

# Communication for polio eradication and routine immunization

Checklists and  
easy reference guides

WHO  
UNICEF  
USAID (BASICS II and CHANGE projects)



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# Acronyms

AD	auto-disable (syringes)
AFP	acute flaccid paralysis
BASICS	Basic Support for Institutionalizing Child Survival (funded by USAID)
CC	communications committee (subcommittee of ICC)
CVP	Children's Vaccine Program at PATH
DFID	Department for International Development (UK)
EPI	Expanded Programme on Immunization
EU	European Union
HW	health worker
ICC	Interagency Coordinating Committee
IRC	International Rescue Committee
JICA	Japan International Cooperation Agency
NGO	nongovernmental organization
NID	national immunization day
PVO	private voluntary organization
SNID	subnational immunization day
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USP	US Pharmacopeia (United States Pharmacopeial Convention, Inc.)
VVM	vaccine vial monitor
WHO	World Health Organization

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February 2002

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# Foreword

The World Health Organization (WHO), United Nations Children's Fund (UNICEF), United States Agency for International Development (USAID), Basic Support for Institutionalizing Child Survival (BASICS), the CHANGE project, and other partners have received numerous requests, both from the field as well as from technical staff and consultants working with international organizations, for quick-reference communication/social mobilization guides. At the mid-year consultative meeting of polio partners on communication for polio eradication (5–7 July 2000), it was recommended that such guides be developed as soon as possible. The urgency, in part, was due to the upcoming synchronized national immunization days (NIDs) for west and parts of central Africa in October/November 2000, as well as the need for communication guidelines on house-to-house, hard-to-reach, community surveillance for AFP, and other polio eradication activities.

These checklists have been laid out in such a way as to make them easy to photocopy. This way, they can be widely distributed to those who require them.

We welcome your comments and suggestions on these checklists. Please contact Grace Kagondug ([kagondug@whoafr.org](mailto:kagondug@whoafr.org)) or Thilly de Bodt ([tdebodt@unicef.org](mailto:tdebodt@unicef.org)).

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# Introduction

This document is a revision and expansion of the checklists and reference guides that the BASICS and CHANGE projects prepared in August 2000 on behalf of WHO, UNICEF and USAID.

The document is intended to complement the *Field guide for supplementary activities aimed at achieving polio eradication – 1996 revision* (WHO/EPI/GEN/95.01 Rev.1). These checklists and guides cover communication and mobilization aspects of routine immunization and disease surveillance, in addition to supplementary immunization for polio eradication. The bibliography lists the sources from which the checklists were adapted or excerpted.

Individual countries and programmes are strongly encouraged to adapt the checklists in line with their current strategies, plans and resources. The lists and guides can be used independently or in combination and can be incorporated into other materials, depending on programme needs. For example, the information can be incorporated into national and subnational guidelines or reproduced and disseminated as stand-alone resource documents to regional/provincial, district, and community-level teams.

As with the previous checklists, most entries are one to three pages in length and are grouped into the following three sections:

- I. **Planning and strategies:** the first section begins with a general checklist for effective communication planning for immunization (No. 1) and a second, brief checklist that focuses on partners and other resources (No. 2). Checklist No. 3 includes the terms of reference for communication committees, which are often responsible for planning. Checklists Nos. 4 and 5 address behaviour change communication objectives: No. 4 reviews basic behaviours for various target audiences and a sample behaviour change strategy, and No. 5 presents a behavioural analysis of barriers to complete and timely routine vaccination and possible ways of overcoming them. Checklist No. 6 provides some general principles for immunization advocacy. Checklists Nos. 7 to 10 discuss strategies for dealing with special situations or audiences: house-to-house immunization (No. 7), tactics for special groups (No. 8), border and conflict situations (No. 9) and dealing with rumours (No. 10). The final checklist in this section (No. 11) offers some lessons learned for introducing new vaccines and technologies.
- II. **Messages and media:** the second section covers messages and media, beginning with some tips on the crucial topic of how health workers communicate with mothers (No. 12). Checklist No. 13 lists key immunization messages for caregivers, and No. 14 outlines key messages for various audiences specifically regarding polio eradication. Checklist No. 15 focuses on message content regarding surveillance for AFP/polio. Checklist No. 16 describes the range of media and materials and their (more and less) appropriate uses.

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III. **Monitoring and supervision:** the final section provides tips on how to monitor communication activities and strategies (No. 17) and then on what to monitor during NIDs (No. 18). The final checklist (No. 19) proposes a series of global communication indicators for immunization-related objectives.

### **Target audiences**

These checklists are intended to be used by national staff in the field, but they also can be used by others to provide technical assistance and/or supervision for polio activities, including:

- Communication/social mobilization planners and managers at national, provincial and district levels.
- District or subdistrict supervisors.
- Vaccination teams, vaccinators, mobilizers and communication specialists/focal persons.
- International consultants and staff.





## Section I.

### Planning and strategies



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# Checklist No. 1:

## Communication for routine immunization, accelerated disease control and innovation

Effective communication activities are an essential type of programme action in support of routine immunization, accelerated disease control (including polio eradication) and innovations (new vaccines and technologies). Communication activities include:

- advocacy
- social mobilization
- behaviour change communication aimed to improve disease control activities and immunization services, as well as public demand and use of those services.

Other key components of effective immunization services include: service delivery; vaccine procurement and supply; cold chain and logistics; training, supervision and monitoring; and surveillance reporting and data management.

Over a significant period of time, an immunization or disease control programme is only as strong as its weakest component, which is why communication strategies and activities are most effective when integrated (or at a minimum are mutually supportive of) other programme components. (Checklists Nos. 18 and 19, on monitoring and appropriate indicators, may also be useful for planning.)

### Principles for effective communication planning and management

The following principles of good communication planning and management are equally applicable at the national, provincial or district levels. It is likely that the most effective programmes are either carrying out these principles already or are working toward implementing them. In a particular country, improving communication planning and implementation may require that the interagency coordinating committee or immunization coordination committee (or its communication subcommittee) revise current strategies and action plans to reflect the principles outlined here.

#### **Effective communication planning**

Effective planning should address advocacy, social mobilization and behaviour change communication related to routine immunization, accelerated disease control (including surveillance) and innovations.

- *Advocacy* focuses on gaining and maintaining the support of decision-makers. Producing an information packet on progress in polio eradication in the country is an example of an advocacy activity.

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- *Social mobilization* aims to gain and maintain the involvement of a broad range of groups and sectors in supporting polio eradication activities. These groups can include private companies and commercial enterprises, other (i.e. non-health) government sectors, nongovernmental organizations (NGOs), and civic groups. Social mobilization also involves informing and motivating the public to participate in immunization activities.
  - *Behaviour change (or programme) communication* encourages behaviour change among target populations in ways that directly support higher and better quality immunization coverage and other disease control actions, e.g. health workers treating mothers with respect and giving essential information clearly and caretakers bringing children for each immunization as soon as they are eligible.

### Key questions

- ☐ *Comprehensive plans*: are there communication plans at national, provincial and district levels that address routine immunization, accelerated disease control and innovations?
- ☐ *Integrated plans*: are these plans integrated into or at least consistent and mutually supportive of other communication plans for maternal and child health? Are these plans integrated into or at least consistent and mutually supportive of the broader plan(s) to address routine immunization, accelerated disease control and innovations?
- ☐ *Operational plans*: are there detailed operational plans, as well as more general plans?
- ☐ *Timely planning*: are plans and funds available soon enough to allow full implementation of plans?
- ☐ *“Living” plans*: are these plans “living” documents that are regularly reviewed, monitored and updated?
- ☐ *Research-based*: are plans for programme communication derived from an in-depth understanding (via qualitative research) of key problem behaviours, reasons for them and obstacles and actions needed to promote improved behaviours?
- ☐ *Logistics*: are there sufficient resources and materials for communication? Are they being effectively allocated to where they are most needed?

### Strengthened communications infrastructure

Communication activities can be improved by strengthening structures for planning, implementing, monitoring and evaluating communication activities at all levels.

### Key questions

- ☐ *Active coordinating groups*: are there active committees or teams responsible for planning and managing communication for immunization at all levels?
- ☐ *Capable, inclusive groups*: do these groups have essential technical capabilities? Do they include all key partner groups?
- ☐ *Focus on communications*: is there a clearly designated person (“focal point”) in charge of social mobilization/communication for immunization and disease control initiatives?
- ☐ *Trained personnel*: are there sufficient trained communication personnel at all levels?
- ☐ *Upgrading personnel*: is there an active programme to upgrade the skills of current personnel and to add experienced and competent personnel?

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- ☐ *Integrated management:* does the Interagency Coordinating Committee (ICC) review plans and results of the major communication activities?
  - ☐ *Active:* Are the communication committees active year-round and not just during planning for NIDs?

### **District level activities**

In many countries, immunization-related communication would be more effective if responsibility and resources were more decentralized.

### **Key questions**

- ☐ *Active provinces and districts:* are provinces and districts active in planning and implementing advocacy, social mobilization and programme communication activities?
- ☐ *National support:* does the national level provide encouragement, guidelines, training, supervision and funding to encourage subnational planning and to implement communication activities?

### **Addressing resistance and obstacles**

It is critical that immunization service staff analyse the reasons for less-than-satisfactory coverage – to determine who and where low-coverage groups are and the relative importance of possible causes for poor results such as limited access to services; health system problems, including inconsiderate treatment of clients; and lack of demand or acceptance of immunization.

### **Key questions**

- ☐ *Coverage analysis:* have the national, provincial and district levels thoroughly analysed coverage (including dropout rates and pockets or groups with low coverage)? Have they explored the possible reasons for any problems? Have they assessed potential solutions?
- ☐ *Use of data:* have the results of these analyses been incorporated into plans and activities at all relevant levels?

### **Communication messages**

Good decisions on messages and media are an important determinant of the effectiveness of communication activities. Monitoring communication is essential to obtain feedback, make changes and avoid continuing ineffective activities because they are not critically considered.

### **Key questions**

- ☐ *Multi-media planning:* does rational decision-making underlie the mix of mass media and interpersonal channels, visual/oral and print channels and centrally produced and locally produced materials and activities? Does the decision-making process include: target audience characteristics, the nature of messages, and time, money and other resources available?

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- ☐ *Research-based messages and materials:* do messages and materials reflect audience research? Are they drafted by communication specialists or simply by immunization experts? Are all messages and materials pre-tested thoroughly with the intended audiences? Are the pre-test findings adequately incorporated?
  - ☐ *Monitoring:* are materials and messages monitored after they have gone into use? Are findings adequately incorporated?
  - ☐ *Evaluation:* are materials and messages evaluated periodically? Are findings adequately incorporated?

#### **Communication support for new priority topics**

Communication interventions are needed to support such new activities as community surveillance and mop-up immunization.

#### **Key question**

- ☐ *Address new objectives:* to what extent do communication plans and activities address local priority topics such as community surveillance, injection safety, measles elimination and introduction of new vaccines?

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## Checklist No. 2:

# Communication aspects of partnerships and other resources

### Resource mobilization

Good planning includes effective and timely identification of needed resources. Governments need to prepare very specific requests when approaching possible supporters, donors and other partners. These partners, in turn, need to do everything possible to avoid the type of bureaucratic delays that can disrupt the disbursement of promised financial support.

### Resource utilization

When developing micro-plans for social mobilization, partners should scrutinize the budgets and ask the following questions:

- ☐ Are these the most cost-effective approaches?
- ☐ Do the messages address known barriers and constraints?
- ☐ Have the messages and materials been pre-tested?
- ☐ Are there sufficient human and financial resources to get the job done?
- ☐ Are the appropriate media channels being utilized to reach all important audiences most effectively?
- ☐ Is the balance between mass media and interpersonal activities right, considering the needs of the programme?
- ☐ Is the level of effort appropriate for the activities planned?
- ☐ Can new partners cover some costs, e.g. the commercial sector?
- ☐ Has the programme made the best use of local people as mobilizers?
- ☐ Have government and private media channels been approached and linked into the overall planning?
- ☐ Are the materials technically appropriate? Do they duplicate other efforts?
- ☐ Are they being distributed on an appropriate schedule and in a timely manner?
- ☐ How are resources and results being used at the national, state/province or lower level? What mechanisms are in place to assure financial accountability and programmatic results? (The ICC should address these issues.)

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## Partner recognition

Partners should actively recognize the hard work of health workers and volunteers, e.g. through a certificate of appreciation or a newspaper advertisement.<sup>1</sup> To avoid complacency, any public communication should note the progress made and also point out that more work is needed in order to achieve the programme's goal.

Give-away items such as T-shirts, caps, or arm bands are good for motivating health workers, and they also help identify the wearer as a member of the campaign and help create a festive atmosphere. Even so, these items have little effect in convincing caregivers to vaccinate previously unvaccinated children, and so the expenditure on such items should be kept to a minimum, and the items purchased should be the least expensive available in the country. Private companies may be pleased to donate this type of item – particularly if their name and logo are readily visible.

The organizational logos of all partners should be included on any social mobilization materials. Not only does this give credit where credit is due, but it helps motivate continued donor participation. These should take up less than 10% of the visual space.

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<sup>1</sup> This section is adapted from “*Tips on Polio Eradication*” (Ogden, July 2000).

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## Checklist No. 3:

### Terms of reference

### for communication committees

The national ICC for immunization should create a communications committee (CC) (subcommittee of ICC) or social mobilization committee.<sup>2</sup> The role of the CC is to plan, coordinate and ensure the successful implementation and management of communication activities for routine immunization, supplemental immunization and disease surveillance. An active CC is critical for increasing and sustaining awareness, support and demand for immunization services and for helping to ensure that efforts to promote demand are appropriate to the level of service availability. The CC should meet throughout the year and should be represented on the ICC.

#### National communications committees (and subcommittees)

##### *Critical responsibilities*

- Advocate for and mobilize resources (to support communication/mobilization activities and NIDs/immunization services).
- Design, produce and disseminate (subcontract, if needed) messages, communication materials and national documents.
- Support the provinces (training, technical assistance and monitoring/supervision of provincial communication activities).
- Monitor, document and evaluate communication, advocacy and social mobilization strategies and activities.

##### *Key activities*

- Develop national communication strategies and plans (annual, five-year, NID-specific) for routine immunization, supplemental immunization and disease surveillance.
- Work with the ICC and individual partners to prepare national directives on communication/social mobilization, identify communication needs and provide recommendations to address these.
- Identify persons (preferably including ministry of health (MOH)/immunization communication representatives) to coordinate CC activities and to liaise with the ICC, MOH and other ministries and partners to ensure that activities are supported, conducted and evaluated.

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<sup>2</sup> Sources: adapted from Communication Handbook for Polio Eradication and Routine EPI, Annex 8 (UNICEF/WHO/Polio Partners, November 2000), and Briefing Guide on Planning, Management and Implementation of Communication for EPI/NID, Annex 1, DR Congo (UNICEF, March 2000).



- 
- Work with immunization staff and other resource persons to plan and manage communication research and to use research findings to develop and implement strategies for addressing problems and obstacles and for seizing opportunities.
  - Oversee and coordinate implementation, monitoring and evaluation of communication for routine immunization, supplemental immunization and disease surveillance.
  - Mobilize international, national and local community resources in support of communication strategies for routine and supplemental immunization and surveillance.
  - Facilitate formation, supervision and support of national and provincial/district committees and other structures to support immunization communication at subnational levels.
  - Develop and implement training, data collection and analysis and other capacity-building activities to strengthen immunization communication at all levels.

### **Membership**

The CC should be multi-disciplinary, with broad membership to enable mobilization of community support and resources from a wide base. The CC should identify focal persons to coordinate specific activities such as NIDs. The committee should include representatives of:

- Public sector organizations and ministries that work with children and/or children's issues:
  - ☐ immunization staff (managers, communication specialists, technical advisers, others);
  - ☐ ministry of health and population (immunization units, health facilities, evaluation unit, others);
  - ☐ ministries of information, social services, education, youth and sports;
  - ☐ medical facilities for military and police;
  - ☐ health insurance representatives;
  - ☐ university and public health professors and staff;
  - ☐ provincial administration, political leaders and health representatives;
  - ☐ representatives of preparatory, primary and secondary school systems.
- National media:
  - ☐ radio, television, newspapers, magazines, press organizations and regional and international affiliates
- Partner organizations for NIDs and immunization services/systems
  - ☐ UN agencies such as WHO, UNICEF, United Nations High Commissioner for Refugees (UNHCR) and others;
  - ☐ bilateral organizations such as USAID and its partners, the Department for International Development (DFID), the European Union and others;
  - ☐ NGOs and private voluntary organizations (PVOs) such as Rotary, Red Cross, International Rescue Committee, World Vision, CARE, Africare and others.

- 
- Social groups (with national representatives) who work with children and/or children's issues:
    - ☐ religious leaders;
    - ☐ religious organizations;
    - ☐ youth, women and men's groups and societies;
    - ☐ local and national NGOs working in health.

### **Provincial/district communication committees**

The overall responsibilities of committee (and subcommittees, if needed) include:

- Conduct advocacy and mobilize resources to support communication/mobilization activities and NIDs/immunization services.
- Mobilize and build partnerships with provincial/district social groups (such as NGOs, PVOs, and religious organizations).
- Work with local media and traditional communication channels for immunization advocacy.

### **Tasks of the committees**

- Adapt national communication/social mobilization strategies to accommodate local challenges, resources, languages
- Monitor application of national directives and their implementation in communication/social mobilization activities for immunization services and NIDs.
- Ensure the implementation of advocacy, resource mobilization, interpersonal communication, social mobilization and provincial media for immunization services, NIDs and surveillance.
- Tailor key messages and materials to the local context and languages.
- Disseminate documents developed at national level.
- Coordinate and monitor communication activities at the district and community levels.
- Report on activities, accomplishments and needs for communication and social mobilization to the central level.
- Provide feedback, supervision and recommendations to district and community levels.
- Participate in operational and formative research activities, and document and evaluate provincial and district activities, particularly with groups that are hard to reach or to convince.
- Ensure that district level trainers receive appropriate training and supervision in undertaking communication and social mobilization activities.

### **Membership**

As at the national level, local MOH representatives with experience and/or training in communication and social mobilization should play key roles in local CCs. The committee members should include provincial/district representatives of the organizations and ministries noted for inclusion on the national level communication committee (see above).



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## Checklist No. 4:

# Behaviours needed to achieve immunization objectives

Programme communication activities can serve several functions: they can simply inform people and/or make them aware of something, but they also can inform and motivate specific audiences to carry out specific actions or behaviours. When planned and executed strategically, communication activities can play an integral role in encouraging and supporting improved (health promoting) practices.

The first step in developing a comprehensive behaviour change strategy is to determine what actions are desirable for various groups of people (audiences) in order for essential programme objectives to be reached. Some broad desirable behaviours for immunization are listed below.

The next step is to consider the acceptability and feasibility of the desired behaviours, and to refine them as needed. The final strategy should include communication and complementary activities in training, service delivery and other areas to promote these behaviours and make them easier for people to carry out. The analysis required to carry out these steps can be conducted using existing information, but the strategic plan is likely to be much more effective if such analysis is based on focus group discussions or in-depth interviews that can uncover existing understanding, perceptions and attitudes towards immunization related issues.

A sample of a general strategy is provided for one desirable behaviour – that health workers give mothers essential information and invite their questions. The left side of the format shows a behavioural analysis of the desired action: the current behaviour, the desirable behaviour and the obstacles and facilitating factors that a behaviour change strategy must address. The right side of the format illustrates how actions in communications and a number of complementary areas can be mutually supportive in reducing barriers and making it easier for people to carry out health promoting actions.

### **Desirable behaviours for immunization**

#### ***Mothers and other primary caretakers***

- Bring your babies to immunization service delivery points at the ages recommended in the national schedule.
- Always bring the child's health or vaccination card.
- Treat any side effects as recommended.
- Encourage relatives and friends to have their babies immunized on schedule.
- Seek and/or accept tetanus immunizations for yourself. (This is applicable to mothers and other women of childbearing age.)

- 
- Look for and report any new case of acute flaccid paralysis (AFP); if a child develops AFP, bring the child immediately to a health facility and cooperate in having the child provide two stool samples.
  - For campaigns, bring children of the recommended ages to immunization sites on the day(s) recommended. Or, for a house-to-house strategy, keep those children around the home and have them immunized when the team arrives.

### ***Fathers***

- Take babies yourself for vaccinations at the ages recommended in the national schedule, or encourage their mothers to do so.
- Provide mothers with the money they need for transport or other expenses related to immunizing children.

### ***Health workers who immunize***

- Perform all immunization service tasks correctly, including those that ensure safe vaccine handling and injections.
- Treat mothers with respect (do not yell or criticize).
- Give mothers and other caretakers the following essential information: when the next immunization is due and where to get it, what side effects are possible and what to do if any occur.
- Organize/reorganize immunization services to make them as convenient for and acceptable to mothers as possible.
- Implement schemes to honour families whose children are fully immunized by age one.

### ***Policy-makers***

- Allocate sufficient financial and human resources to immunization and disease-control and eradication activities.
- Demonstrate to the public and to the health staff your personal support for immunization and disease-control and eradication activities.

### ***Community leaders***

- Explain to families the importance, benefits and safety of vaccination.
- Ensure that families know when their child needs to get the next dose(s) of vaccine.
- Motivate families to complete each child's basic immunizations in the first year of life.
- Inform families about special immunization days such as NIDs, subnational immunization days (SNIDs) and mobile brigade visits and about the introduction of new vaccines or other improvements in the immunization service.
- Help mobilize community support for immunization activities.

**Behavioural analysis and strategy for one desirable behaviour**  
**Target audience: health workers (HWs) who immunize**

Behavioural analysis			Behaviour change strategy (activities to support the desirable behaviour)					
Current behaviour	Desirable behaviour	Barriers/ obstacles	Motivations/ facilitating factors	Communication activities	Training	Service delivery changes	Institutional changes	Other activities
HWs may write the return date in the child's health card, but few give mothers any other information or invite questions.	Give mothers/ caretakers essential information, including when the next immunization is due and where to get it; and what side effects are possible and what to do if any occur.	HW training does not provide skills or focus on importance of communicating with mothers.  There are real or perceived social, economic, class and possibly ethnic differences between HWs and clients.  HWs lack time to give good counselling (because so many people are waiting for care).  Mothers don't expect to receive information and/or be invited to ask questions.  HWs and mothers do not speak the same language or dialect (in some settings).	HWs should get positive feedback from clients and community members if they communicate better and give essential information.  HWs should see an impact in improved coverage and reduced dropout rates.	Use radio, TV (where appropriate), posters, community meetings and other channels to build the idea that there is an essential partnership between HWs and mothers to improve child health.  Develop and use a job aid to remind HWs of essential information to give to mothers and how to talk effectively to mothers.  Orient community volunteers and school children on immunization and on the necessity of a partnership between parents and HWs. Encourage them to discuss these ideas with others.	Train HWs on the importance of providing good counselling, with essential information during immunization visits.  Train HWs to use job aids.	Make changes in health facility organization to provide HWs more time with each mother. This may involve: expanding hours when immunization is offered, doing more one-on-one counselling and fewer group talks or adding staff or volunteers.  If language is a barrier, organize a network of community volunteers who can facilitate communication.	Modify supervision and monitoring systems and procedures as necessary to focus on and acknowledge good counselling re: immunization and other topics.  Commence monitoring of dropout rates at all levels, down to the individual facility, and give feedback.	Arrange for community members to tour health facilities and hear about their services, organization and constraints.



## Checklist No. 5:

# Addressing barriers to complete and timely immunization

Possible barriers	Possible programme actions
Parents' low motivation to immunize children because of their vague understanding of its purpose and importance	<p>Orient community leaders and encourage them to talk to parents and youth about immunization.</p> <p>Improve talks and counselling by health workers.</p> <p>Encourage radio and press coverage.</p> <p>Teach about immunization in health fairs and other events.</p>
Parents' false beliefs/perceptions (e.g. that immunization protects against malaria, that mothers' tetanus immunization protects babies against many diseases)	<p>Orient community leaders.</p> <p>Improve talks and counselling by health workers.</p> <p>Encourage radio and press coverage providing basic immunization information.</p> <p>Teach about immunization in health fairs and other events.</p>
Parents' fear of side effects	<p>Develop a counselling aid to remind health workers to always tell mother/ caretakers: 1) when to come for the next immunizations and how to remember, and 2) that side effects may occur and what to do should they occur.</p> <p>Give practical training on counselling/using the aid and sensitize about how crucial their treatment of mothers is to programme success and impact.</p>
Parents' concern with adverse events following immunization	<p>Increase funding and priority for training and supervision to improve health worker practices.</p>
Mothers don't know their baby's age and/or when their baby's next immunization is due.	<p>Learn the strategies of illiterate mothers who bring in their babies on time and then disseminate the best examples.</p> <p>Develop and disseminate local calendars and/or memory aids.</p> <p>Develop child-to-child programmes, e.g. students can "adopt" a certain number of families to ensure that they know when to seek services.</p> <p>Coordinate with primary schools and adult literacy classes to be sure that they teach how to read the immunization schedule and child health card.</p> <p>Develop a counselling aid to remind health workers to always tell caretakers:</p> <ol style="list-style-type: none"> <li>1. when to come for the next immunizations and how to remember, and</li> <li>2. that side effects may occur and what to do should they occur.</li> </ol> <p>Give practical training on counselling/using the aid and sensitize re: how crucial their treatment of mothers is to programme success and impact.</p>



Possible barriers	Possible programme actions
Husbands/partners and/or other influentials don't want mothers to take babies for immunization because of time/lost labour, expense, and/or fear of side effects.	<p>Encourage radio and press coverage that addresses the barrier.</p> <p>Orient community leaders and carry out advocacy with community groups.</p> <p>Teach about immunization in health fairs and other events.</p>
Parents' refusal to have their children immunized due to religious beliefs.	Educate religious leaders, particularly the ones favourable to immunization in order to gain their support and empower them to encourage their fellow members to have their children immunized.
Families have poor access to immunization services.	<p>Create more facilities or posts.</p> <p>Work with communities to improve roads.</p> <p>Increase funding for mobile brigades.</p> <p>Work with community and private sector groups to arrange transport from communities to facilities or to improve outreach to communities through appropriate transport, additional staff or other mobilization.</p>
Low staff motivation regarding immunization.	<p>Give training and/or orientation to teach skills and change attitudes.</p> <p>Each facility can monitor dropout rates (by comparing DPT1 and DPT3 or measles each month).</p> <p>Develop and use other indicators so that individual facilities and health workers get feedback on how they are doing.</p>
Mothers' perceptions of unpleasant treatment at health facilities, e.g. long waits, health workers yelling at mothers for forgetting the child health card or bringing the baby in late, criticizing dirty babies or clothes, not talking to mothers in the language they are most comfortable with.	<p>Improve treatment via practical training on counselling/using the counselling aid and sensitize re: how crucial their treatment of mothers is to programme success and impact.</p> <p>Use radio (e.g. testimonials, drama) to spread the image of the friendly, trustworthy health worker and the importance of parents and health workers working together for children's health.</p>
Long waits at health facilities.	<p>Long term: build more facilities/hire more staff.</p> <p>Short term: study reasons for delays and try to address them; e.g. not waiting until there are sufficient mothers to give a health education talk.</p> <p>Lengthen immunization service hours.</p>
Health workers' charging mothers for the child health card or other supplies or services that should be free of charge.	<p>Create and place a poster in all facilities that clarifies what is free, for what there are charges, and how much.</p> <p>Give better support and supervision to health workers; raise health workers' salaries so they do not have to supplement their income.</p> <p>Encourage community groups to provide small incentives to health workers.</p>
Lack of reliability of services, i.e. health staff are not present to vaccinate when they are supposed to be available.	<p>Districts should improve facility-based monitoring.</p> <p>Community groups should be encouraged to report problems to the district health manager.</p>

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Possible barriers	Possible programme actions
Occasional lack of vaccine or other essential supplies and equipment.	Districts should improve stock monitoring and report stock-outs.  Community groups should be encouraged to report problems to the district health manager.
Inappropriate schedule of immunization services for both facilities and mobile brigades (e.g. services available when mothers are busy in fields, markets, etc.).	If this is a general problem, modify services days and/or hours; give districts and individual facilities more flexibility to adjust their immunization days and hours.
Source: Adapted from an analysis from CHANGE project work with the immunization services in Mozambique (2001).	



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## Checklist No. 6:

# Advocacy for polio eradication and routine immunization

Two publications are briefly summarized here: *Advocacy: A Practical Guide with Polio Eradication as a Case Study* (WHO/V&B/99.20), October 1999, and *Advocacy for Immunization: How To Generate and Maintain Support for Vaccination Programs* (GAVI, January 2001). The first offers practical ideas for planning and implementing effective advocacy for polio eradication, which are summarized in the table below; the second outlines a series of steps for advocacy programmes, which are summarized below.

Targeting advocacy messages to different audiences		
Audience	Potential concerns	Possible messages
<b>Decision-makers/ politicians</b> <ul style="list-style-type: none"> <li>■ President/prime minister</li> <li>■ Ministers of health, planning, finance</li> <li>■ Local administrators</li> <li>■ Parliament and congress</li> </ul>	<ul style="list-style-type: none"> <li>■ Budgetary implications</li> <li>■ Public opinion</li> <li>■ Opportunity to show leadership and take credit for success</li> <li>■ The liabilities of inaction</li> </ul>	<ul style="list-style-type: none"> <li>■ Immunization is the most cost effective health intervention</li> <li>■ Immunization is the right of every child</li> <li>■ Polio eradication is establishing access to children who have never been reached before</li> <li>■ As long as polio exists, every child is at risk</li> <li>■ Eradicating polio will save the world US\$ 1.5 billion annually</li> </ul>
<b>Donors</b> <ul style="list-style-type: none"> <li>■ Foundations</li> <li>■ Bilateral agencies (e.g. SIDA, USAID, DFID, JICA)</li> <li>■ Multilateral agencies (e.g. World Bank)</li> </ul>	<ul style="list-style-type: none"> <li>■ Ability to produce and document results</li> <li>■ Cost-effectiveness of an intervention</li> <li>■ Feasibility of integrating strategy with existing initiatives</li> <li>■ Sustainability of project</li> <li>■ Potential domestic benefits</li> </ul>	
<b>Journalists</b> <ul style="list-style-type: none"> <li>■ Health reporters</li> <li>■ Foreign correspondents</li> <li>■ Editors</li> <li>■ Feature writers</li> <li>■ Columnists</li> <li>■ Economics/labour reporters</li> <li>■ Women's issues reporters</li> </ul>	<ul style="list-style-type: none"> <li>■ News value and timing</li> <li>■ Potential "CBS" (Controversy, Big names or Sensation)</li> <li>■ Has the story been told before?</li> <li>■ Are there good visuals and spokespersons?</li> </ul>	<ul style="list-style-type: none"> <li>■ Key messages will depend on the outlet; e.g. highlight the economic benefits for a financial publication</li> <li>■ Feature stories on the success of the eradication initiative and immunization and the people who deliver and benefit from it</li> <li>■ News stories on outbreaks, trends, NIDs, ceasefires</li> <li>■ Human interest stories about volunteers delivering vaccine</li> </ul>
<b>NGOs</b> <ul style="list-style-type: none"> <li>■ Relief organizations</li> <li>■ Development organizations</li> <li>■ Human rights organizations</li> <li>■ Children's organizations</li> <li>■ Practitioners' organizations</li> </ul>	<ul style="list-style-type: none"> <li>■ Donor and membership support</li> <li>■ Impact on beneficiaries</li> <li>■ How message fits with mission statement</li> <li>■ Common agendas and shared visions</li> <li>■ Potential to play a unique role</li> </ul>	<ul style="list-style-type: none"> <li>■ Polio eradication and successful routine immunization depend on mobilizing communities</li> <li>■ Your constituents can help</li> <li>■ Help build local infrastructure to improve the health of your constituents</li> </ul>
<b>Health practitioners</b> <ul style="list-style-type: none"> <li>■ Public and private sector health workers</li> <li>■ Medical associations</li> <li>■ Research, academic institutions</li> </ul>	<ul style="list-style-type: none"> <li>■ Feasibility of eradication</li> <li>■ Opportunities to use new research and innovations</li> <li>■ Financial and legal implications for one's work</li> </ul>	<ul style="list-style-type: none"> <li>■ The polio eradication strategy and routine immunization are proven, effective interventions</li> <li>■ Polio eradication helps build health infrastructure, puts surveillance systems in place and train health staff</li> <li>■ Polio eradication is helping to strengthen immunization and other preventive health services</li> </ul>
<b>Corporations and Industry</b> <ul style="list-style-type: none"> <li>■ Multinationals</li> <li>■ Local businesses</li> <li>■ Labour organizations</li> </ul>	<ul style="list-style-type: none"> <li>■ Impact on workforce</li> <li>■ Impact on markets</li> <li>■ Cause-related marketing potential</li> </ul>	<ul style="list-style-type: none"> <li>■ Polio eradication and routine immunization are good and measurable social investments</li> <li>■ There is no such thing as a local health problem</li> <li>■ Your investment can help the local community</li> <li>■ Investing in polio eradication offers good exposure in local markets</li> </ul>
<b>General public</b> Issues popular with the public find their way onto the political agenda and a groundswell of public opinion can have a strong influence on governments	<ul style="list-style-type: none"> <li>■ Personal level of risk</li> <li>■ Response of government/health authorities to protect the public</li> <li>■ A moral duty to help others</li> </ul>	<ul style="list-style-type: none"> <li>■ Helping tackle problems in poor countries can make good business sense</li> <li>■ Poliovirus can be imported into a country in a matter of hours</li> <li>■ The savings from eradicating polio can be used for other purposes</li> </ul>
Source: <i>Advocacy: A Practical Guide with Polio Eradication as a Case Study</i> (WHO/V&B/99.20), October 1999.		

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## **Generating support, step-by-step**

*Advocacy for Immunization* (GAVI, January 2001) recommends the following steps:

### ***Step 1: Gathering information***

Assemble facts and figures, create charts and graphs, analyse policies and practices, analyse the media, define your audiences (potential partners, key policy and decision-makers, mass media, the public and potential adversaries).

### ***Step 2: Building a plan***

Develop advocacy objectives; assess available resources; determine scope, timeline, and budget.

### ***Step 3: Creating messages and materials***

Create compelling messages, develop educational materials (charts and graphs, physical samples, immunization success stories, information on diseases and outbreaks, brochures, presentations, news clippings, posters and promotional materials, public service announcements, video and radio programmes)

### ***Step 4: Building a strong coalition***

Build it, then maintain it.

### ***Step 5: Engaging policy and decision-makers***

Schedule face-to-face meetings with policy-makers or their staff, invite policy-makers to visit immunization sessions and children's wards, communicate regularly with policy-makers.

### ***Step 6: Informing and involving the public***

Narrow the audience, deliver messages through proper channels.

### ***Step 7: Working with mass media***

Be the first person reporters turn to for information on immunization, create a press list, develop press materials, create press opportunities, expect the unexpected.

### ***Step 8: Monitoring and evaluating your work***

Document your process (monthly or quarterly), evaluate the outcomes (biannually or annually), evaluate your impact on long-range goals (every three to five years).



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## Checklist No. 7:

# Communication planning for house-to-house immunization

Some countries are undertaking house-to-house polio NIDs as a strategy to reach every child, especially “zero-dose” children.<sup>3</sup> To succeed, however, this strategy requires even more planning, training and supervision than NIDs based on vaccination posts. Local level advocacy and interpersonal communication targeted to special groups are particularly important.

☐ **Complete micro-plans that include detailed mapping and enumeration of target populations**

Local teams should prepare or obtain (from the government or a local NGO) detailed maps of areas and communities and enumerating the target populations (the number of eligible children per community or catchment area). These planning tools are particularly important in hard-to-reach/low-vaccination coverage areas. Where feasible, mapping and enumeration can also be used to track which teams are covering which areas and thus help to avoid overlap or gaps in coverage of households. Any maps should be updated each year to capture any movement or displacement of populations.

☐ **As part of micro-planning at provincial/district levels, local planners, in collaboration with the national level, should review plans and coverage results from the previous rounds**

Micro-planning at least a month prior to NIDs helps to determine if more vaccination teams are needed and where these teams should go. Each house-to-house vaccination team should be expected to cover no more than 200 children per day. Plans for communication/social mobilization should be included in every micro-plan.

Planning teams should examine coverage data from difficult areas to help identify target populations and unvaccinated areas and to help target intensive interpersonal communication the week before the second round and during the three days of vaccination (using megaphones, house-to-house volunteers in “hot spot” areas, etc.). This communication focus should be complemented by a service-delivery focus on these areas, for example, by using extra vaccination teams, giving first day/morning vaccination priority and designing special coverage strategies for teams going long distances. If feasible during planning, local planners should hold discussions with key informants and community members to gain insights into the possible reasons for low coverage, as well as into social values and perceptions and beliefs related to immunization.

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<sup>3</sup> This checklist is adapted from the following sources: *Field Guide for 1999 NIDs (House-to-House Strategy), Nigeria*, National Programme on Immunization, 1999; *IEC Consultation for First Round 1999 NIDs, Egypt*, (Shimp, October 1999); and *Communication Handbook for Polio Eradication and Routine EPI, Chapter 5* (UNICEF/WHO/Polio Partners, November 2000).



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☐ **Plan and carry out training on interpersonal communication for all immunizers, mobilizers and other volunteer**

All NIDs supporters should have training and practice in the basics of interpersonal communication and key messages. (See checklists Nos. 12, 13 and 14.)

☐ **Include communication questions/indicators specific to house-to-house strategies in supervisory training and checklists**

Train all supervisors to include communication questions and observations during field visits (see checklists Nos. 17, 18, and 19) and, if possible, include communication specialists in supervision.

☐ **Messages and instructions for vaccination teams and supervisors in difficult areas should emphasize the importance of going to the hardest-to-reach areas first and then working backward to cover the entire target population**

Training and supervision should encourage teams to:

- ☐ Go first to higher floors of apartment buildings or to homes and/or farms outside the main communities.
- ☐ Look in each dwelling and ask about potentially unvaccinated children (especially sleeping children, sick children, neonates and visiting children).
- ☐ Have a volunteer (a community leader, student, teacher or other members of the community) knock door-to-door or go out to peripheral areas to encourage children to be brought for vaccination. Having a community volunteer accompany each vaccination team can also help ensure that every available child immunization card is reviewed and that caregivers are informed and/or reminded about when the next routine immunization is due.

Where door-to-door vaccination is not possible, pre-planning teams (mapping and census representatives, for example) should inform communities that residents in densely populated areas or very remote homes and/or farms should be prepared to bring children for immunization when mobile teams come through the area. Vaccination teams and monitors should use data on the defaulters, zero-dose children, and/or lower coverage pockets from each round to cross-check that these areas and target populations are vaccinated during subsequent rounds.

☐ **Include simple communication guidelines for *local level* health staff and mobilizers in house-to-house field guides and micro-planning training guides**

Guidelines should describe:

- ☐ the role of local health staff and mobilizers in observing and following supporting vaccinator teams;
- ☐ social mobilization and key messages for the local media for local leaders and for interpersonal communication (megaphones, door-to-door, religious leaders, women's groups, etc.);
- ☐ the important role of health teams in giving key messages and following good interpersonal counselling principles.

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## Checklist No. 8:

# Communication strategies for special groups

For a variety of reasons, certain groups of people remain unreached by immunization services or reject them. These reasons range from religious and traditional beliefs and practices, to difficult access due to infrastructure and terrain, to economic and/or political situations that have caused populations to migrate, among others. The following table identifies some special groups and outlines some possible communication strategies to reach them. In all cases, communication planning should begin early; should be sensitive to people's beliefs, practices and constraints; and should utilize interpersonal communication to the extent possible.<sup>4</sup>

### Strategies for reaching special groups

Group	Communication strategies
Nomadic/migratory groups and families	<p>Determine dates, entry and exit points and locations where large numbers of this population will come together, then plan/implement activities that correspond.</p> <p>Utilize members and former members of these communities as mobilizers and vaccinators.</p> <p>Prepare/use mobile teams.</p> <p>In border areas, carry out planning and coordinated actions with the neighbouring jurisdiction.</p>
Ethnic or other minority groups (e.g. Pygmies)	<p>Visit the sites with someone from that community.</p> <p>Brief traditional leaders to encourage their support.</p> <p>Put in place a team of local mobilizers/educators to work with these communities.</p>
Families that fear contact with government (e.g. lack proper documents)	<p>Work with local NGOs that provide assistance to these families and use local mobilizers/educators and community groups/leaders to provide information.</p> <p>Visit the families to explain the initiative, the importance of vaccination, and that the government will not be registering their child or asking for their papers.</p>
Groups with difficult physical/geographical access	<p>Ensure transport to reach these groups.</p> <p>Visit the sites with someone from that community.</p> <p>Put in place a team of local mobilizers/educators to work with these communities.</p>

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<sup>4</sup> This checklist is adapted from the following sources: *Communication Handbook for Polio Eradication and Routine EPI, Chapter 8* (UNICEF/WHO/Polio Partners, November 2000); "Briefing Guide for Planning, Management, and Implementation of Communication for EPI/NIDs," Annex 4.4 (UNICEF, March 2000).

Group	Communication strategies
Religious or traditional sects that refuse vaccination	<p>Identify and brief the leader(s) of the sect or religion to encourage their support.</p> <p>With the participation of their leader, meet with members to inform/educate them about the initiative and vaccination.</p> <p>Plan and implement activities with their community groups/leaders at locations and dates that do not conflict with cultural/religious events.</p>
Refugees	<p>Visit camps to explain the initiative and the importance of vaccination.</p> <p>Work with local NGOs that provide assistance to these families.</p> <p>Identify leaders among the refugee populations and organizations in the camps, and then try to convince them to advocate for and educate on vaccination.</p>
Wealthy/elite groups and their staff	<p>Use high-level political and/or society leaders (local Rotary clubs, diplomatic missions, etc.) as advocates – credible, knowledgeable and respected people in that community.</p> <p>Provide educational materials explaining the initiative and outlining the benefits and public health importance of immunization.</p> <p>Engage private doctors and health officials as advocates, educators and vaccinators.</p> <p>Provide information through mass media and interpersonal communication targeted at these individuals.</p>
Homeless families or families in dense urban areas; street children	<p>Visit their communities and individual dwellings to explain the initiative and the benefits and importance of vaccination.</p> <p>Use community mobilizers to provide information in the neighbourhood, particularly at common gathering places (markets, water sources, and others).</p> <p>Identify and engage any leaders, organizations and women's groups who can act as advocates, mobilizers and educators.</p>

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## Checklist No. 9:

# Mobilization/communication for border and conflict situations

### Mobilization at borders<sup>5</sup>

For supplemental immunization, start planning early to coordinate activities on both sides of borders (both national borders and borders between districts and provinces), because border crossing areas are frequently crowded, busy and noisy. Representatives from each side of the border must meet and jointly plan activities to define which vaccination teams will cover which areas. This is particularly important where the border is not clearly defined or where there is a lot of border traffic. Teams always should verify whether communities across borders have been vaccinated. Suggested strategies include:

- ☐ Synchronize vaccination activities for three to four days.
- ☐ Hang a “gateway” sign at the approach to all roads/pathways crossing the border. The sign should include the following information in local languages:
  - Our countries are working together to eliminate the polio disease.
  - Polio vaccine is safe, easy to take (drops given by mouth) and is free to all children under five years of age from any country. Please stop for vaccination.
  - The vaccinators will give your child two drops of oral polio vaccine (include a visual or pictures).
  - Every child counts.
- ☐ Clearly mark the vaccination sites, and make the vaccination team members easily recognizable. Vaccinators and assistants should wear identifiable clothing, such as an apron, armband, hat or T-shirt.
- ☐ If possible, have police or border authorities stop individuals and vehicles and direct them to the vaccination site.
- ☐ Have many vaccinators on the road and at checkpoints. An assistant can mark the tally sheets and provide information on the vaccination.
- ☐ Have mobilizers with megaphones or microphones make regular announcements around border areas.
- ☐ Give orientation and materials to local leaders and local radio stations and ask them to support cross-border immunization.

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<sup>5</sup> This checklist is adapted from: “Tips on Polio Eradication” (Ogden, July 2000); and *Communication Handbook for Polio Eradication and Routine EPI* (UNICEF/WHO/Polio Partners, November 2000).

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### **Conflict situations**

- ☐ Use diplomatic corps and locally influential and credible sources as a liaison among various factions and to provide information and vaccination services (e.g. the Red Cross, UN, NGOs, community organizations, religious leaders). Emphasize that polio eradication is for the benefit of young children; it is “above politics”.
- ☐ Have politicians (or rebel) leaders involved in the conflict sign a “Days of Tranquillity” agreement for all vaccination days in their regions.
- ☐ Disseminate children’s rights messages and information on vaccination and its importance in preventing diseases to political (rebel) leaders and their constituencies.
- ☐ Use international and local media to broadcast information on the Days of Tranquillity and ceasefires. Encourage factions to observe safe passage for vaccinators and vaccination teams. Provide information on the campaign and on where vaccinations will be given.

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## Checklist No. 10:

# Dealing with rumours

- Who starts rumours?<sup>6</sup> Often, people with vested interests start rumours, including health workers, traditional healers, medical or general press, politicians/political groups, anti-vaccine groups, religious/cultural objectors. Examples of rumours: OPV is a contraceptive to control population or to limit the size of a certain ethnic group. OPV is contaminated by the AIDS virus or mad cow disease. Children are dying after receiving OPV.
- What fuels rumours? The spread of rumours often reflects inadequate or inaccurate knowledge, a mistrust of government, ulterior motives such as greed or a desire for publicity, among others.

### Responding to rumours

- Analyse the situation. Move quickly to respond to rumours, but first:
  - Clarify the extent of the rumour or misinformation (type of messages circulating, source, persons or organizations spreading the rumour).
  - Determine the motivation behind the rumour (lack of information, questioning of authority, religious opposition or other).
- Turn the rumour around. Go to the source and ask what the solution is. Acknowledge existing shortcomings if necessary. Offer the source an opportunity to be part of the solution.
- Advocate
  - Target key opinion leaders for meetings (politicians, traditional and religious leaders, community leaders, health workers).
  - Launch a corrective campaign at the highest level, e.g. the minister of health, governors, district administrators, etc.
  - Meet with local leaders at sites where the individuals/groups are comfortable and can feel at ease to ask questions and have peers present.

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<sup>6</sup> This checklist is based on the following sources: "Dealing with Rumours" (Clements and Drake, 18-21 June 2001), "Tips on Polio Eradication" (Ogden, July 2000), *Communication Handbook for Polio Eradication and Routine EPI* (UNICEF/WHO/Polio Partners, November 2000). See also: *Immunization Myths & Realities. Responding to Arguments against Immunization. A Guide for Providers* (Hall and O'Brien, 1998), and *Poliomyelitis, OPV & Misconceptions on Vaccinations* (USP, August 2000).

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- ☐ Strengthen alliances. Involve all immunization partners through social mobilization committees, ICCs, etc. Alert and collaborate with relevant ministries and NGOs. Encourage onward briefings (to stimulate a cascade effect).
  - ☐ Conduct training. Train volunteers and health workers to handle rumours. Disseminate tailored information on common misconceptions and guidelines on response. Promote positive key messages.
  - ☐ Mobilize communities. Empower local people to address and take responsibility for the issue. “Demystify” polio eradication through education, taking the initiative to the community via such channels as films, street players, schools, community seminars and discussion groups.
  - ☐ Recruit assistance from the health community. Seek collaboration from health professionals in the public and private sectors, including doctors, nurses and vaccinators, NIDs volunteers, other members of partner organizations.
  - ☐ Conduct a mass media campaign. Involve all appropriate media (TV, radio, newspapers, street theatre). In particular, seek out media that have already misinformed the public. Call on previously established relationships with the media. Delegate one spokesperson to handle the media questions. Display confidence, for example, have the First Lady photographed giving OPV to her baby; interview pop idols or sports celebrities explaining the truth. Use print materials resources where appropriate to provide answers to common questions, to correct common misconceptions and to deliver positive messages.

### **Preventing rumours**

- ☐ Be “proactive”: implement ongoing activities to prevent and limit rumours.
- ☐ Use local NGOs, religious organizations or community groups that have the respect of these groups/individuals as mobilizers and educators.
- ☐ Involve community leaders in planning and implementing health activities.
- ☐ Approach communities early, and make frequent contact.
- ☐ Present health issues as national social, economic and security issues.
- ☐ Discuss NIDs with public and private practitioners in advance to obtain their support.
- ☐ Make communication and social mobilization a continuous activity. Design strategies that establish continuity between NIDs and routine immunization.

### **Overcoming challenges and constraints**

- ☐ Rumours often start during NIDs, so responses must be immediate to avoid jeopardizing the success of the effort.
- ☐ Resources to undertake a rapid response to rumours are rarely budgeted.
- ☐ Programmes may not want to allocate their limited resources to cover a contingency that may or may not end up being a problem.
- ☐ Rumours are sometimes the result of insufficient attention to communication vis-à-vis “technical priorities.”
- ☐ The process of decentralization may complicate the programme’s ability to launch a rapid response.

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### **Lessons learned**

- Tailor immediate and ongoing strategies and respond accordingly.
- Build ongoing relationships with communities (religious, social, media).
- Disseminate consistent messages.
- Take the time to deal with rumours. Doing so will benefit immunization campaigns as well as routine immunization.





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# Checklist No. 11:

## Communication for the introduction of new vaccines and technologies

This section reviews lessons learned and issues related to communication activities for the introduction of new vaccines and technologies into established immunization services.<sup>7</sup> This topic is particularly important given the substantial support available for new vaccines and auto-disable (AD) syringes through the Global Alliance for Vaccines and Immunization (GAVI) and The Vaccine Fund.

### Improve the overall immunization services

The introduction of new vaccines and technologies can provide an opportunity both to improve overall services and re-motivate health staff as well as to build public demand for routine immunization. It is always important for programmes to analyse causes of low coverage (if possible on the basis of research findings) and to address the major causes. This is especially crucial now to prevent negative experiences with service delivery from damaging the reputation of new vaccines and technologies.

The addition of new vaccines and AD syringes means that a country's immunization service is "improved," since users can now be protected against more diseases (directly through immunization and indirectly through safer injection). This idea needs to be promoted among the public and among the health staff.

### Communication strategies for new vaccines and technologies

#### New vaccines

The communication strategy should be appropriate to the characteristics of the new vaccines or technologies. If the new vaccines require no additional immunization visits and/or no new injections (as in the case of quadrivalent or pentavalent vaccine formulations), parents and caretakers need to take no new action. In this case, the appropriate basic message for the public is that the immunization service is now improved because it offers protection against more diseases. In many cases, this means children receive more protection (or a bonus) with no more effort (no more visits and/or injections). In addition, the new antigens have virtually no side effects.

The introduction of new vaccines, however, does imply that health workers must perform new tasks. Therefore, *health workers should be the focus of much of the communication and training related to new vaccine introduction.*

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<sup>7</sup> This checklist is based on CHANGE Project experiences in Mozambique and Madagascar, and Hepatitis B Vaccine Introduction: Lessons Learned in Advocacy, Communication and Training (Wittet, January 2001).

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The precise type and level of protection of the two most common new vaccines, hepatitis B and Hib, are difficult to explain to the public. In the case of hepatitis B, the effects will not be seen for a generation, since the virus is mostly manifested in liver disease in adults. In the case of Hib, the vaccine protects against *some* (but not all) pneumonia and meningitis. Given these complicated stories, it is probably best to describe the vaccines' benefits only in general terms and avoid going into details that could lead to confusion.

However, health workers *do* need to understand the details regarding the new vaccines, so that they will be convinced of the new vaccines' importance and can respond knowledgeably to questions from the public.

### **AD syringes**

How much and what to say about the introduction of AD syringes depends on the level of public knowledge and concern about injection safety. In countries where injection safety is already a public issue, it is probably best to indicate how AD syringes make safe immunizations even safer. In countries where there is low awareness of the dangers of non-sterile injections, it may be best initially to direct communication messages on this subject only to health workers and then later to the public.

Public knowledge and debate on injection safety is a two-edged sword. On the one hand, public demand for assured safety can encourage better health system and health worker performance. On the other hand, excessive concern could cause some parents to opt out of bringing their children for critical vaccinations. Where there are time and resources, it could be beneficial to carry out some small but in-depth research on health workers' and caretakers' knowledge, attitudes, and perceptions, and to use the findings to formulate the best approach for the country's particular situation.

### **Time for planning**

Ideally, planning should begin at least six months in advance of the introduction of new vaccines and AD syringes. The programme will most likely need to re-design the immunization schedule, child health/immunization card and recording forms; carefully plan the logistics of vaccine and syringe distribution, storage, and re-supply; train health workers in new technical skills and in how to respond to the public's questions; prepare technical and training materials for health workers; establish systems to monitor health worker performance in various areas, including proper use and disposal of AD syringes; and plan for the "launch" of the improved programme as well as for its ongoing promotion. Separate subcommittees may be needed to plan training, logistics, and communication/mobilization (launch events and ongoing promotion of the immunization service).

### **Communication channels**

Principles of good communication planning apply. Maximum effort should be made to receive free broadcast and press coverage of the improved immunization service (see checklist No. 6). This involves preparing press releases and holding news conferences at the national and subnational levels. TV and radio can be used to reach health workers and urban populations, with cost determining the extent of their use.

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The basic strategy for reaching rural populations is to orient local political, social, educational and religious leaders and organizations. Print materials are appropriate for health workers, but many developing country programmes should carefully consider whether they should prepare print materials addressed to the public, given the cost and the public's ability to understand them. Remember that the most important source of information for parents is likely to be local health workers, so be certain that health workers understand the basic messages and are capable of responding to questions and concerns.



## Section II. Messages and media



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## Checklist No. 12:

# Communication during routine vaccination

Below is a description of how vaccinators, in ideal circumstances, should interact with caretakers (who are usually, but not always, mothers).<sup>8</sup> Every programme should adjust these recommendations based on a realistic assessment of the feasibility of implementing them in a given setting (in light of the time available for patient visits, number of people typically waiting for services and other factors). The most essential elements of every immunization encounter are that the vaccinator treats the caretaker with respect, explains when and where to turn for the next vaccination, and advises on possible side effects and what to do about them.

### The ideal health worker/caretaker interaction

- 1) The health worker thanks the caretaker in a friendly manner for coming for vaccination and for her patience if she had to wait.
- 2) The health worker writes the date of the current vaccination(s) being given on the immunization card and explains to the caretaker in simple terms and the local language the disease(s) against which the vaccination protects.
- 3) The health worker mentions possible minor side effects and explains how to handle them.
- 4) If the vaccine received is one in a series (e.g. DPT1 or 2, OPV1 or 2; or HepB1 or 2), the health worker explains to the caretaker the need for the child to complete the series to be fully protected against the disease(s). The health worker uses the vaccination chart on the immunization card as an instructional guide, and congratulates the caretaker if the child has completed the series. Where polio NIDs/SNIDs continue, the vaccinator may have to explain that, in addition to the OPV doses on the card, all children under age five are urged to get doses during special polio vaccination days to be even safer from the disease.
- 5) The health worker writes the date for the next vaccination on the immunization card and tells the caretaker. If appropriate, the health worker associates the date with a “trigger” such as a holiday or seasonal event that will help the caretaker remember to bring the child back for vaccination.
- 6) The health worker explains to the caretaker that if she and/or the child cannot come on the return date, they can obtain the next vaccination at another location or another date close to the due date.

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<sup>8</sup> This was developed by BASICS.

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- 7) The health worker reminds the caretaker that she should bring the immunization card to the location where the child receives the next vaccination.
  - 8) The health worker congratulates the caretaker if the child is fully vaccinated.
  - 9) The health worker asks the caretaker if she has any questions and politely answers all questions.
  - 10) If NIDs or SNIDs campaigns are planned in the coming months, the health worker informs the caretaker about the date of campaign, what vaccination is being given, and (if known) where she should bring the child for the supplemental vaccination.
  - 11) [If consistent with national policy] The health worker asks the caretaker if she has received her five doses of tetanus toxoid (TT) vaccination and explains the importance of protecting the mother and her future children against tetanus.
  - 12) If vitamin A is being given, the health worker explains to the caretaker that it is important to bring the child back in six months (and give the date) for subsequent vitamin A supplementation to help protect her child from infections.

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## Checklist No. 13:

# Sample messages for caregivers regarding immunization

Creating effective messages is not easy; it entails expressing appropriate and truthful technical, practical and motivational information in a way that can be easily understood but not easily misinterpreted by various audiences. Below are some generic messages about immunization that should be targeted at caregivers. In general, however, such generic messages should *not* simply be copied into local materials; instead, messages should be developed on the basis of audience research and then should be pre-tested. Therefore, the messages below should be considered *suggestions* as to the content but not to the actual wording of caregiver messages.<sup>9</sup>

### Routine immunization

- ➔ Immunization protects your infant from certain diseases like polio and measles. Ensure that your infant completes the basic series of immunizations by his or her first birthday.
- ➔ It is your responsibility as a parent to know when and where to take your child for his or her next immunization. Check your baby's immunization card or ask your health worker.
- ➔ To get good protection against many diseases, people need to be vaccinated more than once.
- ➔ All women of childbearing age should be sure to receive enough tetanus vaccinations to protect themselves and their babies. Ask your health worker to check whether you need additional vaccination.
- ➔ It is normal for some injections to cause mild side effects such as light fever, soreness and redness. Consult with a health worker for advice about what to do if this happens.

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<sup>9</sup> This section was adapted from *Communication Handbook for Polio Eradication and Routine EPI*, Annex 4 (UNICEF/WHO/Polio Partners, November 2000); and *Polio Eradication Field Guide, Annex on Social Mobilization* (WHO, 1998).



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### **National immunization days (NIDs)**

- ➔ Polio kills or cripples children – vaccinate and protect your child.
- ➔ Polio vaccine is safe, free and given as drops in the mouth. The vaccine is called oral polio vaccine.
- ➔ NIDs will be conducted to eradicate polio from [name of country]. Take your children under age five to a nearby immunization site for polio vaccination from [inclusive dates] and again from [inclusive dates]. In addition, encourage your relatives, friends and neighbours to take their children under age five to get polio drops. Every child under age five should receive drops every time there is a NID.
- ➔ Before and after NIDs, take your child to the nearest vaccination site for his or her regular vaccination, according to the schedule on the child's vaccination card (or ask your health worker).
- ➔ Doses given during NIDs are additional doses to better protect your child.
- ➔ All women of childbearing age should be sure to receive enough tetanus vaccinations to protect themselves and their babies. Ask your health worker to check whether you need additional vaccination.

### **House-to-house campaigns**

- ➔ During the NIDs this year, vaccinators will come to your house to vaccinate your children under age five. Please welcome vaccinators warmly. Try to ensure that all children under age five are home to receive their polio drops.
- ➔ (Also provide the messages listed under NIDs.)

### **AFP surveillance**

- ➔ Immediately take any child under age 15 to the nearest health facility if he or she suddenly loses strength in one or both legs or arms. Likewise, take any baby who suddenly stops crawling, standing, or sitting to the nearest health facility. If this is not possible, inform the facility or a health worker immediately about the child's condition.
- ➔ Health workers must take stool samples from children under age 15 who exhibit a sudden loss of strength in one or both legs or arms to determine if the child has polio. Parents, please allow the taking (collection) of stool samples from your child.
- ➔ If you take a child with sudden loss of strength in one or both legs or arms to a traditional healer, be sure that this does not delay you in taking him or her to a health facility to be tested for polio.
- ➔ It is very important to act immediately if you become aware of a child under age 15 with sudden loss of strength in one or both legs or arms (which is called sudden floppy paralysis). Quick action can 1) allow the family to know sooner whether the child has polio or not, 2) help the family get advice on how to limit the disability caused by the disease, and 3) alert health workers to quickly give polio drops to other children so they will not come down with the disease.

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### **Vitamin A supplementation**

- ➔ Your children require vitamin A for proper growth and health.
- ➔ Vitamin A helps the body fight infections like measles and diarrhoea.
- ➔ Lack of vitamin A can cause night blindness.
- ➔ Take all children over age six months and under age five to receive vitamin A drops, in addition to polio drops, during the [round] of NIDs on [date]. Both polio drops and vitamin A drops are safe, free and effective.
- ➔ Ask your health worker about where and when to take your children for their next vitamin A dose. Each child should receive a new dose of vitamin A every six months.

### **New vaccines and technologies (see also checklist No. 11)**

- ➔ The national immunization service now offers protection against an additional disease(s): (name of disease[s]).
- ➔ Hepatitis B vaccine protects against serious diseases of the liver. The vaccine prevents infections in children that can cause death when they reach adulthood many years later.
- ➔ Hib vaccine protects against many, but not all, cases of pneumonia and meningitis – two diseases that kill many, many children.
- ➔ Your children will receive the new vaccine at the same time they already receive protection against other diseases (diphtheria, tetanus, and whooping cough) [if quadrivalent or pentavalent is being used, in the same injection also]. Therefore, the new vaccine is like a bonus for your children – more protection with no more effort.
- ➔ The new vaccine is extremely safe and causes no new side effects.
- ➔ From now on, injections for immunization will be given in special syringes that make it easier to ensure that every vaccination is safe.



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## Checklist No. 14:

# Message topics on polio eradication for key target populations

### Policy- and decision-makers need to know:<sup>10</sup>

- ☐ progress to date in polio eradication and the current country situation;
- ☐ the benefits of polio eradication activities to disease control and other areas of public health;
- ☐ improvements to public health laboratory network and vaccine-preventable disease surveillance;
- ☐ the steps necessary for achieving certification;
- ☐ a realistic timeline for eradication and for reaching important benchmarks (e.g. interrupting transmission, finalizing containment, maintaining surveillance at certification standards);
- ☐ their roles throughout the year and what actions they can take to improve performance (e.g. monitoring, agreeing to policy changes, making speeches, releasing funds);
- ☐ (where applicable) that synchronized NIDs are being conducted in many African countries;
- ☐ the importance of conducting quality NIDs that will reach all children;
- ☐ (where applicable) the need to use house-to-house vaccination during NIDs in order to reach those children who have been persistently missed;
- ☐ the importance of their support of surveillance in order to achieve polio eradication.

### Community and religious leaders need to know:

- ☐ many of the above;
- ☐ that campaigns supplement, and do not replace, routine immunization;
- ☐ how they can help mobilize their community and reassure parents about the safety of the vaccine and the need for every child in the community to be immunized;
- ☐ the immunization status of their community's children;
- ☐ that they should help report to senior health officials if vaccine is unavailable, if vaccinators are not at post, if vaccinators are rude or unprofessional, or if there are any other problems with service;
- ☐ that in conflict situations, the programme is for the benefit of all children, regardless of their families' factional affiliation.

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<sup>10</sup> This checklist is adapted from "Tips on Polio Eradication" (Ogden, July 2000).

**During NIDs/SNIDs, health workers need to know (via training, materials, and supervision):**

- ☐ that they are an important source of information and that their polite behaviour, positive attitudes and words of encouragement and praise will increase participation in NIDs/SNIDs as well as routine immunization;
- ☐ accurate information about the vaccine (safe, effective, prevents polio), eligibility criteria for vaccination and vitamin A administration and the routine vaccination and vitamin A supplementation schedule;
- ☐ the importance of surveillance in order to achieve polio eradication and their roles in surveillance;
- ☐ what to say and what NOT to say (see box).

THINGS TO SAY (in addition to the messages in checklist No. 13):	THINGS NOT TO SAY
<p>Thank you for bringing the child (children).</p> <p>It is important to vaccinate your child. You are helping prevent your child and other children in the community from getting polio. If you vaccinate your child against diphtheria–tetanus–pertussis (DTP), tuberculosis, and measles, it will help prevent those diseases too.</p> <p>How old is your child? Has she or he ever received oral polio vaccine? Remember to get your child immunized on schedule. [If a health card is available] the child's next routine immunization is due [when].</p> <p>The next NIDs/SNIDs are scheduled [dates]. You need to bring your children to that one too.</p> <p>Do you know of anyone in the community who is NOT participating? If so, why? Where are they?</p> <p>Are you aware of any new cases of paralysis in previously healthy children under age 15?</p> <p>You should not be concerned about your children receiving too many doses of polio drops.</p> <p>There may still be still cases of AFP, despite very successful NIDs, because many of these cases are caused by other viruses besides polio.</p>	<p>These drops will make your child healthy.</p> <p>Polio vaccine is candy or a sweet.</p> <p>If the child is sick, she or he doesn't need to be immunized.</p> <p>Don't feed the child until 30 minutes after vaccination.</p>

# Checklist No. 15:

## Communication on

### AFP/sudden paralysis

### (possible polio)

#### What persons in the community should look for:

A child under 15 years of age who suddenly develops floppy paralysis (loses strength in one or both legs or arms, not caused by injury); also, any baby who suddenly stops crawling, standing, or sitting.

#### More detailed description:<sup>11</sup>

<b>Explanation</b>	AFP (acute flaccid paralysis) may be caused by polio or by other viruses. It is critical that all AFP cases be seen by health workers so they can determine whether or not the cause is polio and how the child can be helped. Knowing this information helps the health workers know how best to help the child and helps the health system know if it has eradicated polio or if it must take new actions to protect children.
<b>Symptoms</b>	Usually the child first comes down with cold symptoms, often with fever, vomiting, diarrhoea and sore muscles. A few days later a part of the body becomes weak or paralysed. Most often, the paralysis happens to one or both legs. In time, the weak limb becomes thin and does not grow as fast as the other one.
<b>Treatment</b>	Although the disease itself cannot be treated, health staff can teach the family certain exercises for the child that will minimize the disability caused by the paralysis; or they may put the family in touch with an organization that will do this.
<b>Prevention</b>	Polio can be prevented if a baby receives polio drops in the mouth three or four different times in the first year of life, as well as extra protection from drops during polio vaccination campaigns.
<b>Family/community actions</b>	<p>Anyone who notes a child who developed floppy paralysis in the last two months should urge the family to bring the child <i>immediately</i> to the closest health facility that is equipped with a refrigerator. The family should do this as soon as possible after noting a child with sudden loss of strength in one or more legs or arms. Health workers and community collaborators should sensitize and enlist the support of traditional healers, who are often the first people outside the family to see the child with AFP.</p> <p>As soon as paralysis is noted, the health staff will want to take two stool samples, 24 to 48 hours apart, in order to test them to see if the paralysis is caused by polio or by some other disease. The health workers also should give the child's caretakers advice on massage and exercise to help minimize the child's disability.</p> <p>Some national or local organizations may facilitate the child going to a facility by providing transportation or money or reimbursement for the cost of public transportation.</p> <p>If the family <i>refuses</i> or is unable to bring the child to the health facility, someone from the community should immediately inform the health facility about the child's symptoms and the family's exact location, so health workers can visit to seek agreement from the family to collect stool samples.</p>

<sup>11</sup> This description was adapted from *Community Surveillance Kit* (CHANGE, 1999).



# Checklist No. 16:

## Channels of communication

### 1. Mass media

Examples:

- |              |                   |                |                    |
|--------------|-------------------|----------------|--------------------|
| ■ Radio      | ■ Posters         | ■ Miking       | ■ Town criers      |
| ■ TV         | ■ Flyers/leaflets | ■ Videos/films | ■ Gong gong beater |
| ■ Newspapers | ■ Loud speaker    | ■ Press kits   |                    |
| ■ Booklets   | ■ Announcements   | ■ Media guides |                    |

Typical materials	Typical formats
<p>Development and use of logos, leaders' statements</p> <p>National addresses by presidents and other high-level officials</p> <p>Publicity for NIDs by celebrities, including goodwill ambassadors</p> <p>Press conferences</p> <p>Newspaper editorials</p> <p>Public advertising: calendars; banners; billboards</p> <p>Promotional materials: T-shirts, hats, banners, bags, and pens</p> <p>Announcements via megaphones, microphones, loud speakers</p> <p><b>Often good for:</b></p>	<p>Different radio/TV formats: interviews, success stories/ footage from countries, phone-in questions or reports from the field, talk shows, guest of the week, press conferences, panel discussions; advertisements</p> <p>Broadcasting/posting of basic information on NIDs (what, when, who, why?)</p> <p>News coverage of NIDs preparations and implementation</p> <p>Interviews with leaders, satisfied caretakers and experts</p> <p>Public service announcements, spot announcements, on-location promotion/ announcements</p> <p><b>Not usually good for:</b></p>
<p>Creating general awareness</p> <p>Giving the basic facts</p> <p>Giving information a sense of importance and legitimacy</p> <p>Popularizing and reinforcing messages</p> <p>Creating a bandwagon effect that can encourage and pressure people to join in</p> <p>Providing time-sensitive information (when, where, who is eligible)</p> <p>Creating a festive atmosphere, reinforcing information, identifying vaccination teams</p> <p>Giving short, key messages on schedules, dates, location, basic information (local language posters)</p> <p>Reaching many people simultaneously</p> <p>Reaching rural communities (local radio)</p> <p>Reaching health workers and urban and peri-urban audiences (radio and TV)</p> <p>Reaching elites (including politicians and decision-makers), middle class and their household help (gardeners, housekeepers, nannies)</p>	<p>Facilitating interaction with audiences</p> <p>Giving detailed explanations</p> <p>Responding to individual questions or concerns</p> <p>Providing appropriate messages for people in a variety of circumstances and with different levels of intention to act</p> <p>Being understood by all members of the audience (dialect, vocabulary, and/or images)</p> <p>Saving expenditures (mass media is expensive to produce, and broadcast time may be a huge expense; posters are logistically difficult to distribute in a timely way and are not always seen by many of the intended audience).</p> <p>Reaching key groups (the illiterate, those without radio access, etc.)</p>



## 2. Interpersonal communication

Interpersonal communication can be very effective in influencing and reinforcing positive behaviour change, but it requires thorough advance planning, particularly of logistics (e.g. to determine the need for additional mobilizers/volunteers, food, per diems for team members, or training).<sup>12</sup>

### A. Group channels

Examples:

- Group discussions
- Seminars/workshops
- Religious services
- Meetings
- Performances
- Celebrations

Typical materials	Typical formats
Slides, film strips Announcements in places of worship, rallies and processions Fact books and programme briefs to stimulate questions and discussion Role plays Demonstrations	Public meetings Religious events Traditional ceremonies Sports events Exhibitions, fairs Travelling/community theatre Traditional music and dance performances
Often good for:	Not usually good for:
Facilitating interaction and allowing people to share ideas Explaining details and responding to questions and doubts Legitimizing messages and building consensus Providing support for changing attitudes and behaviour and maintenance of new behaviour Addressing rumours and misinformation Using audience members as guides/key mobilizers Reaching places where people may not have heard about immunization activities (mobilizers with megaphones) Using local languages Improving trust and demand for health services (if health workers with good attitudes serve as communicators) Ensuring uniform message content	Responding to questions of a personal nature Encouraging the active participation of certain groups such as minorities Encouraging use of public-sector health services (if health workers have bad attitudes) Reaching large sections of the population at the same time Reaching those people who won't actively participate or ask questions

<sup>12</sup> This checklist was adapted from *Communication Handbook for Polio Eradication and Routine EPI, Annexes Two and Three* (UNICEF/WHO/Polio Partners, November 2000).

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**B. One-on-one counselling or discussion**

Typical materials	Typical formats
Counselling cards Pocket fact books Stories and examples Pictorial booklets and pamphlets used for teaching and given to target audiences to take away Photographs used to stimulate discussion	Visits and discussions with key allies Lobbying and telephone contact with individual allies Use of ICC members to lobby for the programme Inviting national or international experts to confer with national leaders Counselling at health facilities Discussions with family members during home visits Child-to-parent educational activities Hotline telephone contact to report AFP
<b>Often good for:</b>	<b>Not usually good for:</b>
Supporting behaviour change (addressing obstacles and doubts and motivating/persuading) Legitimizing, reinforcing and sustaining new knowledge, attitudes and behaviours Responding to questions and needs of a personal nature Identifying and filling information gaps Being flexible to individual schedules and needs	Reaching many people quickly, without extensive planning and training of many staff or volunteers, followed by good monitoring and supervision Providing clear and consistent information or messages if communicators are not well trained and oriented Preventing communicators' biases from entering communication



## Section III.

### Monitoring and supervision



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## Checklist No. 17:

# Effective monitoring of communication strategies and activities

Process and impact monitoring of communication strategies and activities for routine immunization and NIDs is essential.<sup>13</sup> Effective monitoring helps determine:

- if all hard-to-reach groups are being reached;
- if appropriate channels are being utilized;
- what channels are most effective at reaching various target populations (broadcast media, interpersonal, print media);
- the effect of messages, information and motivational interventions on the target audience's knowledge, attitudes and practices;
- the need for and nature of actions to take for continuous improvement of activities.

Two key indicators can be used to monitor programme management and activities:

- 1) The extent to which communication/social mobilization committees exist (with clear terms of reference and partners identified) and meet regularly to implement advocacy, social mobilization and communication activities (e.g. monthly, bi-weekly, or more frequently for events such as NIDs).
- 2) The presence and active use of annual and five-year integrated communication plans for NIDs, routine immunization and surveillance that have been approved by the ICC and are being implemented by partners. (These plans can be most effective if they are included within the overall annual and five-year immunization action plans of the ICC.)

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<sup>13</sup> This checklist is adapted from Communication Handbook for Polio Eradication and Routine EPI, Chapter 5 (UNICEF/WHO/Polio Partners, November 2000), and Briefing Guide for Planning, Management, and Implementation of Communication for EPI/NIDS, Annex 5.1 (UNICEF March 2000).

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Some suggested monitoring activities for communication include:

- ☐ Conduct regular spot checks of materials distribution at representative points in the field.
- ☐ Hire a media monitoring company or recruit volunteers to determine if planned programme activities are being implemented according to set schedules.
- ☐ Review and document feedback from the field (from supervisors, health teams and caregivers) regarding what materials are present and sources of people's information on NIDs.
- ☐ Monitor key media channels.
- ☐ Conduct exit interviews with caregivers at vaccination sites or door-to-door to determine which messages they received and their knowledge, attitudes and practices regarding NIDs and routine immunization services.
- ☐ Hold focus group discussions between rounds or after a campaign, including questions on service delivery, social mobilization and communication messages (reach, comprehension, impact).

To the extent possible, document the achievements of and lessons learned from social mobilization, advocacy and programme communication activities at the national, provincial and district levels. Use photos, anecdotes, testimonials, press reports and media coverage. Use this information to improve the programme, motivate programme staff and volunteers and advocate for needed resources.

All supervision of immunization activities should incorporate communication/social mobilization issues. Training and checklists for NIDs supervisors should cover communication/social mobilization as well as the cold chain, personnel issues, logistics/transport, use of vaccine vial monitors (VVMs), and procedural guidelines. There is no one model or standard set of questions that can be applied uniformly in every country. Periodically, each country programme should evaluate supervisory training and support materials and revise them if needed, as well as ascertain that the information collected is analysed and used to improve programme activities.

Supervision and monitoring checklists also should enable supervisors to make small but important improvements during and between NIDs rounds.

### **Key questions for NID supervision**

Here are a few key questions that should be included in any NIDs supervision (either in supervision checklists or in interviews done via grab samples):

- ☐ Does the caretaker know that there will be additional rounds?
- ☐ Does the caretaker know to continue with routine immunization?
- ☐ Does the caretaker know to report any paralysis?
- ☐ How did the caretaker learn about the NIDs?

Additional questions and things to observe are listed below. For NIDs specifically, see checklist No. 18.

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### Observations of health staff and vaccination teams

- ☐ What information is communicated by the vaccinators and mobilizers during the immunization activities? (Differentiate between facilities, mobile teams, and door-to-door vaccinators, as appropriate.)
- ☐ Do health workers remind caretakers to bring eligible children back for the second round and for routine immunization?
- ☐ Do health workers welcome and thank caregivers for bringing the children?
- ☐ Do health workers ask caregivers if they have questions about immunization or polio eradication?
- ☐ Do health workers ask caregivers to inform and encourage other members of the community to have their children vaccinated?
- ☐ Are vaccination teams actively looking for and reporting zero-dose (i.e. unvaccinated) infants?

### Questions for caregivers

- ☐ How did caregivers hear about the immunization campaign (through what channels or media)?
- ☐ When did the caregiver receive the information about the NIDs?
- ☐ What encouraged the caregiver to have the child vaccinated?
- ☐ Is this the first time that their child has received these drops? Does the caregiver know?
- ☐ Why these drops are being given?
- ☐ When should the child be brought for the next NID round?
- ☐ Does the caretaker know anyone who has not brought his or her child to be immunized?
- ☐ What is the basic sign of a possible polio case?
- ☐ What should be done if a child has sudden floppy paralysis? Who should be informed?
- ☐ What are some of the worst effects of polio on someone who has been infected by the disease?
- ☐ Does the caretaker know of any children who are newly paralysed?
- ☐ What are the benefits of vitamin A?
- ☐ When should the caretaker bring the child for his/her next routine vaccination (if applicable)?

### Questions for community leaders and media

- ☐ How have they supported the NIDs?
- ☐ What messages have they provided on the NIDs to their communities?
- ☐ Have they provided messages on routine immunization and surveillance to their communities?
- ☐ Do they know when the next round of NIDs is being held?



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## Checklist No. 18:

# Process monitoring checklists for NIDs

Based on its plans, each country programme should adapt the following list of items to monitor.<sup>14</sup>

### Before NIDs

#### *Advocacy and resource mobilization*

- ☐ Advocacy documents produced/revised, printed, and disseminated
- ☐ Meetings and advocacy briefings held with political leaders, media, organizations
- ☐ Meetings and/or special events (e.g. dinners and sporting events) held to mobilize resources and build awareness of the NIDs
- ☐ Launching ceremonies at all levels prepared, including recruitment of celebrity or recognized leader to give a speech and administer OPV to a few children
- ☐ Media coverage for launch and announcing NIDs arranged and conducted
- ☐ Bank accounts opened and funds received and distributed

#### *Intersectoral collaboration and social mobilization*

- ☐ Communication/Social Mobilization Committee formed (see checklist No. 3) and meeting regularly
- ☐ Communication focal points identified and functioning at national and provincial levels
- ☐ National plan of action developed and implemented by Communication (Social Mobilization) Committee, including specific partner activities
- ☐ Social mobilization materials produced and distributed (mass and traditional, media spots/messages, megaphones, posters, banners, leaflets, T-shirts, hats, smocks, arm bands, and others)
- ☐ Mobilization teams identified and trained, and transport arranged

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<sup>14</sup> This checklist is adapted from Communication Handbook for Polio Eradication and Routine EPI, Chapter 5 (UNICEF/WHO/Polio Partners, November 2000), and Briefing Guide for Planning, Management, and Implementation of Communication for EPI/NIDs, Annex 5.1 (UNICEF March 2000).



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### ***Social mobilization and communication planning***

- ☐ Messages on polio and OPV, vitamin A (if included), NIDs dates and locations, AFP surveillance, and the importance of routine immunization revised, pre-tested and included in communication materials, training documents and micro-planning (see checklists Nos. 13 and 14)
- ☐ Communication briefings/meetings held to design NIDs strategy, outline activities, and monitor progress
- ☐ Mobilizers, vaccinators, and community groups provided with key messages and trained for their communication roles
- ☐ Health workers and caretakers know basic logistical information, e.g. dates, places, ages, etc.
- ☐ Special groups identified and mobilizers assigned to conduct communication/social mobilization activities with these groups (see checklists Nos. 8 and 9)
- ☐ Communication specialists and members of the social mobilization committee involved in development and revision of micro-planning guides and in conducting micro-planning activities and training
- ☐ Communication specialists identified and trained to participate in NIDs supervision
- ☐ Questions on communication, social mobilization and advocacy included in supervisory checklist
- ☐ Materials distributed and interpersonal, group and mass media begun

### ***During NIDs rounds***

- ☐ Mobilizers and vaccinators going into communities to provide key messages and mobilize people through interpersonal communication, particularly with special groups
- ☐ Mobilizers and vaccinators providing key messages on NIDs, polio, vitamin A, AFP surveillance and the importance of routine immunization during vaccination and are thanking caregivers and communities for participating
- ☐ Questions on communication and social mobilization being asked by supervisors to vaccinators and caregivers, and supervisory checklists being completed
- ☐ Political, religious, and traditional leaders working with mobile teams and/or facilities to advocate for NIDs and encourage caretakers to have children vaccinated
- ☐ Communication/mobilization findings identified during each day addressed with support from supervisors — that is, an appropriate person (local leader, medical officer) visits and tries to convince refusers
- ☐ Mass and traditional media disseminating key messages on the NIDs
- ☐ Feedback provided to the media to encourage community participation and boost the morale of vaccination teams
- ☐ (If possible) Communication findings analysed on a daily basis during supervisory meetings and corrective actions planned for the next day
- ☐ For house-to-house strategy, findings analysed and needed actions planned in the course of a mid-round meeting (third day of the five-six day NIDs)

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### Between NIDs rounds

- ☐ Key messages on the NIDs, AFP surveillance and routine immunization provided through mass and traditional media, vaccinators and mobilizers at health facilities and in the communities
- ☐ Communication/mobilization findings from the supervisory checklists analysed and information fed back to all levels (see checklist No. 17)
- ☐ Communication/social mobilization committees meet, analyse observations and findings from previous round and draft and implement recommendations for subsequent round(s)
- ☐ News on success disseminated through mass and traditional media (anecdotes; coverage reports; acknowledgement of caregivers, vaccinators, leaders, mobilizers and human interest stories)
- ☐ Communication plans revised, and recommendations based on findings from previous rounds implemented
- ☐ Key issues identified and necessary corrections made for the second round
- ☐ Feedback and suggestions on performance given to all partners

### After the last round of NIDs for the cycle

- ☐ National and provincial communication/social mobilization committee meets within one month of last round of NIDs to review and analyse the findings, observations and supervisory checklists for each round and drafts recommendations for next year's NIDs
- ☐ Recommendations from the national communication/social mobilization committee included in the NIDs recommendations from the ICC
- ☐ Feedback and suggestions given to all partners
- ☐ Results presented to local authorities and community leaders during communication/social mobilization committee meetings
- ☐ Messages on routine immunization and surveillance disseminated through mass and traditional media and feedback/update given to all partners
- ☐ National integrated communication plan for NIDs, routine immunization and surveillance is revised, disseminated and implemented with partners
- ☐ National communication/social mobilization committee meets at least once per month to implement advocacy, social mobilization, and communication activities for routine immunization and surveillance and to plan for the next year's NIDs



# Checklist No. 19:

## Proposed global communication indicators for routine immunization, polio eradication and surveillance

The indicators in the table below were selected by a working group at the mid-year meetings of the advisory group of polio partners on communication for polio eradication, UNICEF House, New York, 18–21 June 2001. These indicators were chosen with the hope that they might be comparable among countries.

### Proposed global communication indicators for routine immunization, polio eradication, and surveillance

Indicator	How to collect in countries doing NIDs	How to collect in countries NOT doing NIDs	Comments
<b>Routine immunization</b>			
1. % of primary caretakers of infants under age one who know (correctly or within two weeks of the date) when the next immunization is due.	This should be asked of caretakers leaving various NIDs sites.	Ask caretakers in grab samples in a variety of communities (urban/rural, close/far to facilities, roughly representing major national and ethnic groups).	If the caretaker has the child's immunization record, he or she can consult it when answering the question. The (knowledge) interviewer can use the card to determine if the answer is accurate. If the caretaker does not have the child's immunization record, the interviewer must ask questions and then make a judgement about whether the answer is accurate.
2. % of primary caretakers of infants under age one who know the number of visits needed for complete childhood immunization (knowledge).	This should be asked of caretakers leaving various NIDs sites.	Ask caretakers in grab samples in a variety of communities (urban/rural, close/far to facilities, roughly representing major national and ethnic groups).	
3. % of primary caretakers of infants under age one who know where to take their child for routine immunizations (knowledge).	This should be asked of caretakers leaving various NIDs sites.	Ask caretakers in grab samples in a variety of communities (urban/rural, close/far to facilities, roughly representing major national and ethnic groups).	

Indicator	How to collect in countries doing NIDs	How to collect in countries NOT doing NIDs	Comments
<b>NIDs</b>			
4. % of caretakers at NIDs who understand that NIDs do not replace routine immunization (health workers' practice and caretakers' knowledge).	This should be asked of caretakers leaving various NIDs sites.	This indicator is only applicable in countries that are doing NIDs.	It should be explained to vaccinators that people are being asked one or two questions only for the purpose of monitoring and improving service quality. The responses reflect pre-NIDs communication as well as counselling during NIDs.
5. % of caretakers at NIDs who are advised about routine immunization during NIDs.	This should be asked of caretakers leaving various NIDs sites.	This indicator is only applicable in countries that are doing NIDs.	It should be explained to vaccinators that people are being asked one or two questions only for the purpose of monitoring and improving service quality. The responses reflect pre-NIDs communication as well as counselling during NIDs.
<b>Communication planning</b>			
6. % of district plans that identify and give strategies to address resistant or difficult groups, including "zero dose" children (practice).	Information can be collected from examining the district plans.	Information can be collected from examining the district plans.	
<b>AFP surveillance</b>			
7. % of vaccinators who know how to recognize AFP (polio-like illness) and where such a case should be reported (health workers' and volunteers' knowledge).	This should be asked in a variety of randomly selected NIDs sites.	This can be asked of a variety of randomly selected facility-based and community-based health workers and volunteers.	
<b>Vaccine and cold chain</b>			
8. % of vaccinators who can correctly explain how to interpret and use VVMs on polio vaccine vials (health workers' knowledge).	This should be asked in a variety of randomly selected NIDs sites.	This can be asked of a variety of randomly selected facility-based and community-based health workers and volunteers who vaccinate.	Correct knowledge of VVMs, of course, does not indicate correct practices. However, this would be difficult to accurately assess. Only a full explanation of correct use should be accepted as a "correct" answer.

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## Other indicators

In addition to collecting and using this information, individual programmes should also gather information on selected locally relevant indicators, given their own programme's strategies and challenges. A few suggestions of such indicators follow:

- % of babies who are fully immunized when they reach their first birthday;
- % of women of childbearing age who have two or more tetanus immunizations;
- % of babies who are born protected against neonatal tetanus;
- % of routine immunizers who always talk to mothers about the immunizations provided, the return date and its importance and possible side effects and their treatment;
- % of caretakers of children under age one eligible for an immunization who bring their child's immunization card to clinic visits;
- % of caretakers of children under age one who know that measles immunization is due at nine months;
- % of caretakers of children under age one who know their babies' birth date and/or age in months;
- % of caretakers of children under age one who know when and where their child should receive his/her next vitamin A dose.

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