Sanon Adama	Chief Medical Officer, Bobo-Dioulasso
Dr Savadogo Saidou	EPI Acting Director, Ouagadougou
Dr Seydou Ouattara	Chief Medical Officer, Boromo
Dr Sieba Youssouf	Chief Medical Officer, Solenzo
CRBF volunteers (57)	Bobo-Dioulasso, Boromo, Dedougou, Solenzo Branches

GPEI partner agencies

Mr Anand Balachandran	WHO, Geneva
Dr Ben Nkowane	WHO, Geneva
Dr Chris Maher	WHO, Geneva
Dr Elias Durry	CDC, Atlanta
Mr Hans Everts	WHO, Geneva
Mr Jonathan Veitch	UNICEF, Geneva
Ms Linda Muller	WHO, Geneva
Dr Robert Kezaala	WHO, Geneva
Dr Tom Grein	WHO, Geneva

Annex 7

South Sudan vaccination team supervisory checklist and NID/SNID monitoring form

Instructions (for the vaccination team supervisory checklist on page 64 and NID/SNID monitoring form on page 65)

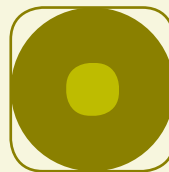
- > Each supervisor (FA, CS/SS, FP, international, independent, and partner) must complete at least 4 supervisory checklists for their region during each NID/SNID round. Different areas should be supervised each day, including at least one hard-to-reach or high risk area. Supervisors should always carry vaccine and immunize any children missed in the surveyed houses!
- > All sup. checklists must be submitted to the Focal Point 2 days after completing the NID/SNID round. Include feedback regarding actions taken for areas with low coverage.
- > The checklist has two parts. The first part is designed to record information on vaccination teams supervised during the NID/SNID. The second part is designed to record information from a household survey (10 houses) during the NID/SNID. The vaccination teams reviewed in the first part do not have to be the same ones covering the area of the household survey on the second part.

Vaccination team supervisory checklist

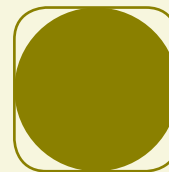
- > Fill out your information and the information for each team you are able to meet.
- > Circle the area type that best describes your area. Then circle Y or N for each question.
- > Community Meeting is defined



1=good OPV



2=good OPV



3=bad OPV



4=bad OPV

Annex 7

South Sudan NID/SNID vaccination team supervisory checklist

Name:		Organization:										Date:		
State:		County:												
Team #:		Name of team supervisor:												
		Names of vaccinators:												
Please circle														
Payam:														
Village/parish:														
Area type:														
IDP	Cattle camp	Fishing camp	Scattered houses (Bomas)	Village	Town	Seasonal/Nomadic	Other							
Vaccination team														
Team wearing polio T-shirts or hats?	Team has village list?	OPV given correctly?	Tally sheets filled correctly?	Identifying zero dose children?	Vials used matches tally?	Cold box in the shade?	Ice packs cold?	VVM good?	Enough vaccine carried?	Empty vials kept properly?	NID/SNID poster displayed?	Community meeting announcement made?	Mega-phones used?	Other events (soccer, concert, etc...)
Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Actions taken/Comments:														

Polio NID/SNID monitoring form

(This form should be filled by TRAINED hub and above level WHO staff, consultants and external monitors)

DIRECTIONS: Randomly select 10 households in an area with at least one child present under age 5 in each house. Ask all questions below at every house. If you find ANY unvaccinated children in 3 or more houses, vaccination team must be sent back to recheck the entire area. (See detailed instruction sheet)

Date:		State:		County:		Payam:				
Village/Area:		Evaluator name/Agency:		Scattered houses area		Town/Houses close together				
Circle the type of area monitored:		Other (write description)		Name of vaccinators: 1.		2.				
Cattle or fish camp										
Name of team supervisor:										
House #	Was the house visited by vaccination team?	How many children in this house are under 5 years?	How many children have marked fingers?	How many children were NOT vaccinated?	Reasons for missed children	Age of zero dose	Reason for zero dose	Does family know about OPV benefits?	How did family learn about NID?	Was family asked about AFP by team?
1	Y/N	Write #	Write #	Write #	1. Team did not come 2. Child not home 3. Refused OPV 4. Other	Below 1 year 1 year and above	1. Team never came 2. Child never home 3. Refused OPV 4. Newborn	Y/N	**see key below	Y/N
2										
3										
4										
5										
6										
7										
8										
9										
10										
Total										

**Key: How did family learn about NID? 0 = Did not know about NIDs 1 = Church/Mosque 2 = Chief 3 = Community meeting (market, wedding, dance, etc.) 4 = School 5 = Poster 6 = Sporting event
7 = Field Assistant/Vaccinator 8 = Megaphone 9 = Radio 10 = Other (explain)

Source: Forms courtesy of WHO Office for South Sudan, Juba

Annex 8

Funds allocated* and volunteers mobilized: Africa polio outbreak emergency appeal 2009

Country	Funds allocated (CHF)	Total volunteers mobilized	Campaign dates (2009)
Angola	81,318	558	14–27 June
			14–17 August
Benin	74,115	621	27–30 March
			26–28 June
Burkina Faso	78,485	1,080	27–30 March
			29 May–01 June
Central African Republic	51,548	550	05–12 June
Côte d'Ivoire	165,817	1,128	27 February–03 March
			27–30 March
			29 May–01 June
Dem. Rep. of the Congo	137,143	1,800	14–17 August
			07–09 May
Ethiopia	67,342	3,236	24–26 April
			15–17 June
Ghana	63,040	800	27–30 March
			29 May–01 June
Kenya	255,888	3,120	25–27 April
			23–27 May

* Due to currency fluctuations financial totals are approximate and do not represent precise figures. Amounts are expressed in Swiss francs (CHF).

Campaign dates included in the table are those for which emergency appeal funding was used. National Societies may have participated in other polio rounds.

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Mali	35,881	661	29 May–01 June
Niger	89,698	859	27–30 March
			29 May–01 June
Sierra Leone	48,800	328	29 May–01 June
Sudan	248,265	7,880	27–30 April
			07–09 December
Togo	79,872	630	27–30 March
Uganda	223,910	7,708	25–27 April
			06–08 June
Total (CHF)	1,701,112	30,959	

Source: IFRC reporting data

The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity

The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality

It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality

In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence

The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service

It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity

There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality

The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

Evaluation of the Red Cross and Red Crescent contribution to the 2009 Africa polio outbreak response

Final report, January 2010

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The International Federation of Red Cross and Red Crescent Societies promotes the humanitarian activities of National Societies among vulnerable people.

By coordinating international disaster relief and encouraging development support it seeks to prevent and alleviate human suffering.

The International Federation, the National Societies and the International Committee of the Red Cross together constitute the International Red Cross and Red Crescent Movement.
