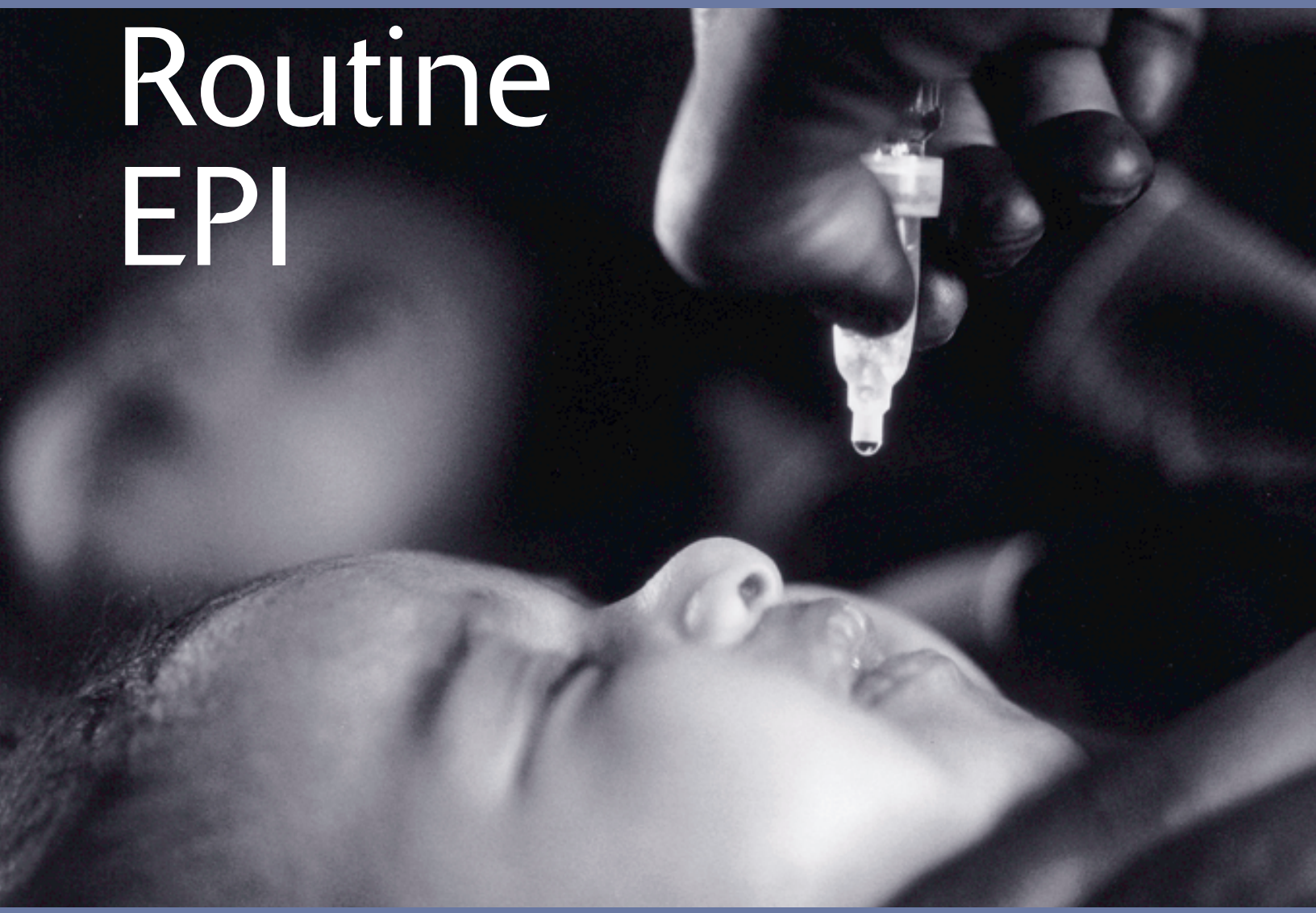
Communication Handbook for

Polio Eradication and Routine EPI



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Communication Handbook for

Polio Eradication and Routine EPI

Developed by
UNICEF and WHO

in collaboration with Polio Partners and ministries of health representatives

Acknowledgements

The *Communication Handbook for Polio Eradication and Routine EPI* is the result of a collaborative effort between Polio Partners: UNICEF, WHO, Rotary International, BASICS and the EPI Communication/Social Mobilization Officers from Ministries of Health in Africa.

Funding for this project was generously provided by USAID.

We strongly believe that with the support of all partners, the research-driven and participatory approaches advocated in this Handbook will substantially accelerate polio eradication, increase and sustain routine immunization and firmly establish community-based surveillance systems.

We thank all those who contributed to the design and review of this Handbook for their time and effort.

April 2000

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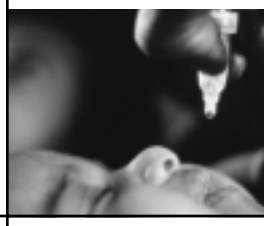
Foreword



The countdown to the fulfilment of the year 2000 polio eradication goal has already begun. The achievement of this goal depends on conducting successful supplemental immunization campaigns, increasing and sustaining routine immunization coverage and carrying out effective disease surveillance.

Although social mobilization has played an important part in the successes achieved to date, much remains to be done to utilize the full potential of communication for development in support of polio eradication, routine EPI and surveillance. For instance, communication for NIDs and EPI has too often been reduced to social mobilization, neglecting other aspects of communication that can directly impact on sustained behaviour change at the individual, family and community level. In addition, in recent years most of the focus of communication efforts has been directed at supplemental immunization campaigns, while the necessary tie with routine immunization and community-based disease surveillance was not receiving sufficient attention.

To succeed in eradicating polio requires an integrated communication approach cutting across polio eradication, routine EPI and surveillance. It also requires that the available communication for development strategies (advocacy, social mobilization and programme communication) are utilized taking into account the specific context of the country. It demands that communities are fully informed and involved and actively participate in the programme. Finally, for the polio eradication efforts to succeed, it is essential that communication strategies and activities are grounded in research and that they address specific barriers that might occur within a given country.

This Communication Handbook is a step towards filling some important gaps: lack of integration among the different aspects of EPI and polio eradication; underutilization of the potential offered by communication for development; and the only marginal involvement, so far, of the communities. Developed by UNICEF and WHO in a team effort with EPI communication focal points in ministries of health and Polio Partners, this Handbook aims to provide programme officers with guidelines and a framework to design and implement research-driven communication programmes that will strengthen all aspects of EPI (supplemental campaigns, routine immunization and disease surveillance). It offers a menu of ideas, strategies and tools from which programme officers can select according to their country-specific reality, in order to accelerate polio eradication and strengthen routine EPI. The Handbook is structured in a step-by-step approach that should prove user-friendly and guide the officers through the planning, implementation and monitoring of an integrated communication intervention for routine and supplemental immunizations and surveillance.

Although the content of this Handbook emphasizes polio eradication and routine EPI, the methodology it proposes can be readily utilized to guide other health communication interventions as well. We invite you to study and apply the guidelines in the Handbook, and we hope that the strategies and ideas provided will succeed in initiating, reinforcing and institutionalizing the integration of a sound and research-driven communication approach in your programme.

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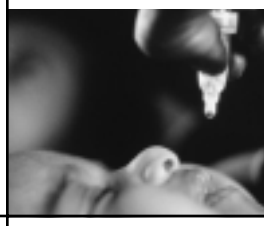
Acronyms

AFP	acute flaccid paralysis
ACADA	assessment, communication, analysis, design and action
BASICS	basic support for institutionalizing child survival
CC	communication committee
CIHI	Center for International Health Information
CSM	communication and social mobilization
DANIDA	Danish International Development Agency
DHS	demographic health survey
DPT	diphtheria, pertussis and tetanus
DFID	Department of International Development
EPI	Expanded Programme on Immunization
FGD	focus group discussion
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
ICC	inter-agency coordinating committee
IEC	information, education and communication
IPC	interpersonal communication
JICA	Japanese International Cooperation Agency
KAPB	knowledge, attitude, practice and behaviour
KI	key informant
M&E	monitoring and evaluation
MOH	Ministry of Health
NGOs	non-governmental organizations
NIDs	national immunization days
NT	neonatal tetanus
NW	northwest
OAU	Organization of African Unity
OPV	oral polio vaccine
OPV3	three doses of oral polio vaccine
PHC	primary health care
PLM	participatory learning method
PRA	participatory rapid appraisal
RRA	rapid rural appraisal
SMART	specific, measurable, appropriate, realistic and time-bound
SNIDs	subnational immunization days
TOR	terms of reference
TV	television
UCI	universal child immunization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	village health committee
VOA	Voice of America
WHO/AFRO	World Health Organization, Africa Regional Office
ZANU-PF	Zimbabwe African National Union—Patriotic Front

About the Handbook



This Handbook is designed to help you, the programme officer, design and implement effective, research-driven communication programmes to meet present and future needs of your EPI programme. Although it emphasizes EPI, the content of the Handbook can be applied to other health communication activities as well.

How the Handbook is organized

The Handbook is organized into nine chapters and a set of annexes:

- Background
- Communication for development
- Step-by-step development of an integrated communication plan
- Developing messages and educational materials
- Implementing the communication plan
- Communication for disease surveillance
- Participation and capacity-building
- Strategies for addressing other priority issues in immunization
- Research, monitoring and evaluation
- Annexes

The Background chapter reviews the status of both routine EPI and polio eradication activities and identifies strengths and weaknesses that are later addressed in the Handbook. Chapter Two introduces a communication for development model and the ACADA communication planning framework based on the Triple A planning cycle.

Chapter Three is devoted to step-by-step communication planning, while Chapter Four addresses message and material development. Chapter Five offers tips on how to implement communication programmes.

Each of the next four chapters addresses a key area of general concern in EPI programmes: communication for disease surveillance (Chapter Six); participation and capacity-building (Chapter Seven); strategies for addressing selected priority issues in EPI programmes (Chapter Eight); and research, monitoring and evaluation (Chapter Nine). The Annexes contain some quick references for ease of use.

The Handbook strongly recommends a systematic, research-driven approach to communication. This approach is not only goal-oriented, but is also responsive to changing programme needs.

How to use the Handbook

When you first receive this Handbook, take time to look through it from beginning to end to get an idea of the ground it covers. You will notice that many of the sections contain more ideas than can be used at one time. This is deliberate. The field officers who generated the draft wanted to have in their hands a resource with a menu of ideas they could select from to improve their communication programmes.

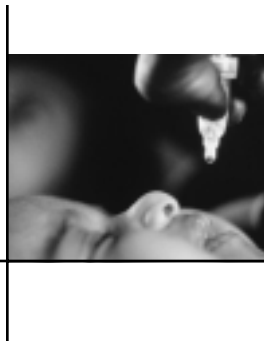
After looking through the Handbook for the first time, read through it again more thoroughly to gain a more complete appreciation of the content. This should help you identify portions of immediate benefit to your programme. Detailed reading should also help you assess the value of the guidelines and how best to use them in your programme.

You do not have to be a communication expert to use this Handbook successfully. All you need is interest, a genuine commitment to improving the performance of your programme, a desire to learn and a willingness to try out new ideas. Shortage of staff should not hinder full utilization of the ideas in the Handbook either.

The following tips should prove useful as you use the Handbook.

- Facilitate development of plans that can operationalize the guidelines. All units of the EPI department, as well as the supporting committees, should be involved in developing such plans. The support of the EPI team and volunteers will enable effective implementation of the guidelines.
- Identify in your country or region an inventory of skills and other resources you can draw from as you implement the guidelines. The resources may be at local universities, research institutes, training institutes, within NGOs, in private companies or with individuals. Consult databases of development agencies, such as WHO, UNICEF, USAID and BASICS, for additional communication resources.
- Facilitate training of a core team that can support efforts to operationalize the guidelines in this Handbook. Participants for such training may be drawn from collaborating agencies, the communication committee and collaborating training and research institutes. Technical support for such training could be obtained through WHO, UNICEF, USAID and its contractors, such as BASICS and CHANGE or other development agencies working in your area.
- Develop an inventory of research carried out in your country or region in areas of interest to EPI communication. Members of the communication committee, universities and research institutes may provide information in this area. Review and use the findings of relevance to the communication effort. This should reduce duplication of efforts and save time.
- Subcontract work that can be subcontracted and leave the limited paid staff time to manage the process. Annex Nine gives tips on subcontracting and managing the communication process.

Definitions of Terms



Definitions of terms used in this Handbook:

Communication for development is a researched and planned process, crucial for social transformation, operating through three main strategies: *advocac*y to raise resources and political and social leadership commitment for development goals; *social mobilization* for wider participation and ownership; and *programme communication* for changes in knowledge, attitudes and practices of specific participants in programmes.

Advocacy is a continuous and adaptive process of gathering, organizing and formulating information into arguments to be communicated through various interpersonal and media channels, with a view to raising resources or gaining political and social leadership acceptance and commitment for a development programme, thereby preparing a society for acceptance of the programme.

Social mobilization is a process of bringing together all feasible intersectoral social partners and allies to identify needs and raise awareness of, and demand for, a particular development objective. It involves enlisting the participation of such actors (including institutions, groups, networks and communities) in identifying, raising and managing human and material resources, thereby increasing and strengthening self-reliance and sustainability of achievements made.

Programme communication is a research-based consultative process of addressing knowledge, attitudes and practices through identifying, analysing and segmenting audiences and participants in programmes and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass-media channels, including participatory methods.

Empowerment is a process of facilitating and enabling people to acquire skills, knowledge and confidence to make responsible choices and implement them; it helps create settings that facilitate autonomous functioning.

Community participation refers to the educational and empowering process in which people, in partnership with those able to help them, identify problems and needs and increasingly assume responsibility for planning, managing, controlling and assessing the collective action that needs to be taken.

Participatory communication activities involve a process of dialogue and interaction in which communities and other stakeholders increase their understanding of each other's knowledge and priorities and work to identify mutually acceptable approaches and solutions to identified problems.

Participatory research is defined as systematic inquiry, with the collaboration of those affected by the issue being studied, for purpose of education and taking action or effecting change.

Participatory training engages learners in creative problem-solving and provides opportunities for new forms of self-expression. By involving participants in a variety of new ways of learning, learners discover talents and abilities they never knew they had. The discovery increases their self-confidence, which in turn increases participation and improves the quality of both participation and learning.

Ownership refers to direct involvement and commitment of local individuals, communities and institutions to the point where they (and not external groups) become the driving force for change.

CHAPTER 1

Background

1.1 Objectives

The aim of the guidelines in this Handbook are to strengthen EPI communication interventions by making available to communication and EPI managers a menu of ideas they can select from in their efforts to accelerate polio eradication and strengthen routine EPI. The guidelines aim to:

- Facilitate attainment and sustenance of high immunization coverage.
- Initiate and institutionalize sound, research-driven communication and social mobilization methodologies in EPI/polio eradication activities.
- Improve integration of polio eradication, routine immunization and disease surveillance.
- Increase community ownership and participation in EPI programmes.
- Stimulate networking for EPI/polio communication in sub-Saharan Africa.

1.2 Expanded Programme on Immunization

Immunization activities have been implemented in Africa for a relatively long time. Initially, many countries had only low-key and often unstructured programmes. To stimulate reorganization and strengthening of immunization programmes throughout the world, the World Health Organization (WHO) launched the Expanded Programme on Immunization (EPI) in 1974. This gave immunization the impetus it needed to reach higher coverage. Building on this foundation, the world now plans to achieve the following by the year 2000:

- Eradicate polio.
- Control measles.

- Eliminate neonatal tetanus.
- Sustain immunization coverage of at least 80 per cent of children under five.

The strategies for achieving the above goals are:

- Increasing routine immunization coverage.
- Conducting supplemental immunization campaigns.
- Carrying out effective disease surveillance.

The universal child immunization (UCI) acceleration of the 1980s increased immunization achievements substantially, pushing coverage beyond the 80 per cent mark in many countries. Since then, however, coverage has stagnated or dropped in a significant number of countries. By 1996, for example, the average immunization coverage for oral polio vaccine 3 (OPV3) in sub-Saharan Africa had dropped to 54 per cent, with a low of 26 per cent in some countries.

The coverage drop experienced across Africa, a source of concern in EPI programmes, can be explained in various ways. Reasons include inadequate planning; failure of programmes to address issues of sustainability; poor training of health staff; inadequate supervision; lack of national policies for maintenance and replacement of cold-chain equipment; lack of safety guarantees on injectable immunizations; failure of programmes to guarantee a continuous supply of sufficient, potent vaccines; inadequate and poor communication between vaccinators and mothers; top-down social mobilization strategies; and inadequate promotion of routine immunization during national immunization days (NIDs).

1.3 Polio Eradication Initiative

In May 1989, the World Health Assembly (WHA) resolved to eradicate poliomyelitis from the world by the year 2000 using the following strategies:

- Establishing high-level national commitment to the programme to ensure that adequate personnel and financial resources are made available.
- Administering polio vaccinations in a manner that will effectively interrupt transmission of the wild polio virus. The strategy requires that polio vaccinations are administered in a way that will ensure that the programme:
  - Attains a high level of routine coverage (with at least three doses of OPV).
  - Reaches even higher coverage by conducting NIDs.
  - Reaches pockets of transmission of the wild polio virus by conducting mop-up immunization activities.
- Implementing action-oriented surveillance for all possible cases of poliomyelitis.

To interrupt transmission of the wild polio virus, EPI programmes are expected to implement two NIDs a year (four to six weeks apart) to immunize all children under five years of age, regardless of their prior immunization status. NIDs should be conducted three years in a row to be sure to immunize unimmunized and partially immunized children, as well as boost the immunity of the children who are already immunized. At the end of the three years, programmes should review achievements and identify areas of special need (such as

the hard-to-reach or areas of low coverage) which may need subnational immunization days (SNIDs).

Since the first round of NIDs was conducted in the Africa region in 1995, NIDs have become a major area of polio eradication emphasis. By the end of April 1998, virtually all countries in Africa had carried out NIDs or SNIDs, the only exceptions being Liberia and Sierra Leone and the Democratic Republic of the Congo, which were in situations of conflict.

1.3.1 Current and emerging NIDs trends

NIDs are high-visibility campaign activities designed to identify and immunize all eligible children within a two- or three-day time period during two rounds (four to six weeks apart). The original intention was to use NIDs exclusively in order to provide polio immunization, but an increasing number of countries are now using NIDs to simultaneously address related national health priorities. Countries, such as Ethiopia and Eritrea, have used NIDs to distribute vitamin A capsules. Other countries, such as Zimbabwe and Madagascar, are implementing measles NIDs. Combining polio eradication NIDs with other health concerns and organizing NIDs for other health concerns are trends that are expected to continue in years ahead.

1.3.2 Achievements

Implementation of NIDs activities has yielded some important benefits for the EPI programme as a whole. They have raised immunization high on the agenda of nations, making it possible to immunize more than 54 million children in Africa alone; increased political support and funding for the EPI programme; strengthened intersectoral collaboration for health promotion; improved relations between ministries of health, the media and other social and development agencies; and provided an opportunity for strengthening disease surveillance systems in many countries.

Overall, the infrastructure being established to facilitate polio eradication activities should greatly benefit future EPI efforts, provided adequate attention is given to routine immunization.

1.3.3 Issues and concerns

In spite of these benefits, some problems and issues remain. Some people do not consider polio eradication a health priority concern, and a section of the educated elite continues to oppose the programme (e.g. in Uganda). Some religious and political groups oppose the programme in countries such as Zimbabwe, Kenya and Uganda, while in other countries some important allies (such as doctors) have remained sceptical about the value of making polio eradication a global priority. False rumours have sometimes been circulated against NIDs in countries such as Kenya and Uganda.

Unfortunately, these issues and misconceptions have not been addressed adequately in the past; NIDs have not been sufficiently used to promote routine immunization or educate the public on the importance and need for immunization; effective surveillance activities have not been implemented in most countries; and while the programme enjoyed high-level political support and involvement in the beginning, the interest of highly placed allies has waned with time.

1.3.4 Weaknesses in communication activities

A programme review meeting held in Kampala, Uganda, in 1997 found that although social mobilization had made an important contribution to the success of NIDs, it remained weak in supporting routine immunization and disease surveillance. The meeting noted that while a lot of time was being devoted to NIDs, not enough attention was paid to promoting routine immunization, and even less time was spent on promoting surveillance. In many cases, NIDs detracted attention and resources away from routine immunization. In addition, while much time was spent on advocacy, public events and dissemination of information through the mass media, little time was devoted to other communication components, such as programme communication and the use of interpersonal communication.

The Kampala meeting noted a prevalence of top-down communication in the programme and recommended a workshop of communication practitioners in the region to review the status of EPI social mobilization and develop comprehensive guidelines for strengthening EPI communication as a whole. The recommended workshop was held in Harare (Zimbabwe), between 6 and 9 April, 1998, and was attended by 24 senior communication officers from ministries of health, WHO, UNICEF and BASICS. A representative of Rotary International also attended the workshop. The deliberations of that workshop formed the basis of this Handbook, the draft version of which was then used as training content for a series of four regional workshops (1998–1999) on communication for EPI and polio eradication for communication officers from the ministry of health, UNICEF and WHO. The Handbook has been revised based on technical input and comments received during the workshops.

CHAPTER 2

Communication for Development

2.1 Communication for development: an overview

One of the major concerns of EPI programmes is that supplemental and routine immunizations have been planned and implemented as if they were two mutually exclusive programmes. NIDs activities have been implemented without reference to routine immunization, and the link between routine and NIDs immunizations has not been adequately established. The apparent lack of linkage has raised questions among child caretakers:

- Why should my child be immunized again when the child has had all the immunizations in the routine immunization programme?
- Does this mean that immunizations given during the routine immunization are not effective?
- Will additional immunizations hurt my child?
- Are the additional immunizations given with an ulterior motive?
- Are the immunizations safe?

When these questions are inadequately answered or left unanswered, both routine and supplemental immunization activities lose out. (Some of these questions are answered in Annex Nine.)

2.1.1 Role of communication in routine EPI, supplemental immunization and surveillance

All EPI programmes are striving to achieve and maintain high immunization coverage in order to reduce morbidity and mortality from immunizable diseases. Achieving this goal has not been easy. The high immunization coverage achieved during the push for UCI in the 1980s has since dropped in some countries and is only coming up again with the push

for polio eradication. Effectively managed, communication can contribute substantially to the achievement and maintenance of high immunization coverage. Communication programmes can:

- Stimulate development of structures (such as health facility committees) that can improve relations between health facilities and communities.
- Promote use of participatory learning and decision-making methods to improve community involvement and ownership of health programmes.
- Support communities to develop strategies for identifying and tracking immunization defaulters.
- Identify and train volunteer motivators to disseminate health messages, facilitating discussion and supporting action in the community.
- Improve the interpersonal communication skills of health workers to disseminate appropriate information, hold discussions and provide counselling services for caretakers.
- Strengthen interpersonal skills of trainers and supervisors in order to improve their training and supportive supervision skills at all levels.
- Develop appropriate communication materials to support message dissemination to key target audiences.
- Publicize immunization achievements to give encouragement to partner agencies, volunteers and other stakeholders.
- Help to strengthen partner and community participation in EPI programmes.
- Support communities to identify and report cases of acute flaccid paralysis (AFP).

EPI management will need to develop effective communication programmes to realize these benefits.

2.2 A model of communication for development

Communication for development may be defined as a researched and planned process crucial for social transformation and operating through three main strategies: *advocacy* to raise resources and political and social leadership commitment for development goals; *social mobilization* for wider participation and ownership; and *programme communication* for bringing about changes in knowledge, attitudes and practices among specific participants in programmes.

The following grid illustrates how the three development communication strategies can be applied to planning. It gives examples of target audiences, activities and outcomes for each strategy.

Strategy	*Participants/targets*	*Activities*	*Outcomes*
Advocacy	• Political leaders • Decision makers • Opinion leaders	*Advocacy with them through:* • Negotiation • Joint planning/review • Lobbying • Special events • Seminars	*Advocacy/action by them for:* • Political will • Resource allocation • Policy changes
Social mobilization (Partners in service delivery)	• Ministry of health • Other ministries • NGOs • Service clubs • Media producers • Advertisers • Artists and intellectuals • Curriculum developers	*Advocacy with them through:* • Orientation programmes • Joint planning • Regular meetings • Joint events • Workshops • Study tours	*Advocacy/action by them for:* • Alliance formation • Organizational motivation • Multisectoral collaboration • Institutional agreements
Social mobilization/ programme communication (Fieldworkers/ other partners in service delivery)	• Health workers • Teachers • Extension workers • Cooperative agents	• Interpersonal communication training • Organizational motivation • Recognition • Feedback • Supervision	• Improved communication with clients • Improved planning • High-quality services • Attitude changes
Social mobilization/ programme communication (Partners in the community)	• Political, traditional and religious leaders • Administrative authorities • CBOs • Women's/youth organizations • Economic organizations • Cooperatives	• Training • Community mobilization, organization and participation • Participatory research, planning, implementation • Strengthening of existing structure, monitoring/ feedback	• Community participation • Service utilization • Community ownership • Community financing • Empowerment
Programme communication (Users/clients)	• Child caretakers • Parents • Men • Women • Individuals	• Audience research • Behaviour analysis • Development and use of educational materials and media • Health education/ promotion by fieldworkers • Training • Dissemination of messages/materials	• Change in knowledge, attitudes and behaviour • Increased and sustained demand for services • Adoption of appropriate technologies • Accelerated programme achievement • Increased immunization coverages • Disease/mortality reduction

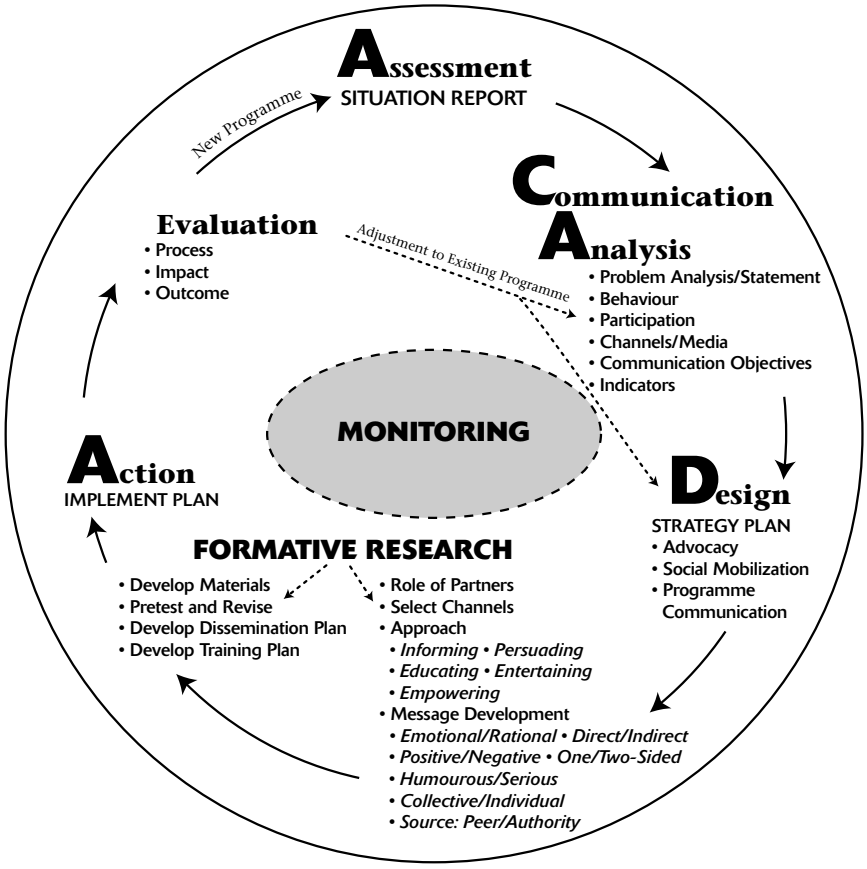
Communication for development goes beyond the term *social mobilization* that is so widely (and often wrongly) used in EPI programmes. In this Handbook, the wider term *communication for development* (or simply *communication*) is used instead.

Communication for development seeks not only to transfer messages, but also to promote interaction around the messages for target audiences to understand them better, accept them and practise the healthy behaviours proposed, not once, but long enough to reap the benefits that such behaviours bring. The ultimate goal, therefore, is a behaviour change, i.e. bringing about and sustaining the desired healthy behaviour. In the case of immunization programmes, one of the promoted behaviours is to take children for immunization regularly, according to the immunization schedule.

2.3 Communication planning framework

Influencing or modifying human behaviour is a complex process that needs to be planned carefully. A number of communication planning frameworks have been developed by different agencies working in development and are available for use. These include the UNICEF-developed ACADA (assessment, communication, analysis, design and action) planning model, the P Process developed by Johns Hopkins University, and others.

ACADA communication planning model



The ACADA communication planning model is based on the widely used Triple A planning cycle (assessment, analysis, action) as modified to suit communication planning needs. Its circular format emphasizes the reiterative nature of planning.

Using the steps in the ACADA communication planning model, the Handbook systematically guides the reader towards developing a research-driven integrated communication plan. As noted in 1.3.4, one of the weaknesses in EPI programmes is that NIDs and routine EPI communication activities do not support each other sufficiently, and communication for disease surveillance has yet to start in many countries. An integrated communication plan includes mutually supportive strategies and activities in:

- Advocacy, social mobilization and programme communication.
- Routine EPI, NIDs and disease surveillance.
- Strategies and activities for special NIDs and mop-up activities in countries that need these.

One of the primary objectives of this Handbook is to improve integration of communication for routine EPI, NIDs and surveillance.

2.4 A brief overview of the elements for developing an integrated communication plan for routine EPI, NIDs and surveillance

The format provided below is a brief overview of the elements recommended for use in developing the integrated EPI/NIDs/surveillance communication plan. This format is based on the ACADA planning steps and is discussed in detail in Chapter Three. The numbers indicate sections of the Handbook that provide detailed information.

I) Situation assessment (3.4 and 3.5)
- Successes
- Weaknesses
- Lessons learned
- Issues and problems

II) Problem analysis and formulation (3.6)
- Problems: manifestations, immediate causes, underlying causes and basic causes
- Differentiate between behavioural and non-behavioural causes
- Problem statement

III) Determination of problem behaviour(s) to address (3.7)
- Behaviour rating and prioritization
- Changeability and importance rating

IV) Behaviour, participant and channels/media analysis (3.8–3.10)
- Behaviour: manifestation, ideal behaviour, barriers to ideal behaviour and factors encouraging ideal behaviour
- Participants: primary, secondary, partners, allies
- Channels: channels to be used in EPI/NIDs/surveillance communication

V) Communication objectives (3.11)
- SMART (specific, measurable, appropriate, realistic and time-bound) objectives

VI) Develop strategies, activities and monitoring and evaluation indicators (3.12–3.13)
- Strategies and activities: determine how we achieve the desired behaviour change
- Monitoring: tracks programme progress
- Evaluation: process, impact and outcome indicators measure programme progress

VII) Develop plans for message and material development and dissemination (3.14–3.16)
- Message: concepts, communication approach and appeal/tone
- Materials: mass media, group settings and one-on-one
- Dissemination: material distribution and utilization strategy

VIII) Develop training plan (3.17)
- Training content, duration, organization/officer responsible and identification of funding source

IX) Put together the communication plan (3.18)
- Combines all of the above information (I–VIII) into a single planning matrix
- Communication objectives for the different strategies: advocacy, social mobilization and programme communication
- Communication objectives for the different programmes: routine EPI, NIDs and surveillance

Integrated communication strategy planning matrix (routine EPI, NIDs and surveillance)

	Problem behaviours (see 3.8)	**Behaviours to promote** (see 3.8)	**Target audience** (see 3.9)	**Comm. objectives** (see 3.11)	**Strategies** (see 3.12)	**Activities** (see 3.12)	**Monitoring & evaluation indicators** (see 3.13)	**Message areas** (see 3.14)	**Comm. approach** (see 3.14)	**Message appeal** (see 3.14)f	**Message tone** (see 3.14)	**Channels of comm.** (see 3.10 & 3.15)	**Comm. materials** (see 3.15)
Advocacy													
Social mobilization													
Programme communication													

X) Plan of action: implementation schedule/time-line for the integrated planning matrix (3.19)
- Expands the integrated plan based on delivery dates and implementation schedules
- Identifies officer responsible for action and source(s) of funds for the various activities

Plan of action: Implementation schedule for the integrated communication strategy planning matrix

Activity	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**Officer/Org.***	**Source of Funds**

* Officer/organization responsible for action

CHAPTER 3

Step-by-step development of an integrated communication plan

Routine EPI, supplemental immunization and surveillance need to be supported by well-planned communication activities. Communication activities supporting the three programme areas should be well integrated to reduce confusion and strengthen the overall programme. The ACADA planning steps introduced in section 2.3 should help communication planners achieve the needed programme integration. The steps are reiterated below and their application in EPI/NIDs/surveillance communication planning is discussed in this chapter.

A. Preparatory activities

3.1 Establish or reactivate a communication committee
3.2 Establish roles for partners and allies
3.3 Develop all plans based on research information

B. Assessment

3.4 Review the status of routine EPI/NIDs/surveillance and related interventions
3.5 Determine overall routine EPI/NIDs/surveillance problem(s) to address

C. Communication analysis

3.6 Problem analysis and formulation
3.7 Determine problem behaviour(s) to address
3.8 Conduct behaviour analysis
3.9 Conduct participant analysis
3.10 Conduct channels/media analysis
3.11 Develop communication objectives
3.12 Develop strategies and activities
3.13 Develop monitoring and evaluation indicators

D. Design

3.14 Develop plans for message development
3.15 Develop plans for material development
3.16 Develop plans for dissemination
3.17 Develop plans for training
3.18 Put together the integrated communication strategy planning matrix
3.19 Write the plan of action

A. Preparatory activities

3.1 Establish or reactivate a communication committee

Many countries have an inter-agency coordination committee (ICC) to oversee the planning, implementation and coordination of all aspects of immunization. If it does not already exist, it is advisable that an ICC be formed for national and district/community immunization programming and that this ICC function year-round. Forming the ICC is the responsibility of EPI management as a whole. Prototype ICC terms of reference are in Annex Eight A.

To enhance planning and implementation of communication activities, a communication committee (CC) should be established (or reactivated) at the national level as a subcommittee of the ICC. The committee should be responsible for the overall coordination of communication activities of routine immunization, supplemental immunization and surveillance (see Annex Eight B for the terms of reference of a CC). Making the CC a subcommittee of the ICC should ensure that communication is seen as an important component of the central programme and not a separate appendage. This should, in turn, promote integration and coordination of the different programme components.

CCs should have broad representation and should include multidisciplinary teams of communication experts, social scientists, clinicians, health workers and community representatives, as well as representatives of the ministry of health, line ministries, key partner agencies and community institutions considered important to the implementation of the communication component of the programme. CCs should oversee the planning and implementation of all aspects of communication, including advocacy, social mobilization, programme communication, community participation and capacity-building. The committees should be maintained in an active state year-round (see Chapter Seven for a more detailed discussion on maintaining participation).

The national CC should be established at least eight months ahead of the national immunization day (NID). Provinces, districts and lower levels should be encouraged to establish similar committees as subcommittees of the main committees for planning, implementing and coordinating NIDs, routine immunization and surveillance communication activities.

Many countries have successfully used committees to involve other sectors and communities in immunization activities. The box on the following page presents the network of committees established and used for NIDs in Uganda. The same committees could be institutionalized to serve routine EPI and surveillance communication needs.

EPI communication delivery structure in Uganda

1 National level

A multidisciplinary committee was established to plan and implement communication and social mobilization activities at the national level with the following membership: Ministry of Health (MOH), line ministries, NGOs, media institutions, security organizations and service clubs. The committee developed a national social mobilization plan, facilitated formation of lower-level committees and structures, identified and recruited partners, developed strategies for reaching special groups, developed and disseminated IEC messages and materials and coordinated and supervised social mobilization activities nationwide.

2 District level

A committee with the following membership was established at the district level: the District Health Team, NGOs, line departments (Education, Information, Gender, Community Development, Security Organizations, Local Government), local political leaders and religious and other partners. This level planned social mobilization activities, trained subcounty social mobilization teams, coordinated social mobilization activities, facilitated formation of lower-level social mobilization structures, supervised lower level social mobilization activities, mobilized local resources, identified and recruited partners, designed strategies to reach special groups, and identified and trained drama groups for NIDs promotion.

3 Subcounty level

A three-person subcounty social mobilization team with the following membership was established: subcounty chairperson, subcounty chief and the health inspector. These individuals were given training in social mobilization and they, in turn, trained parish mobilizers. In addition, they planned mobilization activities, participated in the identification and siting of immunization posts, identified and mobilized local resources, carried out sensitization in schools and coordinated, supervised and evaluated social mobilization activities in the subcounty.

4 Parish mobilizers

Subcounty level volunteers identified and trained three people in NIDs social mobilization. The three then conducted social mobilization activities, guided identification of immunization sites and assisted with work on these sites during immunization.

3.2 Establish roles for partners and allies

Failure to clarify collective and individual roles of collaborating partners is common in health and social development programmes. Unclear roles can result in inactive, unfocused participation.

Annex Eight B gives an example of collective roles of the communication committee. Clear roles will also need to be outlined for participating individuals and organizations. For example, a department of the university may be assigned research and evaluation responsibilities; the Office of the District Commissioner may be responsible for mobilizing vehicles from other departments during NIDs; the Department of Social Services may be responsible for traditional media activities; while the Ministry of Education may be responsible for

coordinating AFP reporting activities of school children. Partners should be given every opportunity to participate in the process of assigning responsibilities and to indicate their capacity and willingness to play the assigned roles. Roles assigned should be entered in the appropriate column in the plan of action (see plan of action format in 2.4 and 3.19).

It is important to:

- Provide opportunities for the various individuals and organizations to report regularly on the activities they are carrying out.
- Thank agencies for work accomplished and generate ideas to facilitate performance of the tasks that remain to be done.
- Agree on new roles and responsibilities for partners when the old roles have been fulfilled.
- Facilitate mobilization of the resources that partners need in order to play their roles effectively.

3.3 Develop all plans based on research information

The importance of research in all forms of planning, including communication planning, is well established. Research provides pertinent information to facilitate development of relevant, focused plans. It also enables programme managers to assess and revise their strategies. It is, therefore, strongly recommended that programmes always use research information in communication planning.

- Conduct research through collaborative institutions. Select research partners who are conversant with development work. Different institutions have different research orientation and will not always collect targeted data that can be easily used in development work. Some of the institutions may need orientation to produce research of benefit to the EPI programme.
- Involve district teams and community members in the research process. This will build research capacity in-country and increase appreciation for the role of research. Involvement in data collection and analysis should give health workers, volunteers and community members an opportunity to interact firsthand with pertinent issues on the ground.
- Summarize research findings and their implications for EPI planning and share with the communities, partners and district-level teams so that they can use the findings to develop their plans.

B. Assessment

3.4 Review the status of routine EPI/NIDs/surveillance and related interventions

Assessment is the first step in preparation for planning and implementation of effective communication activities. In this step, an effort is made to document the status of the EPI programme as a whole and identify successes, weaknesses, lessons, issues, problems, participants, behaviours, credible channels, etc. Assessment should look at all aspects of the programme, not just communication aspects, and should, therefore, be approached as a collaborative effort in which all EPI departments participate. This ensures identification of all the real issues that need to be addressed in the programme. The main activity in assessment, then, is to identify what information is missing and to design and carry out research to fill in the gaps.

The following are examples of documents that could be reviewed during assessment:

- EPI reports and other EPI/NIDs/surveillance records
- Relevant research reports
- Existing policies and practices
- Planning guidelines at all levels

Some of the problems and issues identified during assessment may be the kind that can be solved through communication interventions. Others may not be of a communication nature and may need to be addressed by other departments. Knowledge of these issues should promote comprehensive EPI/NIDs/surveillance planning in which communication and other departments play an important role.

The box on the following page presents a list of lessons African countries have learned from three years of implementing NIDs. The list may provide some guidance on the pertinent questions EPI programmes should be focusing on.

Top 10 lessons learned from three years of implementing NIDs in Africa

1. It is important and beneficial to involve communities (through their leaders) in planning and implementing health activities. By working with communities, NIDs implementers have become more aware of the great achievements that can be made when health services work in close cooperation with communities and caregivers.

2. Cooperation with communities produces optimum results when communities are approached early; when there is frequent contact between the community and health services; when the health issues are presented as national issues that ought to be supported by all; and when the community is allowed adequate leeway to claim ownership of the activities.

3. It is important to start NIDs planning early, at least eight months before the NIDs dates. During the planning and implementing of NIDs activities, it is important to maintain focus on routine EPI and include routine EPI messages in NIDs.

4. NID publicity should have an appeal wide enough to catch the attention, approval and acceptance of all communities in a country. When this is not the case, sections of the community (especially minority groups, people in the top economic bracket, intellectuals, and cultural and religious objectors) tend to see the exercise as meant for other people and not themselves.

5. It is important to make special efforts to discuss the meaning and value of NIDs with private and public medical practitioners ahead of time and obtain their support. Some members of this important category have opposed NIDs in some countries, and when they have done so, people have tended to believe them on the basis that they are more credible, as they are trained medical people who are more knowledgeable on immunization.

6. Whenever a damaging rumour or some other form of opposition to NIDs or vaccination occurs, the programme must find time to investigate the cause as quickly as possible and design and implement appropriate strategies to address the resistance. If this is not done, the situation could become compounded and cause more damage to the programme. Special strategies should be designed to reach the various hard-to-reach and hard-to-convince groups.

7. Great attention should be paid to communication and feedback between the centre and the regions during the planning and implementation of NIDs. Because of inadequate attention to this important area, communication breakdowns have occurred, leading to reduced programme achievement and reporting.

8. There is need to design strategies that establish continuity between NIDs and the regular EPI programme in order to make the two programme components mutually supportive. The strategies should include making communication and social mobilization a continuous activity.

9. Early steps should be taken to involve religious groups as allies, as they have proven to be a potent force for mobilization. It has also been learned that when they do not have a full understanding, some religious and cultural groups stand in the way of health initiatives.

10. NID funds, commodities and materials should be estimated, obtained, and sent out to the regions well in advance of NIDs to facilitate smooth operations.

Example of an assessment of the EPI programme of country X

In 1998, the programme reactivated the inter-agency coordinating committee (ICC) to plan and implement NIDs rounds one and two. There was no committee looking specifically at communication activities. At the end of both rounds of NIDs, the ICC became dormant. Three months later, all the regions have not brought in complete returns on the achievements made during NIDs.

The report compiled by the NIDs contact person shows the percentage of children immunized as the following:

1997		1998	
NIDs Round 1 **95%**	NIDs Round 2 **90%**	NIDs Round 3 **83%**	NIDs Round 4 **87%**

The figures show a declining trend in the percentage of children immunized during each subsequent NID. As in 1997, the northern province and the mountainous parts of the eastern province had the lowest coverage. While parents were enthusiastic to bring their children for immunization in 1997, in 1998 they had many reservations and excuses. Although the causes have not been studied systematically, those participating in immunization activities comment as below:

- Parents ask why their children should receive so many polio immunizations and wondered whether the many immunizations could harm their children.
- In the northern province there was a strong rumour that polio vaccines were laced with contraceptives.
- People felt that their time was better spent searching for food for the family than taking healthy children for immunization.

Before NIDs, the full immunization coverage (all antigens) of children under one year of age was 65 per cent. NIDs have helped raise the coverage to about 85 per cent. It is hoped that 1999 NIDs will raise the coverage to 90 per cent or above. But as happened after attaining UCI in the mid-1980s, it is feared that the coverage may drop after NIDs activities stop. No specific strategies have been developed to ensure that coverage does not drop after NIDs immunizations stop. At the moment there is poor linkage between NIDs and routine EPI. The contact person for routine EPI has complained that health workers take NIDs more seriously than routine EPI, and this makes her work more difficult. Routine EPI is also underfunded. During the first NIDs in 1997, we were lucky to have the First Lady launch activities at a well-attended event in which the ministers of line ministries (Health, Education, Labour, National Guidance, Youth and Women Affairs) participated. Permanent secretaries from these and other ministries, as well as a number of members of Parliament, directors of parastatals and members of the diplomatic corps, attended the occasion as well. In 1998, Justice Emily Lea of the High Court launched the event, with a visibly reduced presence of high-level national dignitaries. The event was attended by the Deputy Minister for Health, Permanent Secretaries for Health, Labour and the Ministries of National Guidance and Youth and Women Affairs. At the moment, there is no AFP surveillance system in place. The technical department is working on a surveillance draft that may be discussed and approved later this year. When the system is in place, the communication department will develop messages to promote it.

Successes

- The immunization programme is well established with basic support structures, such as the ICC.
- NIDs activities have been fairly successful and have increased immunization coverage.
- The programme has achieved high coverage (85 per cent).

Weaknesses

- At 85 per cent, immunization coverage is still low.
- While some parts of the country have high immunization coverage, other parts have low coverage and a poor turnout during NIDs immunization.
- There is no committee/subcommittee looking into communication activities. As a result, communication strategies have shown some weaknesses.
- The ICC falls dormant at the end of NIDs, thus providing no continuity.
- No studies have been done to increase knowledge about areas of difficulty, such as resistance to the programme.
- There is weak linkage between NIDs and routine EPI, and NIDs tend to take attention away from routine EPI.
- Routine EPI is underfunded.
- There is no surveillance system in place and so health workers and caretakers are not reporting AFP cases.

Issues and problems

- Interest in the programme, both among high-level leaders and parents, is waning and there is need to develop more effective strategies to sustain interest in both target audiences.
- There is poor linkage between NIDs and the routine immunization programme. This area needs attention if the gains made through NIDs are to be sustained.
- There is a need to carry out studies to understand better the cause of waning interest, resistance and reduced coverage with each subsequent NID.
- Urgent attention should be paid to the development of both technical and communication components of the surveillance system. There is need to bring communication people into the surveillance development process as soon as possible.

3.5 Determine overall routine EPI/NIDs/surveillance problem(s) to address

At this level of assessment, many problems are identified, some of which may not be related to communication.

For instance, using our country assessment example given on the previous page, some of the problems that need to be addressed are:

1. Immunization coverage is low.
2. There is a decrease in immunization coverage from 1997 to 1998.
3. Some parts of the country (the northern province and the mountainous eastern province) have low immunization coverage and a poor turnout during NIDs.
4. Caretakers are questioning the value of immunizations.
5. Political support for NIDs is waning.
6. NIDs detract health workers and other staff from routine EPI.
7. There is no communication subcommittee within the ICC.
8. There is no surveillance system in place and so health workers and caretakers are not reporting AFP cases.

After assessing the EPI programme, the next stage is to determine the key problem (or problems) that need to be addressed. At this level, the problems need not be related to communication.

C. Communication analysis

3.6 Problem analysis and formulation

The problems identified during assessment may not be problems in their own right, but manifestations, causes or explanations of the main problems. It is important then to begin analysis with the development problem itself, rather than discussing which media to use or what messages to disseminate. Only after painting a clear picture of the problem will it become evident which groups of people, performing particular behaviours with appropriate resources, need to be involved in the communication programme. Analysis also helps to develop messages and strategies that introduce, teach or reinforce performance of desired behaviour more effectively.

Using the worksheet on the following page enables systematic analysis of the problem, tracing its causes and arriving at a problem statement that is sufficiently elaborated.

WORKSHEET 1: Problem Analysis

(A blank worksheet for use and/or photocopying can be found in the worksheet booklet.)

Problem:			
Level of causality	***Behavioural causes***	***Non-behavioural causes***	***Sources of information****
Manifestation	*What is the manifestation of the problem?*		
Immediate causes	*These causes may include programme structure, lack of information, lack of capacity, etc.*	*These causes may include problems of supply distribution*	
Underlying causes	*These are usually at the level of government policy and practices and include causes such as the school system, kinds of health services available, etc.*	*These causes may include lack of infrastructure*	
Basic causes	*These refer to the influence of social, cultural and economic factors*		

*The sources of information column ensures that planners think about the causes and the reliability of the sources they are obtaining information from. It is important that problem analysis be research-based. Research helps to identify and quantify the scope of the problem accurately, including recognition of segments of the population most affected.

An example of problem analysis

(A blank worksheet for use and/or photocopying can be found in the worksheet booklet.)

Problem: Low vaccine coverage			
Level of causality	***Behavioural causes***	***Non-behavioural causes***	***Sources of information***
Manifestation	*High incidence of vaccine-preventable diseases*		*MHC/EPI routine report 1987*
Immediate causes	*Caretakers not reporting AFP* *No records on immunization at district hospitals* *Political and other rumours* *Lack of information among political leaders*	*Inadequate access to health care facilities* *Shortage of data*	*Health workers* *Newspapers and health staff* *Meetings, briefings, one-on-one interaction* *MOH (provincial) and NGOs*
Underlying causes	*Religious resistance* *Low prioritization of EPI among political leaders*	*Transport issues* *Shortage of staff* *Allocation of funds for social services* *Number of staff/number of people*	*Statements by religious leaders* *Newspapers, briefings, one-on-one interaction* *District hospital*
Basic causes	*These refer to the influence of social, cultural, political and economic factors*	*Lack of funds*	*EPI survey 1997* *Government data*

This framework of problem analysis enables us to analyse, in an integrated manner, the problems identified during assessment. In doing this, we distinguish between problems that are behavioural in nature and those that are not. From now on the focus is on behavioural problems and the problem analysis results will be used to arrive at a strong problem statement.

The ***problem statement*** answers the following questions:

1. What is happening (are people doing/not doing) that is a problem?
2. Where and when does it usually take place?
3. Whom does it affect?
4. What are the primary effects of the problem?
5. What are the possible causes?
   (*A blank worksheet for use and/or photocopying can be found in the worksheet booklet.*)

The problem statement should be put in terms of what people are or are not doing so that it will be clear what aspects of the problem a communication programme can address.

Below is an example of one country team's efforts to define the problem more precisely as data from research became available. The final statement makes it clear what aspect of the problem communication would address.

Example of a problem statement:

In an initial team meeting, members agreed to the following draft statement of the problem:

Draft problem statement:
Country X has a very low vaccine coverage believed to be caused by poor planning and lack of infrastructure.

Available data, demographic health surveys and focused research to fill missing information enabled the country team to expand the draft statement to the following final problem statement

Final problem statement:
Country X had low coverage, 35 per cent for measles and 45 per cent for polio among children 0–5 years of age, in the years 1985 and 1986 (data recorded during routine immunizations), resulting in increased incidence of measles and polio. This is a result of poor planning, religious resistance and the absence of outreach services for populations in rural regions and urban high-density areas.

3.7 Determine problem behaviour(s) to address

To determine problem behaviours to address:

- Review all the behavioural causes identified above.
- Rate and prioritize behavioural causes on the basis of changeability and importance.
- Out of important and changeable behaviours, select one to three behaviours to address.

Only a few problems (no more than three) of focus should be selected at any one time. The fewer the problems, the easier it is to come up with a focused plan that will achieve demonstrable results.

3.7.1 Behaviour rating and prioritization

First, what people know or think is important to health programmes. But it is what they do or fail to do that ultimately impacts programme achievement directly. For this reason, communication programmes should focus on behaviour and not knowledge or attitudes. Changes in knowledge and attitudes are only intermediate aims in communication for development. Properly planned, behaviour-driven communication should automatically address concerns about knowledge and attitudes as part of the communication package.

Second, communication is only effective when it is applied to behaviour that can change. The more changeable the behaviour, the more effective communication interventions are likely to be. Another factor to consider is the importance of the behaviour in solving the key problem. Criteria that can be used to determine changeability and importance of a behaviour are as follows:

Criteria for determining changeability and importance of behaviour

Determining importance

- *Relevance*—How strong is the link between the behaviour and the health problem?
- *Occurrence*—How frequently or rarely does the behaviour occur?
- *Impact*—Does the behaviour have a demonstrable effect on the health problem?

Determining changeability

- *Stage of behaviour*—Is the behaviour in a developmental stage or is it already established?
- *Cultural acceptability*—Is the ideal behaviour that should replace the current behaviour compatible with acceptable sociocultural norms and practices?
- *Past successes/failures*—What successes/failures have been realized in efforts to change this behaviour in other programmes in the past?
- *Cost*—At what cost (in time, energy, social status, money and materials) will the ideal behaviour come about? Is the cost acceptable or too high?
- *Consequences*—Will the new behaviour yield positive or negative consequences for the person performing it?
- *Persistence*—Does the new behaviour require compliance over an acceptable or an unrealistically long period of time?
- *Complexity*—Is the behaviour too complex or can it be easily divided into a small number of elements or steps to facilitate learning?

3.7.2 Changeability and importance rating

To arrive at a manageable list of behaviours on which to focus, each problem behaviour using the above criteria is categorized on the changeability and importance worksheet given below.

WORKSHEET 2: Changeability and importance grid

(A blank worksheet for use and/or photocopying can be found in the worksheet booklet.)

	More important	***Less important***
More changeable	***Priority 1*** *More changeable and important behaviours.* High priority for programme focus.	***Priority 3*** *More changeable but less important behaviours.* Low priority except to demonstrate change for "political" purposes.
Less changeable	***Priority 2*** *Less changeable but important behaviours.* Priority for innovative programmes.	***Priority 4*** *Less changeable and less important behaviours.* Not worth spending resources on.

As mentioned in the grid above, Priority 1 behaviours are clearly the most cost-effective to focus communication efforts on. Little purpose is served focusing on Priority 4 behaviours, and Priority 3 behaviours may be of importance only when there is a political need to document change in these areas. Where such a need exists, these behaviours are often given only a temporary priority. More research and good analysis are needed to find innovative strategies for addressing Priority 2 concerns.

Following this analysis, the communication team should now have a short list of feasible behaviours that have an established impact and are amenable to change.

3.8 Conduct behaviour analysis

After determining problem behaviours to focus on, the next step is to analyse the chosen behaviours in order to understand them better and determine the behaviours to promote in their place. The behaviours are analysed on the basis of research findings.

The worksheet on the following page should help in the behaviour analysis process. The grid carries an example based on the problem behaviour: *Caretakers do not take children with AFP to the health facility.*

WORKSHEET 3: Behaviour analysis worksheet

(A blank worksheet for use and/or photocopying can be found in the worksheet booklet.)

Problem behaviour	***Manifestation***	***Behaviours to Promote***	***Barriers to ideal behaviour***	***Factors encouraging ideal behaviour***
Some caretakers do not take children with AFP to the health facility	*They hide children with AFP* *They take children with AFP to traditional healers*	*Take children with AFP to health facilities within 24 hours of onset* *Advise neighbours to take children with AFP to health facility*	*Belief that paralysis is caused by evil spirits or witchcraft* *Belief that paralysis is a shameful disease* *Health workers ridicule caretakers when they take children with AFP to health facilities* *Health facilities are far* *Poverty—no bus fare to health facility*	*Caretakers take children to health facilities for other medical problems* *Health facility committees are being established* *A mechanism for reporting AFP within the community is being identified* *Youth organizations are very active in the community*

3.9 Conduct participant analysis

During participant analysis, **all** categories of stakeholders that ought to be involved in the communication effort as either target audiences, partners or allies are identified and analysed. This includes identifying organizations that can support communication efforts as well.

3.9.1 Primary and secondary target audiences

Communication target audiences are identified in relation to key problem behaviours or behaviours to be promoted. Suppose that one of the problem behaviours identified in 3.5 is: *Some caretakers do not take children for immunization*. To identify key audiences, communication planners ask the following series of questions:

- *Who does not take children for immunization?* (This question helps to identify primary audiences/participants, i.e. the people who must take action for children to get immunized.)
- *Who is in a position to influence those who do not take children for immunization?* (This question helps to identify secondary target audiences in the immediate environment of primary target audiences, such as family and friends.)
- *Who will inform, support, persuade primary target audiences to take children for immunization?* (This question helps planners identify another important category of secondary audiences—the motivators.)

From this set of questions, the following target audiences may be identified:

Primary audiences: Mothers and fathers who have children under five years.

Secondary audiences: Grandmothers, siblings, religious leaders, members of the administration, local opinion leaders (teachers and community-based extension workers), traditional birth attendants, etc. A secondary category of secondary audiences may be identified as clinical officers, nurses at health facilities, family-health field educators and growth monitoring agents.

The general audiences identified above should be reviewed further to determine whether there is a need to subdivide them into narrower audience categories that can be reached more effectively with specific targeted communication efforts.

Take, for example, the problem: *Some caretakers do not take children for immunization*. Primary target audiences were identified as mothers and fathers who have children under five years. To complete the analysis, research information is used to answer questions such as the following:

- Are fathers and mothers with children under five years all the same, or can they be divided into different categories?
- Do they all live in the same place under the same socio-economic conditions?
- Do they all have the same needs?
- Do they all have the same reasons for not taking children for immunization?
- Can they all be reached effectively by the same communication effort, or do they need to be divided into more closely defined, smaller subcategories?

These and related questions should help communication planners decide on the subcategories of the general target audiences they will finally focus on. Ideally, each target group identified should be defined by at least three characteristics, *e.g. mothers who have children under five years, having primary school education, living in the rural area and belonging to the Angels Church*. These characteristics can include marital status, age, level of education, socio-economic status, area of residence, religious affiliation, number of children, etc.

3.9.2 Other partners to involve

In addition to determining primary and secondary audiences, participant analysis is concerned with identifying other individuals and institutions that may be enlisted to support behaviour change and behaviour development in the community. Partners may play an advocacy, social mobilization or programme communication role. Many may play more than one role at the same time. To identify partners, a different set of questions is asked.

Advocacy partners

- Who holds the key to programme acceptance in this community?
- Who are other influential people/groups?

Social mobilization partners

- Which agency or individuals are interested in or working for immunization?
- What facilities do they have (networks in the community, personnel, experience, training facilities, funds, transport, etc.)?

- What is their reputation in the community?
- What influence do they have with the authorities and primary and secondary target groups?

Programme communication partners
Programme communication partners are normally based in the community and are identified by asking the question:

- Who can influence target audiences to adopt the behaviour being promoted?

Possible partners include influential people, leaders, grandmothers or other groups and individuals in the community.

The worksheet below may be used to determine information on individuals and organizations to be involved in a communication effort.

WORKSHEET 4: Participant analysis

(A blank worksheet for use and/or photocopying can be found in the worksheet booklet.)

Problem behaviour	***Participants***			
	Programme communication		***Social mobilization***	***Advocacy***
	Primary target audiences	*Secondary audiences*	*Partners/allies*	*Partners*

The following case study of Zimbabwe provides an example of effective participant analysis.

Zimbabwe

Zimbabwe has one of the most successful EPI programmes on the continent. It has also had some of the most encouraging results in NID activities. Throughout the 1990s, Zimbabwe has reported maintaining OPV3 coverage above 80 per cent. Both rounds of NIDs conducted in 1996 reached an average of 96 per cent of children under five years.

What is the secret behind Zimbabwe's success?

Routine programme: One reason for Zimbabwe's ability to maintain the high immunization coverage on routine immunization is the extensive network of motivators the country has built over the years to support routine immunization. The network stretches from the national to the village level. Each of the country's public clinics is supported by a volunteer clinic committee, village community workers and community-based growth monitoring agents who disseminate health messages at public meetings, in group settings (women's groups, youth groups, etc.) and with couples during home visits.

Most of the time, motivators in Zimbabwe have educational materials on immunization to use, and every effort is made to keep immunization in the media, taking advantage of existing radio and TV programmes on national and local radio and TV networks. Presented as news reports and general interest features, EPI materials often get free air time.

Educational materials are developed at national and provincial levels and displayed on health centre notice boards and other public places with monthly themes, to reduce message fatigue. The country has adapted WHO EPI manuals and is in the process of integrating them into nurses' training curricula.

As is the case in many other countries, there is no explicit communication budget in Zimbabwe's EPI budget. Instead, the communication section sells its services to the budget holding departments, mainly the service delivery department.

NIDs: Both rounds of Zimbabwe's NIDs realized a high success rate because of the all-out effort made to mobilize communities and institutions, along with their resources, from the national to the village level. A workable division of labor was established between the mobilized partners. The programme disseminated key information that the public needed to understand the rationale behind NIDs and take action.

Messages disseminated answered the following key questions: What are NIDs? Why are NIDs conducted? At what venues? Who will be vaccinated? What are parents expected to do? Another message was that OPV doses given during NIDs are extra doses that supplement, but do not replace, the doses given during the usual schedule. Through phone-in programmes, questions asked by the public were answered, and Harare city vaccination points were listed in a local newspaper.

Partners mobilized included: (1) the local Rotary Club, which supported planning and monitoring; provided vehicles; supplied T-shirts, banners, posters, a cold room, food for volunteers, electrical plugs, adapters and ice liners; funded NIDs launching day activities; gave technical advice in developing radio messages and produced radio advertisements; (2) the Ministry of Transport and Energy, which provided vehicles used by health workers to sensitize the community prior to NIDs; (3) community workers: village health workers, farm health workers, city health promoters; (4) community-based distributors, who sensitized the community, worked with health workers at vaccination points, and collected data; (5) health workers and environmental health officers, who trained community leaders; (6) the Red Cross, which mobilized volunteers; (7) local farmers, who provided transport and volunteers; (8) churches, local community leaders, chiefs, politicians and local communities members, who sensitized local communities, donated cash and provided "Kick Polio Out of Africa" sun visors; (9) the Public Health Association, which provided a forum for the community and health workers to discuss and educate each other on NIDs; (10) ZANU-PF secretaries for health, who trained the community at the village level; (11) local radio and television, which gave free air time before and during NIDs; (12) politicians and other leaders, who also participated by launching NIDs at various levels.

Inspired by this success, Zimbabwe moved on to implementing measles NIDs.

3.10 Conduct channels/media analysis

Channels and media analysis provides answers to the following questions:

- What channels of communication are available for reaching the identified target audiences?
- What are the strengths and weaknesses of each channel?
- How effective are the channels in reaching the target audiences we wish to reach with the message(s) we plan to deliver?
- Where do people seek information on health or immunization? Why do they go to this particular place or individual? How can the place or individual be integrated in promotion of immunization messages?

Generic strengths and weaknesses of communication channels are given in Annex Two.

Structures through which messages can be disseminated to reach ultimate beneficiaries in the community should be closely analysed and strategic ones selected and incorporated into the programme. Selection of appropriate structures should ensure that messages reach intended target audiences. The structures should also be those that can help to sustain the gains the programme may make.

Below are some of the structures that have been used by programmers with good results in the past:

- Health worker networks at various levels
- Local authority structures
- Provincial administration
- Churches, mosques, temples and other religious facilities
- Women's organizations
- Youth organizations
- Schools (teachers and students)
- Village-based traditional "health consultants" (such as traditional birth attendants, traditional healers, medicine sellers)
- Motivators (including paid staff and volunteer village workers)
- NGOs

Collectively, these networks have the capacity to reach virtually all households.

The worksheet below should help communication planners approach channels analysis more systematically.

WORKSHEET 5: Channels analysis

(A blank worksheet for use and/or photocopying can be found in the worksheet booklet.)

Target audiences	*Group affiliation (religious, social, economic)*	*Where do target audiences go often/spend substantial time?*	*Whom does the target audience consult on health issues?*	*Who else can influence the target audience in health-related matters?*	*Channels to be used in EPI communication*

3.11 Develop communication objectives

Having carried out the essential assessment and analysis, we are now in a position to state communication objectives to form the basis of our interventions.

First, an objective is a statement of the desired end result. The desired end result in communication for development is change from a *problem behaviour* (such as keeping children with AFP at home) to a *desirable behaviour* (such as notifying a health worker about children with AFP within 24 hours). Since the desired end result is behaviour change, communication objectives should be stated in behaviour (and not knowledge or attitude) terms.

Second, objectives must be specific and must be stated in such a way that they can be interpreted only **one way**. Vague objectives will be interpreted differently by different people and this will cause confusion. Besides, when objectives are vague, it is difficult to establish when they have been met or not. Good objectives are, therefore, SMART:

Specific—Objectives clearly state what is desired in terms of the end result.
Measurable—Criteria are specified for how the output will be measured in terms of quality, quantity, timeliness and/or cost.
Appropriate—Objectives should be culturally and locally acceptable.
Realistic—Objectives should be within realistic control of the individual but ambitious enough to challenge.
Time-bound—Time (and/or milestones) by which objective to be achieved is stated.

Communication objectives are derived from the problem behaviour (see 3.7) and behaviours to promote (see 3.8). Take, for example, the problem: C*aretakers do not take children under 15 years of age with AFP to the health facility and do not inform health workers about AFP cases*. The behaviour to promote may be:

- Caretakers should notify a health worker about children under 15 years of age with AFP within 24 hours.
- Caretakers should tell neighbours who have children with AFP to take the children to the health facility.

From the problem and the behaviours to promote above, SMART objectives could be as below:

Objective 1: *By the end of the year 2000, all caretakers (fathers and mothers) in Botswana will notify a health worker within 24 hours about their children aged 0–15 years who get AFP.*

Objective 2: *By the end of the year 2000, all caretakers (fathers and mothers) in Botswana will advise relatives, friends and neighbours with children aged 0–15 years with AFP to notify a health worker about such children within 24 hours.*

Note: Writing objectives is not as easy a task as many planners believe. For example, it took 20 minutes to write the initial version of the objective above. In spite of that time investment, when a peer reviewed it, she found several points of vagueness. The objective was then rewritten as two objectives and discussed with peers and revised again. Even then, as you read it, you may still notice something that needs changing to make the objective more SMART. Feel free to make that change. And when you write your own objective, subject it to rigorous peer review as this will invariably improve it.

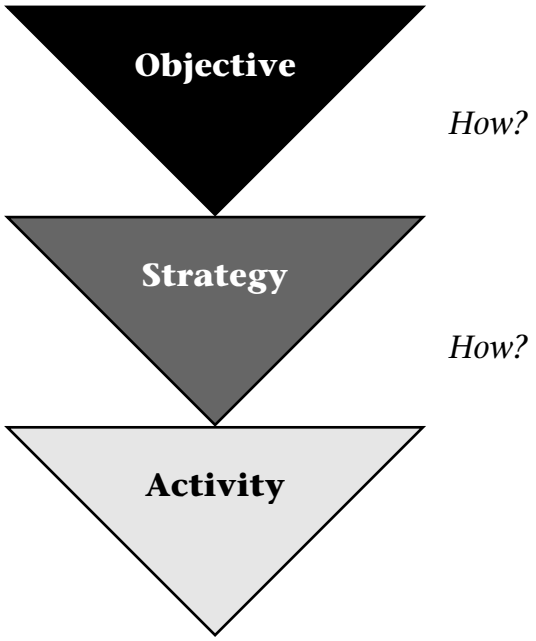
3.12 Develop strategies and activities

As stated in 3.11, an objective is a statement of the desired end result. In this section we seek an answer to the question: *How do we reach the desired end result?*

As all development workers know, we get to the objective by developing and implementing appropriate strategies and activities. The figure below illustrates the relationship between objectives, strategies and activities.

A ***strategy*** is a short statement or phrase indicating a general methodology to be used to achieve a stated objective. In that form, the statement is too general to be implemented. It needs to be redefined and amplified to be acted upon.

Activities amplify a strategy, giving it the details it needs to be implementable. Example: *training health workers to disseminate key messages to caretakers*. As a strategy, it is stated in only one phrase that cannot be implemented. Activities give the strategy greater definition and break it into individual units that can be implemented and scheduled on an action plan (see 3.19 for the worksheet that provides a schedule for the integrated plan of action).



The box on the following page, using the AFP example, illustrates how to move from objectives to strategies and activity statements.

Objective 1

By the end of the year 2000, all caretakers (fathers and mothers) in Botswana will notify a health worker within 24 hours about their children aged 0–15 years who get AFP.

How will the objective be reached?

By implementing the following strategies:

- Training health workers to disseminate key messages to caretakers.
- Using religious institutions (churches, mosques, etc.) and other community groups to disseminate information to caretakers.
- Disseminating information in the mass media.

How will the strategies be implemented?

By implementing the following activities:

Preparatory work/action

- Hold a half-day briefing meeting with partners and EPI contact persons in the districts.
- Develop appropriate training curricula and IEC materials* to support the programme.

Training of health workers

- Identify and train 20 trainers, 2 per district, for 5 days and give them IEC materials to distribute.
- District trainers conduct training for health centre-based EPI contact persons (1 course of 30 per district).
- Trainers and health centre contact persons train operational health workers.
- Trained health workers disseminate messages at health facilities and in the community.

Working with religious institutions and community groups

- Conduct a survey to identify religious and community organizations to work with.
- Hold a one-day workshop with selected organizations to develop strategies for working together.
- Select and train trainers and contact persons from identified organizations (2 courses of 30 participants).
- Contact persons and trainers train identified message disseminators in the various organizations with the help of district trainers and health centre-based EPI contact persons.
- Trained message disseminators disseminate messages during various religious, village and family gatherings.

Information dissemination through the media

- Air radio spots two times a day for six months.

*Monitoring and evaluation***

- On the basis of strategies, activities and indicators (see also 3.13), develop an appropriate monitoring system and formats.
- Conduct routine monitoring at the national and lower levels.
- Receive monitoring data from the districts quarterly and give appropriate feedback to field staff.
- Prepare and disseminate quarterly reports.
- Evaluate communication activities early in the year 2001.

*IEC materials will include electronic and print materials. (See Chapter Four for material development.)

**See monitoring and evaluation in Chapter Nine.

3.13 Develop monitoring and evaluation indicators

Many communication programmes omit monitoring and evaluation, thereby missing the opportunity to track the performance and impact of their programmes. Communication planners are urged to break these practices and ensure that monitoring and evaluation indicators are established and used appropriately in EPI programmes. Monitoring and evaluation activities will enable communication planners to gain greater understanding of their programmes and find ways and means of strengthening them.

Monitoring and evaluation indicators are drawn mainly from programme objectives/activities and may be classified in three main categories, depending on the aspects of the programme to be assessed and how soon after commencement of the project evaluation is expected to take place.

Process indicators focus on short-term achievements of a programme and programme activities and the performance of programme processes and administrative and logistic arrangements. These indicators deal with the following questions: Were activities implemented as planned? How efficiently? How well did administrative and logistic arrangements work?

Impact indicators are useful in assessing medium-term effects of a programme. Impact evaluation usually uses quantitative research methods and provides information on the extent to which programme objectives have been achieved.

Outcome indicators are useful in providing information on the long-term effects of programme interventions. In a health programme, outcome indicators assess change in morbidity, mortality, health status and quality of life. Outcome evaluation uses quantitative research methods.

Example: Possible monitoring and evaluation indicators for Objective 1 in section 3.11

Objective 1 in section 3.11:
By the end of the year 2000, all caretakers (fathers and mothers) in Botswana will notify a health worker within 24 hours about their children aged 0–15 years who get AFP.

Possible activities relating to the objective are listed in the box in 3.12. Taking the objective and activities together, monitoring and evaluation indicators may include the following:

Process indicators

- Half-day briefing meeting is held
- Training curriculum is developed
- Type and quality of IEC materials developed
- Number of national trainers trained
- Number of district trainers trained
- Number of health workers disseminating needed messages
- Type and quality of radio spots developed
- Number of times radio spots aired
- Frequency and quality of field staff reports
- Consistency in giving feedback to field staff
- Consistency in preparing quarterly reports

Impact indicators

- AFP cases reported to health workers
- % of caretakers notifying health workers of AFP cases within 24 hours
- % change in the number of caretakers who know that AFP cases in children 0–15 years should be notified to health workers within 24 hours
- % change in number of caretakers convinced that it is necessary to notify health workers about children with AFP within 24 hours

Outcome indicators

- Botswana certified polio-free by WHO

Notice that process indicators based on planned activities can make a good basis for developing a monitoring checklist. Monitoring provides a basis to try and track programme progress; evaluation measures programme progress. More on monitoring and evaluation is in Chapter Nine.

Communication-related programme indicators for EPI may include the following:

Programme process and management

- Number of communication committees established.
- Number of meetings held by each committee.
- Number of provinces using this Handbook for planning EPI activities.
- Number of districts developing integrated EPI/NIDs/surveillance plans instead of free-standing NIDs plans.
- Number of committees commencing communication planning at least eight months in advance of NIDs.
- Quality of monitoring, documentation and reporting (e.g. reports received on time and correctly completed).
- Type and quality of data collected from the field for decision-making.
- How data collected are used.
- Availability of structures and processes that promote joint planning, consultation and information-sharing between the different EPI departments.

Knowledge

- Percentage of caretakers reached by immunization messages.
- Percentage of caretakers who know the minimum number of times they need to bring a child for vaccination by the age of one year.
- Percentage of caretakers who know the linkage between routine immunization and supplemental immunization.
- Percentage of caretakers who can identify the symptoms of AFP.
- Percentage of community leaders who know why members of the community should report cases of AFP.
- Percentage of community workers who can correctly describe the process of reporting AFP.

Attitudes

- Percentage of caretakers who believe that children should be immunized.
- Percentage of caretakers who are convinced that immunizations given during routine immunization and those given during NIDs:
  - Use the same vaccine
  - Have the same effectiveness
  - Are both safe
  - Are both necessary

- Percentage of caretakers convinced that it is necessary to notify health workers about children with AFP within 24 hours.

Behaviour

- Percentage of caretakers bringing children under one year to receive routine immunization according to the vaccination schedule.
- Percentage of caretakers bringing children under five years of age for both rounds of NIDs immunization.
- Partners and organizations participating in at least 80 per cent of the committees for NIDs and routine immunization.

Training and capacity-building

- Percentage of planned training and capacity-building activities:
  - Implemented
  - Implemented on time
- The number of training activities using participatory training methods.
- Number of people trained.
- Number of supportive supervision activities carried out by the national level and the district teams.
- Level of funds committed to training and capacity-building.

Sustainability

- Level of political and leadership support.
- Level of government funding and funding of donors and other programme supporters.
- Structures established to support communication at the different levels: national, district and community.
- How often research data are used in planning communication activities.
- Quality of long-range communication programmes developed.
- Level of community involvement in planning, funding, implementation, monitoring and evaluation of communication activities.
- Level of decentralization of resource allocation and programme management.

D. Design

Development of monitoring and evaluation indicators above completes the analysis steps. From here, we embark on the design steps. This section discusses how to develop plans in these areas. Other aspects of message and material development are in Chapter Four, while dissemination and training are discussed in greater detail in Chapter Five.

3.14 Develop plans for message development

Planning for message development involves decision-making in three main areas:

- Determining message concepts that will bring about the desired behaviour change.
- Selecting the communication approach.
- Choosing the message appeal or tone.

3.14.1 Determining basic message concepts

Messages to be communicated depend on target audiences, behaviours to promote (see 3.8) and factors likely to influence target audiences to adopt the desired behaviour. The behaviour promotion grid below will help communication planners determine the needed message areas and concepts. Actual complete messages cannot be put on the grid, as these can only be determined on the basis of audience research.

WORKSHEET 6: Message concepts

(*A blank worksheet for use and/or photocopying can be found in the worksheet booklet.)*

Target audience	***Behaviours to promote***	***Factors influencing adoption***	***Message areas/concepts***	***Communication approach***	***Appeal/tone***

Good messages:

- Reinforce positive factors identified on the grid above.
- Address misunderstandings and areas of deficient knowledge.
- Address attitudes.
- Give the benefits of behaviours being promoted.
- Urge specific action.
- State where to find the services being promoted.
- State where to find help, if needed .
- Address barriers to action.

More on message development is in Chapter Four.

3.14.2 Choosing the communication approach

During planning for message development, communication planners determine the basic communication approach they wish to take. Depending on the communication problem and research findings, planners may wish to take any or a combination of the following approaches:

- Informing
- Entertaining

- Persuading
- Educating
- Empowering

3.14.3 Choosing the message appeal/tone

Communication planners also determine the appeal that the messages should have. Depending on research findings, and the behaviours that need to be promoted, planners may select any or a combination of the following possible message appeals:

- Positive or negative
- Rational or emotional
- Mass or individual
- Humorous or serious
- One- or two-sided
- Direct or indirect
- Definite or open-ended
- From a peer or from an authoritative source

3.15 Develop plans for material development

Many different materials can be developed to enhance communication. These materials should be determined on the basis of the target audience and the channel/setting in which the materials will be used. The worksheet below may be used in determining the materials to develop.

WORKSHEET 7: Plans for material development

(*A blank worksheet for use and/or photocopying can be found in the worksheet booklet.*)

Strategy	***Target audience***	***Materials to develop***		
		Mass media	***Group settings***	***One-on-one***
Advocacy				
Social mobilization				
Programme communication				
Training				

Programmes should avoid developing posters, calendars, booklets and similar materials merely because many organizations develop them. Educational materials should be:

- Appropriate to the topic and target audience.
- Appropriate to the context/setting in which they will be used.

3.16 Develop plans for dissemination

Since the beginning of this planning process, many decisions that go into the communication plan have been taken. In this section, we think about how the pieces will fit together:

- How the messages will reach intended audiences.
- How educational materials will be distributed.
- How educational materials will be used.

Developing the dissemination plan involves, first, matching target audiences with activities, the settings in which they will take place, and materials that will be used to support those activities. Second, it involves developing a material distribution strategy and guidelines on how the materials can best be used. The grid below may be used to guide planning deliberations.

WORKSHEET 8: Dissemination plan

(*A blank worksheet for use and/or photocopying can be found in the worksheet booklet.)*

Strategy audiences	***Target audiences***	***Activities' materials***			***Educational strategy***	***Material distribution strategy***	***How material will be used***
		Mass	***Group***	***One-on-one***			
Advocacy							
Social mobilization							
Programme comm.							
Training							

Activities: Generic activities have been identified in section 3.12. They are revised and listed according to the different channels/settings in which they take place—mass, group and one-on-one. Listing activities this way helps to evaluate them and answer the following questions:

- Are there adequate activities in all three communication channels/settings?
- Are the activities mutually supportive?
- Are the proposed educational materials the right kind to support activities in their different settings? Do we need to add more materials or drop some?

3.17 Develop plans for training

Effective implementation of EPI communication programmes may require both paid and volunteer implementers at various levels. Some of the participants may need training in order to:

- Acquaint themselves with the objectives, strategies and activities of the programme.
- Know the roles they are expected to play.
- Acquire information and skills needed to perform assigned roles.

Communication planners should, therefore, develop appropriate training activities to meet programme needs. Training categories may include:

- Various paid and volunteer motivators (e.g. community-based motivators, such as community health workers, people assisting at vaccination points, etc.).
- Immunizers and other appropriate health workers (to improve their interpersonal communication skills and build consensus about key information to be given to caretakers bringing children for immunization).
- Supervisors (to upgrade their ability to provide supportive supervision—see also 5.4.5).

The grid below may be used by communication planners to develop training plans. See 5.4.1 for a more detailed discussion on training and capacity-building.

WORKSHEET 9: Training plan

(A blank worksheet for use and/or photocopying can be found in the worksheet booklet.)

Training target groups	***Training content***	***Duration of training***	***Officer responsible***	***Source of funds***

3.18 Put together the integrated communication strategy planning matrix

In the present chapter (from 3.4 to 3.17), we have been developing sections of the integrated communication plan for the different strategies (advocacy, social mobilization and programme communication) in the different programmes of routine EPI, NIDs and surveillance. In this section, we bring together all the pieces to form one complete plan. We use the integrated communication plan format presented in 2.4 (the grid is reproduced below).

WORKSHEET 10: Integrated communication strategy planning matrix (routine EPI/NIDs/surveillance)

(A worksheet for use and/or photocopying can be found in the worksheet booklet.)

	Problem behaviour (see 3.8)	Behaviours to promote (see 3.8)	Target audience (see 3.9)	Comm. objectives (see 3.11)	Strategies (see 3.12)	Activities (see 3.12)	Monitoring & evaluation indicators (see 3.13)	Message areas (see 3.14)	Comm. approach (see 3.14)	Message appeal (see 3.14)	Message tone (see 3.14)	Channels of comm. (see 3.10 & 3.15)	Comm. materials (see 3.15)
Advocacy													
Social mobilization													
Programme communication													

3.19 Write the plan of action

Item 3.18 presents the integrated communication strategy planning matrix. The plan of action expands the planning matrix and provides information on the delivery/implementation schedule for the activities. Information on the source of funds for the activities and the officer responsible for initiating action is also to be filled in as this provides accountability and assists in tracking and monitoring programme progress.

The worksheet below may be used to develop the plan of action.

WORKSHEET 11: Implementation schedule/plan of action

(A worksheet for use and/or photocopying can be found in the worksheet booklet.)

Activity	J	F	M	A	M	J	J	A	S	O	N	D	Officer/ Org.*	Source of funds

* Officer/organization responsible for action

CHAPTER 4

Developing messages and educational materials

Message and material development are closely related design processes crucial in communication for development. The processes involve:

- Identifying messages to be used.
- Determining the basic characteristics of those messages.
- Formatting and packaging the messages to make them attractive and suitable for use with different audiences and in different situations.

Message and material development should be based on the findings of formative research and are guided by continuous review and pretesting to ensure that the final products are understood by the key target audiences, are acceptable to them and can be effective in supporting development of the desired behaviours.

4.1 Message development

Message development involves:

- Identifying the areas in which messages ought to be developed to support development of the desired behaviour(s) effectively.
- Determining the approach and appeal/tone of the messages.
- Determining the media, materials and editorial format to use.
- Drafting messages and concepts.
- Presenting draft messages and concepts for review to ensure that they are technically correct and acceptable to experts and the commissioning agency.
- Revising text, concepts and illustrations on the basis of review.

- Pretesting draft messages and concepts to find out if they are understood, acceptable and likely to be effective with key target audiences.
- Revising concepts and drafts after the pretest.

4.1.1 Identify areas in which to develop messages

Messages to be disseminated depend on programme concerns and research findings. Identified below are some areas in which messages are often needed on routine EPI/NIDs/surveillance programmes. Sample messages used in EPI programmes in the past are in Annex Four.

These message areas and sample messages are provided to stimulate the thinking of communication planners and should be used only as a guide.

Message themes for round one of NIDs

Advocacy

- Why NIDs are necessary.
- Benefits of NIDs (health, economy, family life).
- Countries that have done NIDs and the successes they have realized.
- Other NIDs/EPI successes in-country and elsewhere.
- Reminder about international/OAU/WHO resolutions and endorsements on polio eradication.
- Examples of other heads of state and leaders nationally, Africa-wide and internationally.

Social mobilization

- Information/discussion with partners about the programme: why NIDs, why eradication of polio and not other diseases, programme goals and objectives, the national programme delivery structure, how NIDs relate to routine immunization.
- The role and responsibilities of the different partners.

Programme communication

- Effect of polio on the health and prospects of a victim.
- Outlook for prevention and treatment.
- Why polio eradication and prospects for achieving eradication.
- Target populations for polio immunization and how many times children should receive polio vaccination.
- Safety and benefits of repeated polio immunizations.
- Polio eradication strategies and how they work.
- Responsibility of individuals to take their children for immunization and inform others about NIDs, routine polio immunization and AFP reporting.
- Where to take children for immunization and the schedule to follow for routine immunization.

Training

- Inform health workers about the NIDs programme and its purpose as a supplement to routine immunization. Answer their questions and allay their fears so that they, in turn,

are convinced and confident to answer questions put to them by caretakers and other members of the public.

Message themes for the second round of NIDs

Repeat NIDs round one messages, as appropriate, and add the following:

- Successes of round one NIDs and coverage achieved.
- Round two as a continuation of round one and as important in building the child's immunity.
- Children immunized in round one need to come for immunization during round two.
- Clarification that even if a child missed round one, the child should still go to round two immunization.
- Emphasize the need to continue with routine immunization before and after NIDs.
- Show caregivers the national immunization schedule.
- Address any rumours and misunderstandings that may have been noted.

Message themes after the second round of NIDs

After round two of NIDs, continue with messages that support routine immunization.

- Compile and disseminate information on the achievements of NIDs.
- Discuss how NIDs have benefited routine immunization and emphasize the need to continue with routine immunization.
- Explain the immunization schedule with emphasis on polio immunization.
- Distribute materials on how leaders and other partners promote routine immunization.
- Intensify interpersonal communication at health facilities.

Surveillance messages

The opportunity to implement NIDs should be seized to sensitize the community about reporting AFP. In Tanzania, for example, 167 cases of AFP were reported during NIDs in 1996.

Surveillance messages should be disseminated throughout the year. These may include the following:

- Effect of polio on the health and prospects of a victim.
- Mode of polio transmission and what caretakers should do to curtail polio transmission.
- Family and community responsibility in reporting AFP cases to health workers.
- Lay definition of AFP.
- Tips on how to go about identifying and reporting AFP cases.
- Advantages of reporting AFP cases, including the rehabilitation health workers/family can give to a child with AFP.

4.1.2 Determine approach and appeal/tone

A communication effort may take an informing, educating, entertaining, empowering or persuading approach. The message appeal/tone may be positive or negative, rational or emotional, mass or individual, one-sided or two-sided, direct or indirect, definite or open-ended, as if from a peer or an authoritative source. These decisions occur during planning and are described in section 3.14.

4.1.3 Determine media, materials and editorial format

A message may be considered as one of the basic elements that go into a communication effort. For it to be effective, the input needs to be packaged for use in a particular medium or setting (such as an interpersonal counselling session at a clinic, a training session of 30 participants or a radio programme). Each communication medium/setting lends itself to different editorial formats. For example, while drama, talk shows, news and magazine formats may be used on radio, suitable formats for one-on-one settings may include counselling cards, small-size flip charts, pictures to stimulate discussions and models.

Decisions on media are, therefore, taken early in the process to pave the way for decisions on suitable materials to develop and effective editorial formats to use.

4.1.4 Draft messages and concepts

After media, materials and editorial format have been selected, message developers now draft messages and sketch concepts for illustrations. The drafts and sketches represent initial ideas of the message development team. During these initial stages, it is advisable to develop several concepts for the same idea to see which one communicates the desired message best.

4.1.5 Review, pretest and revise text and concepts

It is advisable always to develop educational materials with the support of a committee that includes technical experts and representatives of the key target audiences. The committee is of invaluable help in reviewing and advising on factual information and other aspects, such as possible interpretations and other flaws that may creep in. The standing communication committee or its subcommittee is sufficient to play this role, provided it has medical people on it as recommended in 3.1.

Draft scripts and illustrations should be thoroughly reviewed by committee members and other technical people or gatekeepers (such as religious leaders) and appropriate changes made. The revised drafts should then be tested on a limited number of individuals representative of the target audiences. Materials should be pretested with both primary and secondary audiences.

4.2 Development of educational materials

During material development, messages and concepts that have been tested are now developed and packaged into complete educational materials.

Educational materials enhance the communication process in many ways. They:

- Make learning interesting and more effective.
- Increase comprehension and retention.
- Remind target audiences about messages when they are back home.
- Remind the communicator about important points that need to be mentioned.
- Help to spread messages to reach people whom the communicator cannot reach.
- Give messages a sense of importance and credibility.

Good communication materials express ideas simply, clearly and directly, using language, images and examples that target audiences are familiar with.

Effective communication materials:

- Clarify messages.
- Are consistent. They communicate the same messages on all the media and interpersonal channels that the campaign may be using.
- Communicate the benefits of the interventions being promoted. (Benefits motivate people to change.)
- Communicate both practical reasons and emotions that go with those reasons.
- Present truthful information and seek to create trust between the communicator and the targets.
- Command attention in the market place where other communicators are competing for attention.
- Call for action. (In EPI, some examples are taking children for immunization according to the recommended schedule and reporting AFP cases in children 0–15 years to health workers as soon as possible at the onset of symptoms.)

4.2.1 Pretest and revise educational materials

Educational materials should be thoroughly reviewed and pretested. After every round of pretesting, the needed revisions should follow. Concepts, text, illustrations, audio copy, photographs, models, plays, posters, booklets and slogans should all be pretested. Conduct pretests with all important target audiences. Pretest and revise as many times as will make the materials well understood and appreciated by the majority of target audiences. Each material should be pretested at least two times, first to identify problem areas and then to ensure that the revisions are satisfactory.

More details on pretesting are in Chapter Nine.

CHAPTER 5

Implementing the communication plan

This Handbook is developed as a tool to help programme managers improve communication plans in EPI programmes. Individual plans will specify activities to be implemented (see 3.12). This chapter gives general tips on implementing communication activities for routine EPI, NIDs and surveillance. In the ACADA planning framework, this chapter is equivalent to Action and is organized into four main sections:

- Management structures and processes
- Communication management instruments
- Staffing and institutional skills
- Key communication activities

5.1 Management structures and processes

Organizational structures and work processes influence the quality and effectiveness of activities, including communication activities. EPI programmes should, therefore, review their structures to ensure that they have the capacity to support implementation of effective communication programmes.

The following features can help EPI programmes to implement effective communication activities:

- Joint planning involving all EPI departments.
- Regular programme meetings attended by all EPI departments.
- National communication committees (or subcommittees) that work closely with the inter-agency coordination committee (ICC), and duplication of similar committees in the provinces and lower levels (see also 3.1).

- Active partner participation (see Chapter Seven).
- Decision-taking based on research findings (see 7.2).
- Regular and effective supportive supervision (see 5.4.5).
- Effective routine monitoring (see 9.3).
- Periodic evaluation (see 9.4).
- Routine sharing of research, monitoring and evaluation reports between EPI departments and with partners and allies.

5.2 Communication management instruments

The main aim of communication programmes is to bring about the desired behaviour change. The behaviour change process is a complex one and needs to be managed effectively using appropriate instruments. These include:

5.2.1 Communication strategy plan and plan of action

The communication strategy plan and plan of action (see 3.18 and 3.19) form the basis for implementing communication activities and should be developed regularly with the participation of other EPI departments and partners.

The planning process brings together EPI departments and partners, thereby strengthening the EPI team. Additionally, joint planning helps identify programme weaknesses that need to be addressed.

5.2.2 Monitoring system and monitoring formats

Monitoring helps programme managers to know how implementation of planned activities is proceeding. In spite of its importance, systems for routine monitoring of communication activities in EPI programmes remain weak, and many of them are not designed to provide the critical information needed to support the development of strong communication activities. EPI programmes should take steps to strengthen the monitoring component of their programmes (see 9.3 for more details).

5.2.3 Supervision system and checklist

Communication activities are complex. They often spread throughout the country and involve many people. These include paid staff and various volunteers. Some of the people participating are convinced about what they are doing and have the skills and commitment to participate effectively, while others need to be trained, encouraged, guided and supported to make a contribution. Supervision provides the needed on-the-job training, encouragement, guidance and support. The need to develop an effective supervision system with an appropriate supervision checklist is discussed in 5.4.5.

5.3 Staffing and institutional skills

EPI departments are manned by people of different backgrounds. These include journalists, holders of different liberal arts qualifications, and even physical science majors. Few of them are from a programme communication background.

Many of them have since attended programme communication courses and acquired varying levels of skills. But for various reasons, virtually no EPI programme on the continent has routinely used research-based processes to carry out communication activities. Because of the low level of practice, and the widespread shortage of staff in communication departments, the skills needed to implement activities using research-based processes are inadequate in virtually all programmes. There is, therefore, need for EPI programmes to assess the communication skills they have and take steps to upgrade them as needed.

To function effectively, EPI communication departments should have skills to do the following:

5.3.1 Effective communication plans

EPI programmes should develop the capacity to develop communication plans using the process described in Chapter Three of this Handbook. Developing plans by this process takes into account all aspects of the programme and leads to balanced, focused and effective programme implementation.

5.3.2 Effective supervision and monitoring

Supervision is discussed in section 5.4.5 below and monitoring is discussed in Chapter Nine. Skills for both supervision and programme monitoring are critical to the implementation of good communication programmes.

5.3.3 Subcontract and supervise contracts

Because of the widespread shortage of staff and skills in communication departments, the trend is to subcontract work out to experts who can do it. Activities that can easily be contracted out include research, training, material development and evaluation.

While the EPI department does not need to have the capacity to do the work contracted out, the department does need to:

- Have a general understanding of the work.
- Know the contribution the work will make in the wider communication plan.
- Know the processes that need to be followed to accomplish the task.
- Know the product they are looking for.
- Be able to write a good contract specifying products to be delivered during the different stages of implementing the contract.
- Be able to supervise the contract and evaluate the quality of products delivered.

Communication departments that have contracted out work without the ability to do the above have ended up with low-quality, sometimes unusable products. More on subcontracting is in Annex Nine.

5.3.4 Stimulate teamwork and partner participation

Participation of other sectors is key to the successful implementation of communication programmes. Bringing the sectors together can be relatively easy, but maintaining their support can be a major challenge. EPI managers need to acquire and apply team skills to keep partners together. Chapter Seven gives some ideas on what can be done to maintain participation.

5.3.5 Prepare and disseminate reports

Preparing and disseminating reports in an attractive, easy-to-understand format is a skill that can promote teamwork and partner participation. Good reports also identify issues and problems that need to be addressed, thereby promoting programme development. Attractive reports can also help in fund-raising. Programme managers need to learn the skills of report writing and the different formats to be used with different target audiences.

5.3.6 Stimulate programme development

Often, communication activities are approached as unconnected, freestanding events. NIDs, for example, are inadequately connected with the routine EPI programme and are implemented as if they were a freestanding programme. The disjointed programme approach sometimes occurs when managers fail to approach implementation from a programme perspective.

To promote programme development, programme managers should develop skills to:

- Recognize short-term, medium-term and long-term needs of their programmes.
- Articulate those needs.
- Formulate innovative programmes to address programme gaps.

5.3.7 Prepare funding documents

To mobilize more resources, communication managers will need skills to develop documents that make a strong case for increased communication funding. Good fund-raising documents articulate programme needs and identify innovative activities to address programme gaps.

5.4 Key communication activities

This section contains ideas on how to implement key activities that form the backbone of EPI/NIDs/surveillance communication. The ideas/strategies include:

5.4.1 Training and capacity-building

Implementing the present guidelines should help EPI programmes restructure their communication programmes and make them more responsive to emerging needs. But the

envisaged restructuring can only occur if staff, volunteers and other individuals expected to play a role receive adequate orientation and training to work with the new approaches. Programmes will need to include appropriate training activities in their communication plans (see 3.17) and identify funds to be used for the purpose. The new skills should, in turn, facilitate attainment and sustenance of increased immunization coverage.

Short-term training

Short-term training refers to the training and orientation that the various participants need to effectively play the roles assigned to them during the immediate immunization cycle. The cadres needing short-term training may include trainers and supervisors, immunizers, motivators, teachers, extension workers of other agencies, and partners such as media producers, curriculum developers, advertisers and leaders of various community groups (see grid in 3.9).

During training, the integrated EPI programme should be presented, showing clear linkages between NIDs and the routine EPI programme. In addition, the following issues should be discussed during training of the various categories:

Partners

- The role of the different partners in EPI/NIDs promotion.
- Opportunities for collaborating among partners in EPI/NIDs promotion.
- Resources (financial, technical and others) that partners bring to EPI/NIDs promotion.

Trainers

- Utilize participatory training methods.
- Areas needing training emphasis (technical issues and messages in EPI, NIDs, and surveillance; linkage between NIDs and routine immunization; planning and implementing integrated EPI communication activities; interpersonal communication; communication in support of community surveillance; the role of the various cadres in supporting surveillance activities).
- Supportive supervision strategies and processes (see also 5.4.5).

Supervisors

- Role and responsibilities of supervisors.
- Supportive supervision strategies and processes.
- Supervision tools.

Immunizers, motivators and other implementers

- Planning and implementing effective communication activities.
- Interpersonal communication skills and processes.
- Key messages to disseminate during various contacts with mothers and other caretakers.
- Effective use of educational materials.

5.4.2 Using media mix and varied communication opportunities

The need to use a mix of media and communication settings (mass, group and one-on-one) has been emphasized throughout this Handbook. This is because different communication settings have different strengths and weaknesses (see Annex Two), and use of a combination of media and communication settings produces superior results.

As pointed out in Chapter One, a leading weakness in EPI programmes is the tendency to excessively use mass communication and mass events and underutilize interpersonal communication (both group and one-on-one). This is in spite of the fact that interpersonal communication strategies have been proven to be very effective in bringing about behaviour change and are particularly effective in Africa where literacy levels are relatively low.

Programmes are strongly urged to strengthen use of interpersonal communication through appropriate training, supportive supervision and other strategies.

In interpersonal communication, programmes need to particularly:

- Improve the quality of interaction between health workers and caretakers.
- Increase discussion and action in support of immunization and surveillance in the various community groups.

Interpersonal communication is discussed in Annex Six.

5.4.3 Integrating and phasing NIDs/routine EPI/surveillance/mop-up communication

EPI programmes are currently involved in implementing polio eradication activities with NIDs as a major area of emphasis. Implementation of the various rounds of NIDs provides a convenient basis for segmenting EPI communication activities into components. This subsection provides guidelines on communication activities that can be developed and implemented during the following time period:

- When approaching NIDs.
- During the first round of NIDs.
- In between the first and second rounds of NIDs.
- During the second round of NIDs.
- After the second round of NIDs.
- During mop-up operations when polio is almost eradicated.
- After polio is finally eradicated.

Communication for disease surveillance is discussed in Chapter Six.

The subsection provides guidance on how NIDs, routine immunization, surveillance and mop-up messages and activities can be phased in a mutually supportive way.

When approaching NIDs

Planning for NIDs activities should start at least eight months in advance and should use the planning process described in Chapter Three. Planning should take place both nationally and at the microlevel in the districts.

Dissemination of NID information should start at least one to two months ahead of the national immunization day. This will give the public enough time to discuss and comprehend messages. An early start will also give organizers time to reach more people and explain NIDs better.

Communication activities that may be carried out as NIDs near include the following:

- Announce the forthcoming NIDs in the media, religious places and other gatherings.
- Distribute and use educational materials developed for the purpose.
- Announce activities and events planned to promote NIDs (e.g. football matches) in the media, in religious gatherings, in village meetings, at market places and shopping centres, at health facilities, etc. Use influential people (such as administrators and women's group leaders), village criers, loud speakers, posters and leaflets to disseminate messages.
- Make reporting AFP cases a major activity during the NID. Announce plans and procedures for reporting AFP cases during that day. Also, make AFP reporting a major communication activity that should be continued all the time to (1) minimize disability to affected children, (2) protect other children from infection and (3) promote polio eradication.
- Based on research, develop a lay case definition of AFP that people can easily understand. Announce plans and processes for AFP surveillance and reporting. Take every opportunity to sensitize the public on the need to report AFP: during meetings with community leaders, in public meetings, in churches, in youth and women's groups, on the radio, etc.
- Give the benefits of NIDs, who can participate and how, and where immunization activities will take place (see Annex Four for more messages).
- Distribute advocacy materials to leaders (e.g. pocket cards and fact sheets to members of parliament, NGOs, Rotary and private sector leaders). The materials should give the purpose of NIDs, past progress, the task ahead and the role of leaders in promoting immunization and polio eradication efforts.
- Answer questions being asked about NIDs in the print and electronic media. Hold discussions in the communities that do not have good access to the media.
- Visit selected key leaders (e.g. religious leaders) to brief them on the programme, solicit their support and, as appropriate, ask them to officiate at functions (like ceremonial administration of polio drops).
- Implement scheduled training activities and have some of them covered in the media.
- Intensify group education activities in the community. Trained leaders, extension workers and volunteers should disseminate messages at public meetings and in churches, women's groups, youth groups and elsewhere. Individuals contacted in these groups should be given appropriate training and educational materials for personal use and for distribution to other members of the community through informal contacts among peers or house-to-house.
- Intensify interpersonal communication in the community through home visits, with emphasis on areas with resistance or low immunization coverage.
- Promote EPI discussions and message dissemination among hard-to-reach communities (see Chapter Eight for hard-to-reach).

- Monitor public response to communication activities fortnightly/monthly (see monitoring in Chapter Nine) and compile reports for discussion during communication committee (CC) meetings.

Activities and messages should be appropriately phased over the period of publicity, starting with a slow pace at the beginning and building up to a faster campaign beat nearer the NID.

During the first round of NIDs

During the first round of supplemental immunization, communication managers, motivators and volunteers may:

- Recruit a celebrity or a nationally recognized leader to launch the NID and administer OPV to a couple of children. The celebrity should make a speech and the event should be covered in the media.
- Air NID electronic media materials on that day. If developed, a radio/TV spot urging people to take their children for immunization would be ideal in a context where the target audience for the spot has access to TV/radio. Arrange for a radio announcer to tour immunization centres to make live reports and urge people to bring children for immunization. This can prove to be a great boost to the programme. Arrange newspaper write-ups and advertisements.
- Use megaphones and volunteers to disseminate reminder messages in the community, door-to-door if necessary.
- If immunization activities are planned to take more than one day, ensure that first-day activities are featured in the news and other electronic media programmes, as well as in the print media. Successes of day one should be featured and continuation of activities reinforced. If possible, get satisfied mothers interviewed and clippings and recordings of exemplary interactions between health workers and mothers aired. Getting organizers and volunteers to make supportive remarks in the media may provide added motivation.
- **Immunizers should intensify dissemination of key messages to clients at health facilities. They should interact with caretakers in a courteous, friendly and supportive manner and tell clients about the need to bring children to the next round of NIDs and the need to continue with routine immunization. They should also tell caretakers about the need to report cases of AFP and inquire if caretakers have any AFP cases to report.**
- If caretakers have AFP cases to report, health workers should guide them on how to make reports while they are at the immunization site.
- Immunizers should answer clients' questions and explain the linkage between supplemental and routine immunization.
- If information and reminder materials have also been developed, immunizers should use the materials to communicate with clients, tell clients what the materials contain and give them the materials to take home.
- Motivators and others involved in information dissemination should keep a record of activities and prepare reports on the activities after the NIDs.

In between the first and second rounds of NIDs

- The programme should continue communication for routine immunization and surveillance in the mass media, at health facilities and in the community in between the two rounds of immunization. These messages should also be disseminated during NIDs events and during vaccination sessions.
- Programme and communication managers should encourage all districts and units to prepare and submit reports of NID activities carried out, including the number of children immunized and AFP cases reported. Programme/communication managers should compile reports from the districts and units into one report and have the report reviewed by the ICC and the CC to identify lessons to be learned and programme strengths and weaknesses.
- Disseminate news of successes widely in the community and through the media. Provide human interest stories of families who travelled long distances to the immunization sites, cases of AFP that were identified, leaders supporting immunization, etc.
- Thank all who contributed to the success of the NID activities and encourage their continued involvement.
- Respond to questions raised by the public in the media and prepare briefs for use on district stations. The briefs will also help EPI officers and volunteers in the districts to respond to the issues adequately.
- Develop and implement plans to address weaknesses that can be corrected in the limited time available. (Keep a record of major concerns for action after the second round of NIDs.)
- Revise plans for the second round of NIDs, making adjustments on the basis of the experience of implementing the first round.
- Carry out communication for the second round of NIDs in the media and in the community. Get administrators and religious and other community groups to announce the next round of NIDs.

During the second round of NIDs

The second round of NIDs should be used to reinforce the linkage between NIDs and routine immunization. The experience of implementing the first round of NIDs should be used to revise plans. Communication activities similar to those carried out during the first round should be implemented. The activities should:

- Emphasize the importance of continuing with routine immunization until children have completed all the immunizations they need.
- Ensure that caretakers and other members of the community know how to identify AFP cases and how to report them.
- Emphasize the need to report AFP cases during the second round of immunization and at any other time thereafter.
- Use educational materials to remind mothers and other caretakers about the NIDs schedule and give them educational materials and the immunization schedule to take home as reminders.

- Remind caretakers to take their children for the next immunization in the NIDs calendar.
- Give caretakers opportunities to receive answers to the questions they may have during interactions with motivators and immunizers.
- Ensure that motivators and others involved in information dissemination keep a record of activities and events of interest to communication efforts and use the records to prepare reports after NIDs.

After the second round of NIDs

After the second round of NIDs, communication efforts should focus on promoting routine EPI, sustaining the gains made during NIDs and maintaining continuity from NIDs to routine EPI. In addition, communication activities should address programme concerns, correct identified flaws, seek to achieve and maintain high immunization coverage and strengthen surveillance. Long-term activities designed to build communication capacity and strengthen community participation and partnership-building should be enhanced during this phase. Some of the activities will be the same as those carried out between the first and second round of NIDs (such as preparing and reviewing NIDs reports, disseminating success stories and responding to questions raised). Other activities will be to:

- Continue communication on routine immunization and surveillance in the community and in the media. Encourage ICCs and CCs to continue activities for routine EPI.
- Review community surveillance with the full participation of community members and agree with them on ways to strengthen surveillance activities.
- Convene a meeting to review NIDs/EPI/surveillance activities and identify issues that need to be addressed. Take steps to work towards institutionalizing integrated communication planning. Support the ICC and CC to follow up on identified issues, carry out the needed formative research and start a new planning cycle.
- Develop a programme of activities with the CC that encourages the committee to meet continuously (see also Chapter Seven for strategies for strengthening participation).
- Continue communication monitoring activities to detect flaws and make adjustments.

During mop-up operations

Mop-up operations consist of two rounds, four to six weeks apart, of intensive house-to-house OPV immunization in high-risk polio areas. All children in a specified age group (usually 0–59 months) are immunized during mop-up operations, regardless of their immunization status. Each round is completed in as short a time as possible.

High-risk areas are those districts in which the polio virus is still circulating or is likely to circulate. These include districts in which polio cases have occurred in the last 36 months and that have:

- Low immunization coverage.
- Transient populations.
- Dense urban and/or peri-urban populations with poor sanitation.
- Poor access to health care.

What is the value of mop-up polio immunization?

Mop-up immunization is carried out to interrupt polio virus transmission in focal areas where the wild polio virus is still suspected to be circulating. It is the final stage before the wild polio virus is finally eliminated. Even after polio virus is thought to have been eliminated, mop-up immunization may be carried out where the wild polio virus is suspected to have been brought in through cross-border transmission.

When should countries start mop-up operations?

Countries should conduct mop-up immunization operations when NIDs have been conducted successfully for at least three years throughout the country and polio has been reduced from a disease occurring throughout the country (endemic) to a disease that occurs only in focal areas. Mop-up immunization activities are usually carried out during the low polio transmission season.

In countries where the polio virus is thought to have been eliminated or almost eliminated, mop-up immunization may be conducted immediately after a case is confirmed as polio, regardless of the season.

What communication strategies are available for mop-up operations?

Mop-up immunization operations are organized along similar lines as NIDs, except that the area of coverage is limited and vaccinators seek out the target population rather than the target population coming for immunization at a central place. Much of what has been said about communication for NIDs, routine immunization and surveillance applies to mop-up immunization as well. Communication for mop-up immunization activities may include the following steps:

- Review relevant reports (e.g. monitoring, evaluation and other reports) to establish the issues and problem behaviours.
- Identify audiences in whom the behaviours occur and secondary target audiences who can influence the behaviour of primary targets audiences. This will include community leaders, traditional birth attendants and opinion leaders such as teachers and extension workers.
- The lead time between a decision to organize a mop-up operation and the operation itself can be short (e.g. following confirmation of a case of polio) and may not allow adequate time to carry out full-scale research as recommended in the regular EPI/NIDs/surveillance communication programme. Communication staff should nevertheless make efforts to do some planning using available information from sources such as:
  - Past research.
  - Programme, monitoring and evaluation reports.
  - Discussions with elders, community key informants (KIs), health workers and other extension workers working among the affected communities to get information on areas such as reasons for low coverage (if this is the case), social values, norms, perceptions and beliefs relating to the behaviour problems. Information on the social structure of involved communities (including opportunities and resources available to support communication activities) should also be collected.

- On the basis of the information assembled, programme managers should define behaviour problems to be addressed; define key primary and secondary target audiences; identify partners to involve; and develop communication objectives, messages, channels of communication and educational materials (which may also be adapted from those used before). Messages should promote the mop-up operation, routine immunization and surveillance. They should also include the dates and times of immunization, the target age group and information on immunization schedules.
- Review monitoring and evaluation reports on educational materials used in the EPI programme, and select those that can be used in the communities where mop-up operations are planned.
- Develop or adapt and pretest educational materials. If existing materials are used, remember to pretest them in the appropriate communities to find out if they are acceptable or if they need to be modified (see Chapter Nine for pretesting). Do not assume that because the materials have been used in the country before, they are necessarily effective with all communities.
- Develop communication monitoring and evaluation indicators, as well as monitoring formats (see 3.13 and Chapter Nine).
- Develop a communication plan to promote mop-up operations (see format in 2.4 or 3.18). Monitoring and evaluation should be included in the plan.
- Implement the plan and use monitoring information to improve activities.

After polio is finally eradicated

After polio is finally eradicated, the following will continue:

- Routine EPI programme and communication activities that support the prevention of polio and other EPI and infectious diseases.
- Community and facility-based disease surveillance covering polio and other EPI and infectious diseases.
- Supplemental immunization campaigns (such as NIDs and national immunization weeks) for other priority diseases (such as measles).
- Communication in support of EPI and other health programmes.

The guidelines in this Handbook will have been implemented, and many EPI programmes will have worked with research-driven communication approaches, with encouraging results to show in some programmes. The overriding challenge will remain how to continuously improve communication so that it can serve the health sector in general, and EPI in particular, more effectively. This need will be met only if EPI programmes work on:

- Institutionalizing research-driven communication in health and EPI programmes.
- Strengthening the support and involvement of leaders regionally, nationally and locally.
- Strengthening the financial and technical commitment and involvement of development partners.
- Increasing and maintaining community participation and ownership of health interventions.
- Developing improved programmes to promote communication capacity-building.

The opportunity for implementing polio eradication activities should be used to strengthen EPI communication programmes and make them more result-oriented. It is recommended that communication managers study and apply these guidelines for the benefit of EPI and other health programmes as well.

5.4.4 Monitoring communication activities

Routine monitoring, documentation and utilization of monitoring information to identify and correct programme flaws is key to the implementation of good-quality communication programmes. For effective, systematic monitoring to occur, programme managers should:

- Develop monitoring indicators during communication planning (see 3.13).
- Develop monitoring formats or checklists for routine use. The formats should be based on communication objectives, messages, educational material, strategies and activities (see 9.3 for guidance on what to monitor).
- Develop monitoring processes and procedures that:
  - Specify reporting levels (national, provincial, district, health facility, village, etc.).
  - Designate reporting officers and volunteers.
  - Determine reporting intervals (weekly, monthly, quarterly, etc.).
  - Determine what will be reported (different reporting formats may be needed at different levels).
  - Determine the procedure for reporting to the next level.
  - Indicate procedures by which higher levels will provide feedback and support to lower levels.
  - Provide guidance on how monitoring information may be used:
    - Locally by lower-level stations
    - At the head office

The following will need to be included in the routine monitoring programme:

- Communication planning and implementation schedules.
- Electronic media broadcasts and EPI materials in the media.
- The type and quality of interpersonal communication going on in the community and at health facilities.
- Utilization of indigenous media.
- Interim reactions and effects of communication activities, messages and educational materials.

Arrangements should be made to summarize monitoring information routinely and to present summaries for discussion during meetings of EPI management, the communication department and CCs. Successes and failures should be noted and utilized to correct flaws and improve future programme activities.

Tips on how to develop monitoring indicators and checklists and monitor communication activities are in Chapter Nine.

5.4.5 Supervising communication activities

Supervision is one of the weakest aspects of communication programmes, including EPI communication. On many programmes, supervision rarely takes place, and when it does, the approach taken leaves a lot to be desired.

During a recent workshop of senior ministry of health staff, a participant described supervision as *quick trips you make in the field to see how things are going on*. Unfortunately, this is a widespread view of supervision. Approached this way, supervision is neither supportive nor worthwhile.

Effective supervision should ideally have the following four elements:

- Routine monitoring of field activities to find out what is happening on the ground.
- Discussions with the people on the ground to identify strengths to be reinforced and weaknesses to be corrected.
- Developing follow-up and improvement strategies.
- Supporting the team on the ground to implement improvement strategies.

These make supervision a key instrument for continued on-the-job training, capacity-building and programme improvement. Supervision should, therefore, always be part of the overall immunization programme strategy.

What should EPI programmes supervise?

Areas to be supervised will depend on the programme approach and emphasis. The programme may develop one supervisory checklist with different sections: clinical, communication and administration. It could also have separate checklists. Either way, the checklist(s) should give priority to areas that need emphasis.

In an EPI programme, the following areas should be considered for monitoring and supervision:

- Planning and scheduling of communication activities.
- Communication at public meetings.
- Group communication activities and skills.
- Interpersonal communication (IPC) activities and skills.
- Public reaction and client satisfaction.
- Staff deployment and relations.
- Community reactions and participation.

The supervision process

Effective, supportive supervision implies continuation of team-building, programme improvement and continuous on-the-job training. All these processes take time and attention. The following steps will help programme managers give supervision the attention it needs:

Step one: Before going for supervision, review the necessary records and determine the areas that need to be examined closely. The records to be consulted should include the programme plans, objectives, plan of action, schedules for various activities, standards, job descriptions, past supervision reports and decisions, programme performance reports and monitoring reports.

Step two: While on location, observe activities on the ground.

Step three: Conduct interviews with relevant health workers, clients and community members, including committee members and KIs. (This step runs simultaneously with step two.)

Step four: Meet with health workers to discuss questions such as:

- What do you think about your work?
- Are there any issues and gaps you are concerned about?
- How can the issues and gaps be addressed?
- What can we at the head office (district level, if appropriate) do to help or support your work better?

During discussions, agree on a programme of activities to address the concerns.

Step five: Write a report to the next level. Have the report discussed through appropriate management structures and corrective action agreed upon.

Step six: Give feedback to the district/area/health facility supervised.

Step seven: Support the district/area/health facility supervised to implement the corrective measures.

Step eight: Conduct follow-up supervision to establish progress and identify further assistance that may be needed.

This process makes supervision an important means of monitoring progress, building a team, introducing innovations and developing skills.

Supervision aids

The key instrument for supervision is the supervision checklist. An example of items that go in the communication supervision checklist is in Annex Seven.

5.4.6 Evaluating communication activities

Communication programmes need to be systematically evaluated to determine their performance, their accomplishments and the action that needs to be taken to improve the situation. Evaluation is discussed in detail in Chapter Nine. Evaluation findings should be discussed by appropriate staff and volunteer forums and corrective decisions taken and implemented.

CHAPTER 6

Communication for disease surveillance

In the *Field guide for supplementary activities aimed at achieving polio eradication,* WHO lists 18 steps for developing AFP surveillance. The steps are developed from a clinical perspective, but also provide for a communication input (see page 63). Step 15 alludes to the community without elaborating. This section provides guidelines on how to develop the role of communication and the community components of surveillance. Additional information and examples of surveillance activities are in Annex Five.

6.1 Routine EPI, NIDs and surveillance communication

Chapter Two of this Handbook recommends that surveillance communication be planned as an integral part of routine EPI and NIDs communication. This should ensure programme integration and harmony. However, many programmes have not commenced surveillance communication and may want to develop this component separately and integrate it with other communication components at a later date. This section is planned to assist programmes that wish to take the latter option.

6.2 Need for a multidisciplinary approach

Surveillance is a crosscutting service that concerns all EPI departments and is best approached as such. Many EPI programmes have surveillance subcommittees. However, many of these committees are comprised only of medical people who are primarily concerned with the clinical and epidemiological aspects of surveillance. There is clearly a need to include professionals in other specializations in these committees, especially communication professionals. Including other professionals should facilitate discussion and promotion of other important

aspects of surveillance that are currently de-emphasized. Options for effecting the needed change include inviting other non-medical professionals to join existing committees straight away or arranging a multidisciplinary discussion to generate ideas on how to proceed.

6.3 Need for greater community participation

The WHO guidelines on developing AFP surveillance in the box on the next page are based largely on a facility-based surveillance system. But such a system has many limitations. In many countries, health workers may not be able to make the recommended visits in the community to identify AFP cases due to transport and budget limitations. Besides, many countries have not conducted adequate research to determine the proportion of caretakers able to identify children with symptoms of AFP and willing to take them to health facilities. In Bangladesh, for example, research found that a whole 75 per cent of caretakers having children with AFP sought help outside health facilities! This is a humbling finding. It emphasizes not only the need to strengthen community participation in AFP surveillance, but also underlines the role of research in establishing AFP reporting systems.

6.4 Communication for community-based surveillance

EPI and NIDs communication have been in place in most countries for some time. Still, few countries have commenced communication in support of surveillance. The suggestions below aim to help countries initiate and maintain surveillance communication.

6.4.1 Preparing the ground for surveillance communication

The clinical arm of EPI is expected to take the lead in establishing the surveillance system. This includes taking decisions on: diseases to be reported, reporting procedures, reporting sites, reporting processes and formats, specimen analysis and procedures, reporting of analysis results, dissemination and sharing of technical information, etc.

Some of the above decisions are of interest to the whole EPI team, including communication personnel. The first step in initiating surveillance communication, therefore, is to broaden existing surveillance committees to also include people responsible for managing communication activities. This and other steps that need to be taken are discussed below.

Broaden surveillance committees to include communication managers

Including communication managers in surveillance committees should:

- Help communication personnel gain a better understanding and appreciation of surveillance.
- Ensure that decisions taken by the committees consider all aspects of surveillance, including issues relating to communication and community participation.
- Provide the needed link between surveillance and communication.
- Strengthen integration and teamwork between the various departments of EPI.

Steps to develop AFP surveillance (WHO, 1996)

1. Define information needs and determine what will be reported.
2. Develop a case definition for suspected polio.
3. Identify key reporting sites (major hospitals, pediatric wards, rehabilitation homes, etc.).
4. Establish a network of collaborators (virologists, epidemiologists, clinicians and EPI staff).
5. Develop the needed reporting forms to be used for various purposes (eight different formats are recommended).
6. Assign a number to each specimen received.
7. Train a team of investigators (medical) at the various levels (national, provincial, district, etc.).
8. Develop the reverse cold chain in which specimens will be transported to the laboratory at the right temperature.
9. Hold a clinicians' advocacy meeting.
10. Establish an expert committee comprising the EPI manager, an epidemiologist, a pediatrician, a senior professor from a medical school and a virologist.
11. Begin routine AFP surveillance at major reporting sites (major hospitals, pediatric wards, rehabilitation homes, etc.).
12. Conduct weekly or biweekly active surveillance. By this process, a designated official of the ministry of health visits reporting sites to look for AFP cases. He/she reviews the records and consults the key people in those facilities.
13. Expand surveillance to institutions of lesser importance (such as provincial, district and lower-level health facilities).
14. Follow up late or incomplete reports by visits, telephone calls, faxes and other available means.
15. Begin active case finding. This strategy involves health workers going into the community to seek information about recent cases of AFP. They do so by asking community leaders, teachers, mothers, traditional healers and other individuals likely to have the information sought.
16. Monitor and evaluate progress in reporting (analyse the kinds of cases being reported, distribution by year, age, immunization history and locality).
17. Provide feedback to reporting sites.
18. Raise awareness about the polio eradication initiative and the need to report AFP cases.

- Promote a holistic approach to programme planning and implementation.
- Promote teamwork.

Review reports and literature on surveillance

It is beneficial to address problems starting from what is known. Review records, reports and other literature to find out what is known about surveillance. Identify initiatives that have

worked well elsewhere, including positive factors, issues and problems. (Examples of surveillance experiences from Africa and elsewhere are in Annex Five.)

Strengthen communication committees to include surveillance

Encourage communication committees at all levels to include communication in support of surveillance in their activities. The committees should develop surveillance communication plans, including plans to involve communities in reporting cases of AFP.

Carry out research

Carry out formative research to collect information that can guide development of focused surveillance strategies, activities and messages. The needed information will include what people know and believe about polio, what they consider to be AFP, how they describe AFP in their own words, whether they are willing to notify health workers about children with signs of AFP, preferred reporting procedures, what can be done to promote reporting, administrative arrangements that are needed to facilitate reporting and structures that need to be developed in the community to promote reporting. The needed research may be carried out alongside formative research for other aspects of the EPI programme.

Research of this kind is best done in a participatory manner (see Chapter Nine), with the full involvement of the community. As much as possible, members of the community should be involved in collection and analysis, as well as programme planning and implementation.

6.4.2 Planning communication for surveillance

Communication for surveillance should be based on research findings. This is particularly important since surveillance is an aspect of EPI in which programmes have little experience at the moment. The following steps should guide planning of communication for surveillance:

Identify key problems to address

On the basis of research findings, identify key problems to focus on. These may include problems such as the following:

- Members of the community are not involved in reporting AFP cases.
- Members of the community do not support the EPI programme as much as they should.

Identify problem behaviours

Section 3.6 should help planners carry out a detailed problem analysis. Out of the analysis, problem behaviours are identified. These may include the following:

- Caretakers do not take children with AFP to health facilities; they take them to traditional healers instead.
- People talk about AFP cases in hushed tones and only to close family members.

Problem behaviours should be stated clearly to facilitate accurate analysis.

Analyse problem behaviours

Section 3.8 should help planners analyse problem behaviours and identify behaviours to promote.

Develop a lay case definition of AFP

Community surveillance relies on the ability of ordinary lay people to recognize a disease condition and report it. Members of the community need information that will help them recognize AFP. A lay case definition should be derived from research findings. Once formulated, the definition should be pretested to ensure that it is understood by the majority of the people.

Determine target audiences for surveillance messages

Determine target audiences by asking the following questions:

- Who is engaged in the problem behaviours? (Primary audiences.)
- Who is in a position to influence and provide support to the categories that are engaged in the problem behaviours? (Secondary audiences.)
- Who will inform the primary audiences about the correct behaviour/action? (Secondary audiences, motivators.)

Identify messages

Identify messages on the basis of target audiences and behaviours that the programme wishes to promote. Sections 3.14 and 3.15 and Chapter Four provide guidance on messages and materials to develop.

Determine channels to use

Determine communication channels on the basis of research findings and target audiences. The format given in 3.10 should facilitate channel identification. Those identified should include mass, group and interpersonal channels.

Develop surveillance objectives

Develop surveillance objectives on the basis of target audiences and behaviours to promote. Take for example the problem behaviour: *Caretakers do not take children with AFP to health facilities; they take them to traditional healers instead.* The behaviour to promote may be getting caretakers to take children with AFP to the health facility. The objective might be: *By December 2000, all caretakers (mothers and fathers) in Gari and Loko Districts of Country X whose children get AFP will take such children to the health facility within 24 hours of the onset of sudden weakness in the limbs.*

Develop strategies and activities

Develop communication strategies and activities to help achieve surveillance objectives. Surveillance strategies that have been used elsewhere include the following:

- Routine reporting of AFP cases by health facilities.

- Active weekly visits by a health worker to health facilities to record and report suspected cases of AFP.
- Reporting of AFP cases by caretakers who also motivate neighbours to take their children with AFP to health facilities.
- Reporting through paid and/or volunteer agents. (Agents that have been used in other programmes have included existing volunteer fieldworkers, religious leaders, TBAs, traditional healers, teachers, school children, etc.)
- Village-by-village search using a large number of personnel from various sectors who travel from village to village and door to door over a short period of time to identify, report and channel AFP cases to health services.
- Village-based surveillance (where one individual per village is appointed and supported by a committee to monitor and report AFP cases).
- Surveillance for case containment. This strategy promotes early detection and immediate reporting in order to contain the spread of the disease. Usually a reward is given to anybody who reports a case within the stipulated time (e.g. within 24 hours).

These and other options should be reviewed at a multidisciplinary surveillance committee meeting and suitable strategies selected. The communication committee should then work with the community to develop activities that can operationalize the selected strategies. Activities should be developed in:

- Advocacy—to explain surveillance to leaders at the various levels and seek their support.
- Social mobilization—to identify and work with organizations that can help with the various surveillance activities.
- Programme communication—to promote various mass, group and interpersonal communication activities.
- Training—to provide orientation and skills to managers, motivators and other cadres expected to play a role.
- Monitoring and evaluation.

Other activities may include publicizing surveillance:

- During NIDs.
- By disseminating a government statement.
- Through interviews with the minister of health and other senior government officials.
- Through talk programmes on radio, emphasizing the role of the community.
- By conducting question-answer programmes, etc.

Provide supportive supervision to field and community-level teams (see 5.4.5).

Identify, develop and pretest educational materials to support communication

The grid in 3.15 should help planners identify the educational materials needed to support surveillance communication. Educational materials should be tailored to the needs of specific target audiences. Materials may be needed for:

Immunizers and other health workers: With information about the surveillance system and the role health workers can play to support it.

Community educators: With information about the surveillance system and strategies for providing education and other kinds of support to primary and secondary targets.

Community leaders: To explain the need for surveillance, surveillance processes and what leaders and community members are expected to do to make the system work. The materials should also discuss the purpose and benefits of surveillance.

Primary target audiences: To explain the need for surveillance, surveillance processes and the roles and responsibilities of caretakers and other members of the community. The materials should also give the benefits of surveillance.

The need for a combination of materials from the following categories should be considered: (1) materials that give limited information and call attention to surveillance such as posters, stickers and spot announcements; (2) materials that give more details such as pamphlets, booklets and flyers; and (3) teaching aids such as flip charts or counselling cards.

Develop and pretest educational materials following the process described in Chapter Four.

Develop monitoring and evaluation indicators

Develop monitoring indicators from objectives, strategies and activities. Indicators could include the following:

- Percentage of target audiences who know why AFP cases should be reported.
- Percentage of target audiences who can correctly describe the process of reporting AFP.
- Villages/communities routinely sending in AFP reports.
- Percentage of target audiences who believe that it is their responsibility to report AFP cases.
- Percentage of immunizers routinely telling caretakers to report AFP cases.
- Volume of AFP messages in the media.

Implement planned activities

Communication for surveillance is a new area for many EPI programmes, and so teams in the outlying districts will need much support from the centre to start and maintain surveillance communication. Supportive supervision will, therefore, form an important component of programme implementation. Monitoring and evaluation will also play an important part.

CHAPTER 7

Participation and capacity-building

Polio eradication is currently an emphasis activity in EPI programmes throughout the world. However, the initiative should not be undertaken at the expense of the routine immunization programme. Instead, polio eradication activities should be used to strengthen the EPI infrastructure and increase its capacity to develop and deliver more effective, quality programmes. This chapter discusses the four key areas that need to be addressed to ensure continuous programme improvement:

- Involving leaders
- Mobilizing development partners
- Strengthening community participation
- Building communication capacity

7.1 Involving leaders

The early enthusiasm shown by high-level leaders at the beginning of the polio eradication programme is waning (see top 10 lessons learned in 3.4). This trend is not entirely unexpected, given the number of years the programme has been running. It is, nevertheless, a cause for concern. Research should be conducted among policy makers/decision makers/leadership to find out their attitudes, level of commitment, how they perceive their role, what they are prepared to do for the programme and how they could be encouraged/motivated to take a stronger role in polio eradication/EPI/surveillance activities. Based on the results of the suggested research, a strategy should be developed to help boost leadership interest and participation in EPI programmes. Other strategies that could rejuvenate leadership involvement include the following:

- Request a high-level leader, such as the president, vice president, prime minister or the first lady to become the patron of polio eradication activities. The patron's influence in the political and leadership system should help in mobilizing resources and leadership support. A patron could also be a religious leader, traditional leader, a celebrity or a well-known leader in business or social circles.
- Assign the patron a clear, meaningful role in the programme, such as fund-raising, mobilizing the support of other leaders, speaking for the government when there is need, etc. Support the patron to play his/her role by arranging his/her press appearances, preparing speeches for him/her, etc.
- Maintain frequent telephone and interpersonal contacts with the patron. Brief him/her adequately and continuously on significant programme developments, such as the successes of NIDs, plans for upcoming NIDs/mop-up operations, the role leaders have played, etc. Let him/her announce some of the successes and major events.
- Develop appropriate leaders' brochures/pocket cards featuring the objectives and benefits of polio eradication and EPI initiatives. The materials should include information on why leaders should support the EPI/NIDs programme. The materials should be updated and redistributed regularly.
- Make appointments and call on selected leaders (e.g. leaders of key partner agencies, such as religious organizations, the ministry of information, the ministry of education) with the brochures/pocket cards to explain the objectives of the programme and seek their support or other specific action as necessary. Leave some of the brochures/pocket cards behind for the leader to read and share with other people.
- Organize meetings of high-level leaders as appropriate. Get the patron or other high-level government officials to open the meetings. If well managed, such meetings can provide a good opportunity for leaders to share experiences and reinforce positive attitudes. Distribute brochures/pocket cards to leaders during the meetings. Maintain a list of participants and other key leaders so that you can get in touch with them whenever there is a need to do so.
- Send leaders EPI/NIDs updates from time to time. The updates may contain information on previous and future NIDs and the role leaders at various levels have played and can play in future.
- Ask some of the leaders to perform functions such as opening workshops, making TV appearances and launching NIDs at the various levels.
- Publicize programme successes widely in the media. Like other people, leaders like to be associated with successful programmes.

7.2 Mobilizing development partners

Most EPI programmes seek to involve development partners through participation in inter-agency coordinating committees (ICCs) or communication committees (CCs). However, most of these committees operate only during the NIDs and fall dormant until the next NIDs season. This leaves little partner participation to support the routine immunization

programme. It also gives the impression that supplemental and routine immunization are mutually exclusive, with one needing intersectoral collaboration and not the other.

The gains made in NIDs and related programme activities in recent times have convinced many programme managers about the value of mobilizing partners for development and health activities, and many programmes are now seeking ways of keeping both ICCs and CCs actively in service throughout the year. The integrated EPI/NIDs/surveillance planning process recommended in Chapter Three can be a strong tool in stimulating and maintaining partner participation. (1) It generates enough engaging work to occupy partners throughout the year, and (2) it addresses programme issues in a comprehensive manner likely to interest partners.

Other measures that can stimulate partners' participation include the following:

- Carry out advocacy work with relevant agencies from a wide spectrum to support establishment or revival of the CC.
- Generate the terms of reference of the CC with the full participation of members (see Annex Eight for an example of terms of reference).
- Involve the committee in all stages of planning and implementation of communication for routine EPI, NIDs and surveillance. Use the integrated planning format recommended in Chapter Three.
- Define the roles of the different organizations represented in the committee. Assign responsibilities and require the organizations to prepare and submit regular progress reports to the committee.
- Retain the committee to conduct a review of the routine EPI, NIDs and surveillance activities: identify strengths, weaknesses and areas needing attention (such as rumours). With the committee, develop a programme of activities to respond to identified needs.
- Ensure that the committee meets regularly and frequently to oversee the implementation of the programme of activities. Involve interested committee members in fieldwork as appropriate.
- Use participatory methods to facilitate committee meetings. Participatory methods promote participation and increase commitment. Use teaching aids, such as slides, transparencies and videos, to make presentations. This will make meetings more lively. Promote joint decision-making to increase commitment.
- Use high-quality research, monitoring and evaluation data for decision-making and programme refinement. This should help the committee come up with focused, effective interventions that will keep members interested.
- Build mobilization on mutual benefits and interest in serving and working with the community. Avoid creating expectations for monetary or other rewards.
- Train mobilization and other pertinent cadres in communication methods and processes to improve their performance.
- Provide strong executive guidance to the committee. Provide adequate information to guide informed decision-making.
- Decentralize activities without sacrificing central guidance.
- Organize high-visibility programmes, such as NIDs and media events, from time to time. Such activities motivate partners, capture national interest and create peaks in programme implementation.

- Promote continuous monitoring, programme assessment and analysis to facilitate continuous programme improvement.

7.3 Strengthening community participation

To stimulate and maintain community participation, communication staff members and EPI managers should:

- Conduct research to find out community members' perception of their role in health; what they are prepared to do to promote their own health; barriers to community participation; knowledge, attitudes and practices relating to immunization and the use of immunization services.
- As much as possible, involve the community in research, planning and implementation of communication activities.
- Work with the community to develop strategies for increasing community participation. Define the role the community can and is willing to play in health promotion. Define the role of leaders and other cadres involved in health promotion. Involve the community and/or their leaders in all stages of programme design, implementation, monitoring and evaluation.
- Encourage development and/or strengthening of structures that support communication in the community (such as village health committees, community health workers, traditional birth attendants and other groups).
- Strengthen the link between health facilities and the community through mechanisms such as health facility committees and joint community/health facility planning and implementation of projects. Work with the community/health facility to plan and implement projects. Work with the community to set joint health goals and plans of action.
- Provide orientation training to key leaders and skills training to volunteers to equip them for their roles. During training, use interactive methods, such as group discussion, story telling, role plays, VIPP techniques, etc. (VIPP stands for visualization in participatory programmes and is a facilitation method based on collecting group ideas on cards that are then arranged appropriately.)
- Decentralize programme activities to give communities an opportunity to plan and implement their own programme.
- Encourage communities to invest resources in health programme activities. Their active involvement will strengthen their commitment to the programme.
- Use participatory processes, such as group discussion and participatory rapid appraisal (PRA) techniques (see Chapter Nine for PRA), to empower communities to analyse their own situation and take the needed decisions and action in promoting immunization practices and programmes.
- Avoid paying people for their participation. Instead use tokens, such as certificates, to reward service. Monetary incentives are not sustainable in the long run and often kill commitment and the volunteer spirit.

- Maintain frequent contact with the community. Provide continuous, supportive supervision of activities being implemented. During supervision visits, meet leaders and volunteers to share ideas, provide guidance and offer encouragement.
- Through traditional media, groups, interpersonal and mass media, popularize the role of communities in health, with emphasis on immunization. Stage plays or soap operas on the theme of community participation as necessary.
- Monitor community activities (with the full participation of community members) and give feedback to participating communities. Thank communities for the good work they do through letters, during visits or in the media. Devise tokens (such as certificates) for recognizing achievement.

7.4 Building communication capacity

The aim of EPI/NIDs/surveillance communication is to help caretakers understand the benefits of immunization and disease control well enough to take their children for immunization, not once, but repeatedly, until the children receive all the immunizations they need. This aim can only be achieved if communicators understand their current and potential clients and tailor communication activities to clients' needs. Research helps communicators obtain the data they need to design relevant, focused strategies, messages, activities and teaching aids.

The activities below should help EPI programmes to develop and/or strengthen their capacity for research-driven communication processes.

- Promote these guidelines at an inter-agency planning workshop organized by an ICC. The workshop should be attended by all EPI departments and addressed by key policy makers and managers (who may include the minister/permanent secretary for health, director of medical services, EPI manager, local WHO and UNICEF representatives, and Rotary). During the workshop:
  - Highlight the elements and processes of effective EPI communication.
  - Review EPI communication structures and processes and make recommendations that can facilitate effective, sustainable EPI communication.
  - Develop strategies for strengthening integration and coordination of the activities of the different departments and disciplines involved in EPI in order to improve their synergy and facilitate design of crosscutting communication activities.
  - Develop a national programme of activities for implementing the next cycle of NIDs.
  - Adapt and simplify these guidelines and distribute them widely (in original or adapted version as necessary).
  - Initiate/reinforce utilization of research-based communication processes by implementing the following activities:
    - Identify an effective communication focal person within the EPI programme.
    - Conduct a communication and social mobilization assessment to identify and document in-country resources that can contribute to the development and implementation of communication programmes. Such resources will include individuals and

organizations with relevant expertise, development organizations with networks that can reach key targets, resources in the media, advertising agencies, media production houses, relevant research and training institutions, etc.

- Conduct a quantitative knowledge, attitude, practice and behaviour (KAPB) study to establish a baseline against which to measure future progress (see Chapter Nine).
- Conduct formative research on issues of concern identified in the project.
- Develop focused, integrated EPI communication strategies based on the findings of the studies.
- Design a system of supervision that promotes development of key communication components and use it in the programme. The system should give emphasis to critical areas, such as efficiency in materials distribution and use, development of IPC skills at all levels and dissemination of key messages at points of contact.
- Document communication achievements and share with committees, key policy makers, partners and managers of EPI activities.
- Organize a communication review and forward planning meeting once every year. Invite all EPI departments to attend. This should facilitate coordination between the different departments, make partners feel appreciated, provide good plans that all involved can support and demonstrate the value of using improved communication approaches.
- Use opportunities for carrying out communication research with local institutions and involve EPI staff and volunteers as needed. This will enhance capacity for communication research in local institutions and among individual development workers.
- Identify national collaborators in communication capacity-building and work with them to develop appropriate capacity-building plans.
- Conduct a national communication trainers' course to create a pool of experts the programme can call upon.
- Ask for additional communication expertise from international development partners, such as UNICEF, WHO, USAID, BASICS and others.

CHAPTER 8

Strategies for addressing other priority issues in immunization

The grids in this chapter summarize the strategies and activities that can be implemented to address selected priority issues in EPI/NIDs/surveillance programmes. They also identify partners that programmes can work with on the issues.

8.1 Reaching the hard-to-reach

Issues and Concerns	*Participants/Targets*	*Partners*
Reaching the hard-to-reach These may include: populations with low coverage, living in an area of civil unrest, with a disproportionate share of disease burden, living in densely populated areas, with poor sanitation, with poor access to health care; migrant workers and other transient populations that are internally displaced; refugees; minority groups; people living in the mountains or other areas with poor access; nomads.	Assign good staff members to these groups. Carry out research/investigate why the populations are marginalized or otherwise hard-to-reach. It may be essential to work with NGOs and other non-official partners to reach the populations. Use concepts/ideas already in the culture. Develop special strategies for the groups. Start NIDs communication early and continue a little longer after other areas stop. Extra time and effort may be needed to elicit action. Emphasize interactive methods (group/IPC). Use music, dance and drama or other channels popular with these groups. Monitor closely and carry out spot checks to be sure that the interventions are having the intended effects.	NGOs International agencies Religious and opinion leaders Community leaders District health teams Private sector organization leaders Research institutions Political leaders Parliamentarians Media

(continued on next page)

Issues and Concerns	*Participants/Targets*	*Partners*
Reaching the hard-to-reach *(continued from previous page)*	Transport: Use mobile units, the army, flying doctors, Red Cross, camels, boats, etc. as applicable. Use community health workers, religious organizations, local radio stations to disseminate messages. Use the administration to convene meetings. Make special vaccination trips lasting two to four days. **In areas of conflict:** Improve contact with political leaders on both sides. Inform relief groups about your work and solicit their support. Disseminate key child rights messages (such as the Convention on the Rights of the Child) to political leaders and parliamentarians. Collect data on problems suffered by children and use them as an advocacy tool with government and other leaders who can change the situation. Increase media materials featuring child victims of strife, nationally and internationally. This will raise awareness about the situation and could raise funds to assist affected children. Improve direct participation of children in media programmes and media events. Improve access to children in areas of conflict. Sensitize the government on the need to develop a plan to alleviate children's suffering, improve access to primary health care, including immunization. Implement the Convention on the Rights of the Child. Solicit moral and material support from the private sector.	Donors Children Religious leaders Private sector leaders

Uganda

The Uganda programme identified the following hard-to-reach populations: pygmies, nomads, people living in military barracks, refugees and displaced persons, people living in fishing villages, the urban population, groups resisting immunization on political or ethnic grounds, people travelling during NIDs, people in the high-income bracket and the elite.

Strategies used to reach these groups include the following:

- Involving urban authorities in planning, implementation and monitoring of social mobilization activities.
- Using NGOs and religious organizations already working in areas with these populations.
- Using security personnel to mobilize and provide immunization.
- Holding meetings with leaders of groups resisting NIDs immunization.
- Visiting families known to be resisting NIDs immunization (especially those living in urban areas and market places) and holding discussions with them.
- Using urban leaders.
- Using megaphones and community theater in hard-to-reach areas with low levels of literacy.
- Setting up immunization posts in special places like taxi ranks, bus stations and airports.
- Intensified use of mass media, with emphasis on discussion programmes.

8.2 Reaching the hard-to-convince

Issues and Concerns	*Participants/targets*	*Partners*
Reaching the hard-to-convince/dealing with rumours and misconceptions These may include: religious objectors, intellectuals, doctors, politicians, objectors on grounds of cultural beliefs.	Strategies that can be used to reach the hard-to-convince include the following: Identify the groups that are involved. Conduct research to find out the nature and reasons for rumours/resistance. Develop strategies to address the issues. The Uganda programme has used interactive radio programmes, national debates, panel discussions and phone-in programmes to defuse opposition to NIDs by intellectuals and politicians. In Zimbabwe, EPI staff held discussions with leaders of resisting groups. In the end, the groups resolved they would get their children to be immunized "if the government asks us to do so." Use people who were previously opposing EPI and are now convinced of its benefits. Seek endorsement statements from credible authorities (government, church leaders, medical professionals, etc.). Hold seminars/symposia with opposing intellectual groups. Invite respected/trusted authorities to participate and discuss the issues. Visit influential people/leaders (such as opposing doctors) for one-on-one discussions. Explain the programme and solicit their support. Invite influential people to play a role/advocate for the programme. Ask opposing individuals to play a role in EPI/NIDs, if appropriate (e.g. opening a NIDs seminar). They may be convinced of the value of immunization in the process. In the future, explain the programme and seek endorsement of important sectors, such as the medical profession, the church, the political establishment, etc. Engage leaders of resistance groups in dialogue and identify and train their own people to work with them. Support those leaders, intellectuals and organizations to develop programmes and materials for the people.	Government High-level political and religious leaders Medical, nursing and other health professionals Intellectual community Research institutions International agencies

8.3 Dealing with outbreaks

Issues and Concerns	*Participants/Targets*	*Partners*
Dealing with outbreaks and other disease emergencies	Investigate the outbreak to establish severity and cause. Establish the structure for dealing with the emergency (e.g. setting up key committees, including the CC, which develops immediate plans for education). Mobilize the leadership in the area (administration, traditional leaders, politicians, prominent business persons, etc.) and brief them on the outbreak. Discuss with them strategies that leaders and other members of the community can play in controlling the outbreak. Ask leaders to facilitate dissemination of messages in the community. Organize special seminars for categories such as health workers, teachers, leaders of women's groups, and youth groups, etc. to give information to be passed to others (their members, peers, students and families). Provide educational materials for use. Mobilize extension workers and the administration to intensify education at public meetings, in market places, house-to-house, etc. Use megaphones as necessary. Use the radio and newspapers to announce the outbreak and control measures that people should take. If control measures include immunization, give information about the immunization site location/times, eligible age, reason for supplemental immunization, etc. During immunization, give mothers and other caretakers information on other precautions to take to prevent/treat the disease. Issue regular press statements to allay fears and encourage continuation of control measures.	Local administration Leaders Teachers Students/youth Extension workers Churches, mosques, etc. NGOs The public as a whole

8.4 Documenting and utilizing experiences

Issues and Concerns	*Participants/Targets*	*Partners*
Documenting and utilizing experiences and lessons learned	Identify a documentation focal person at the national level. Identify documentation focal persons in regional offices. Develop guidelines for focal persons. Monitor the press, make cuttings of interest and maintain a file. Collect and maintain a library of sample educational materials. Use WHO and Polio Partners web services to create an electronic database of sample materials. Establish a materials library at WHO/AFRO and UNICEF country/regional offices—these should also include country EPI/NIDs reports. • Ask EPI programmes to send four copies of the materials and documentation they generate to the nearest WHO country office. • Ask country offices to forward copies to the WHO regional office. • WHO/AFRO prepares an annotated list of materials. • WHO/AFRO photocopies the list and sends copies to people and agencies that request it. • Annotated lists are updated annually. Establish web systems at WHO country offices.	Ministry of health WHO/AFRO communication unit WHO documentation officer Community level coordinator

8.5 Advocating for adequate budget allocation

Issues and Concerns	*Participants/Targets*	*Partners*
Advocating for adequate budget allocation for communication and social mobilization work	Launch these guidelines at an appropriate seminar. During the seminar, explain the value of communication to the overall programme. During the seminar, develop proposals for operationalizing the Handbook. From the recommendations of the seminar, develop a communication plan of action providing for the initiation of research-based processes, capacity-building, etc. Develop a budget for the plan. Have the plans discussed and approved through the normal programme process and presented for funding. Give research, monitoring and evaluation a strong role in the programme: • Conduct formative and operations research to assess programme performance and collect information in problematic and less-understood areas. • Monitor the programme closely and use data to make the necessary adjustments. Share monitoring data within your organization, with partners and with development agencies. • Make monitoring data the basis for developing well-reasoned annual programme proposals. • Carry out periodic programme review and planning meetings. Invite partners to attend. Present detailed, well-argued programme proposals and budgets. Preset the budget in good time. Lobby with key people as necessary. Make sure that the EPI manager, your chief executive and key managers, and programme officers in development agencies understand and support your proposals. Through appropriate reports and meetings, brief office colleagues, management, ICC, communication and international development agencies on progress. Involve key people in different departments of your organization in communication planning so that they can appreciate the value of the communication budget. (Currently, communication activities are not understood in many organizations, and if there are budget cuts, it is the communication budget that is cut first.)	Ministry of health, ministry of local government National, regional, district, subdistrict and lower-level tiers of government Local authorities NGOs International development agencies Private companies

8.6 Mobilizing additional resources for communication

Issues and Concerns	*Participants/Targets*	*Partners*
Mobilizing additional resources for EPI/NIDs/surveillance communication activities from outside the main source of funding	Almost any big company with good financial standing and sensitive about its public image can sponsor development activities. Companies in the following sectors have shown greater willingness to be involved: food and beverage companies, airlines, banks, insurance companies, postal companies, drug companies and media companies (mainly donating media space and air time). Organizations that have supported EPI activities in the past include Rotary (international and local Rotary clubs), WHO, UNICEF, USAID, BASICS, British DFID, ROYAL Netherlands, Canadian High Commission, Irish Development, Danish Association for International Cooperation and the Red Cross. **Other sources** Resources can also be raised directly from the public, small-scale business communities, farmers, professional associations, trade unions, etc. through: • Direct fund appeals. • Organizing fund-raising meetings (public meetings, dinner dances, etc.). • Special fund-raising events (such as concerts, fashion shows, etc.). • In-kind donations of foodstuffs, vehicles (from individuals, other government departments and private companies) during functions and special events. Development agencies are more likely to fund projects that respond to issues that further improve quality of life; benefit women and children; are innovative, timely and in line with the mandate of the agency; and have an evaluation component. Also, they like putting money into successful projects that respond to important needs. Development agencies often support projects in the form of supplies, commodities, equipment and technical expertise. They may also provide cash for project work. Companies are more likely to fund projects that will give them a good image and provide an opportunity to be associated with a good cause. An opportunity to carry company advertisements alongside health messages may be an added bait. But in this case, make sure companies selected are "respectful" and	International development agencies NGOs Government departments The business community and the private sector Individuals Donors

(continued on next page)

Issues and Concerns	*Participants/Targets*	*Partners*
Mobilizing additional resources for EPI/NIDs/surveillance communication activities from outside the main source of funding *(continued from previous page)*	do not deal in products that are unacceptable from the point of view of developmental ethics (such as breastmilk substitutes). Companies prefer to sponsor public events, media, materials, procurement of materials, such as T-shirts, food and drinks, some of which development agencies will find difficult to fund. Review programme files, reports and research materials. Generate programme ideas. Develop a one-page outline of the key features of the project for which you want to seek funds. List the organizations likely to be interested in your idea. Think of local NGOs, private sector organizations, religious and cultural institutions. Visit and discuss your ideas with officials of the different agencies/companies. Explain your project convincingly, giving its benefits to the public and to the agency. For development agencies, show that the project is innovative/relevant/timely and in line with the mandate of the agency from which you are seeking funds. When an agency/company shows interest, discuss the ideas the agency would like included in the proposal. Ask for a proposal format, if the agency has one. Revise the proposal in consultation with officials of the agency/company as necessary. When the money is allocated, make sure that you **show good results** and **account for all the money** to the satisfaction of the funding agency/company. (Low-achieving, non-accounting recipients are unpopular with organizations and unlikely to receive further support.) Write a thank you letter. Prepare progress reports, including expense reports, to the agency/company as appropriate. These will help you negotiate further funding with the same agency/company and demonstrate your accountability. Acknowledge the contribution for the agency at every opportunity—in public speeches, publications, etc. At the end of the funding period, prepare appropriate programme and financial reports and submit to the agency with a thank you letter.	

8.7 Influencing health sector reform to strengthen communication

Issues and Concerns	*Participants/Targets*	*Partners*
Influencing health sector reforms to strengthen communication and social mobilization activities	Lobby for strong communication representation on health sector reform committees. Attend meetings regularly and contribute to discussions. Advocate for participatory methods and processes in reform activities. Explain that reform involves changing people's behavior and strong communication activities are needed to achieve these. Prepare briefing papers for relevant reform committees. Explain the role and the appropriate structure for communication and advocate for the use of research-based communication processes.	Reform committee members Minister of health Permanent secretary of ministry of health Officials of the reform secretariat Staff of the health education unit

CHAPTER 9

Research, monitoring and evaluation

In spite of the wide recognition of communication as an important component of development programmes, this programme area tends to be relegated to lower levels of respect, priority and funding. Reasons include:

- The tendency to implement communication activities in a haphazard, unfocused way.
- The failure to quantify, document and disseminate the contribution made by communication.

Many EPI communication activities are not systematically monitored and are rarely evaluated. EPI communication programmes need to strengthen their research, monitoring and evaluation components in order to establish this programme component as a respectable professional area with a significant, quantifiable contribution to make. Strengthened research, monitoring and evaluation components should lead to improved communication programmes with built-in mechanisms for detecting and correcting programme flaws.

9.1 Research

9.1.1 Critical points of research in a communication programme

Communication can benefit from research during all stages, from planning to evaluation, but it is more critical in the following areas:

- Before commencement of the planning process (formative research).
- In pretesting of educational materials.
- In monitoring programme performance.
- During evaluation.

The use of research in these areas is discussed in this chapter.

9.1.2 Classification of research methods

Communication uses the same research methods as those used in other areas of social development. The methods may be divided into two broad categories, *quantitative* and *qualitative*. Both categories of research are needed in communication. Quantitative research is descriptive and statistical and is concerned with numbers, measurements and percentages. Qualitative research is interpretive and probes motives, attitudes and feelings. The grid below gives additional differences between quantitative and qualitative research.

Qualitative research	*Quantitative research*
• Provides depth of understanding	• Measures level of occurrence
• Asks "Why?"	• Asks "How many?" and "How often?"
• Studies motivation	• Studies action
• Is subjective	• Is objective
• Enables discovery	• Provides proof
• Is explanatory	• Is definitive
• Allows insights into behaviours, trends, etc.	• Measures level of actions, trends, etc.
• Interprets	• Describes
• Relies on small, purposeful sampling	• Relies on statistical, large random sampling
• Does not allow generalizations	• Allows for broad generalizations of findings to larger populations
• Focuses on processes	• Focuses on outcomes
• Allows for interaction between facilitator and participants	• Facilitates the use of statistics for aggregating, summarizing, describing and comparing data

9.1.3 Social research methods

Within the two broad classifications of qualitative and quantitative research are many research methods available to social researchers. The grid below summarizes some of these methods.

Qualitative research	*Quantitative research*
Focus group discussions	Knowledge, attitude, practice and behaviour (KAPB) survey
Observation	Other kinds of sample surveys (random sampling surveys—person, mail and telephone)
In-depth interviews	Records review
Intercept interviews	Demographic and health surveys
Exit interviews	Intercept interviews
Participatory rapid appraisal (PRA)	Censuses
Ethnographic research	

Sample surveys

Sample survey research methods are useful in validating a hypothesis (e.g. mothers with secondary school education are more likely to take their children for immunization than illiterate mothers) and in determining relative prevalence of knowledge, beliefs or practices. The sample survey uses statistical methods and works with large, statistically significant sample populations representing the study population. The method is strong in examining relationships (e.g. between a belief, practice or knowledge level) with background characteristics, such as age, level of education, socio-economic status, locality or exposure to communication messages. Sample surveys use questionnaires with close-ended questions that can be coded for computer-based analysis. This research technique is most valuable when programme planners have a specific notion of what they need to know and have generated good research questions.

Knowledge, attitude, practice and behaviour (KAPB) surveys

KAPB surveys are a commonly used type of sample survey. It is a research technique used to obtain information when that information needs to be used to describe a large population group. The technique uses quantitative methods and a relatively large, statistically significant sample. The main data collection instrument is a questionnaire with close-ended questions. The instrument permits the researcher to interview many people in a relatively short time. But like other survey designs, it is limited in its ability to probe into the knowledge, attitudes, practices and behaviour it seeks to examine. While KAPB surveys can describe the prevalence of knowledge, attitudes, practices and behaviour, they often need to be used in combination with study techniques, such as focus group discussions (FGDs) and in-depth interviews, which probe opinions, motives and feelings to provide data needed to develop programmes designed to bring about behaviour change.

Demographic health surveys (DHS)

DHS surveys are among the forms of research most commonly conducted by ministries of health. They are conducted in cooperation with Macro International and are usually based on large national samples to measure health practices and changes in health status. DHS surveys provide rich epidemiological data on a wide range of health items to show patterns in health practices over time. In many countries, the studies are usually carried out nationally every 10 years. DHS studies form an important source of comparative baseline data on a wide range of health interventions.

Census

Census is a research design that attempts to count the number of people, animals or other subjects (such as cars, etc.) in a given area. Data collected during census research may stratify the population according to the needed categories and carry out cross tabulations to establish relationships between the different factors. Census methods usually attempt to reach and count each individual subject in the population and use complex statistical formulas to account for the proportion of the population they may have missed. The best example of census research is the national census exercise that takes place in many countries every 10 years. Census research is highly statistical, labor intensive and expensive.

Ethnographic research

Ethnographic research is in-depth studies of the culture in which a practice is taking place. They are useful in determining how aspects within the culture can be used to support new behaviours and in identifying taboos and other factors that development workers need to be aware of to work successfully in that culture. Ethnographic studies can be carried out using many different methods. The most commonly used methods include participatory rapid appraisal (see next page) and rapid assessment procedures (which use FGDs, mapping and observation techniques). FGDs and observation techniques are discussed below.

Focus group discussions (FGDs)

A focus group is a group of 6 to 12 individuals, representative of the target group under study, who do not know each other, but come together to participate in a discussion. FGD members not only have similar characteristics with the study population, but they have similar characteristics among themselves in regard to age, education, socio-economic status, etc. Because they are a homogeneous group, FGD members can engage in discussion more freely.

FGDs are qualitative study methods that use a discussion guide rather than a questionnaire. The guide is flexible, and the discussion moderator is free to depart from it to follow emerging themes and thought lines. This flexibility allows deeper probing of opinions, motives, attitudes and feelings.

In-depth interviews

In-depth interviews are similar to FGDs, with the difference being that only one interviewee is interviewed at a time. In-depth interview respondents are normally the key informants (KIs), and because they are interviewed individually, they can give more information on sensitive issues than if they were in a FGD. Like FGDs, an in-depth interview is conducted using a question guide.

Intercept interviews

An intercept interview is an interview carried out with a member of the target group to gain immediate insight into the interviewee's decision about or feelings towards a particular service, product, programme or event. To carry out the interviews, the interviewer positions him/herself in a location frequented by members of the target group and "intercepts" subjects to interview them. Only a few focused, close-ended questions are asked. This method often combines the interview with observation. As the questions are being asked, certain aspects related to the subject of the interview are observed.

Exit interview

Exit interviews are a form of intercept interviews and use the same methods as the latter. The main difference is that the interview is carried out at the point of exit (such as the clinic gate) to interview respondents soon after the respondent has received a service or been involved in an activity. Exit interviews may be conducted at a clinic gate with a mother who has taken her child for immunization. As he/she interviews, the interviewer may look at the child's clinic card to see the immunization a child has received. He/she may ask the mother what immunization the child has received, when the child is due to return for the next immunization and what the health worker told the mother. The questions and observations

may help to study the quality of interaction that takes place between the immunizers and caretakers.

Observation

Observation techniques are commonly used study techniques. They normally use a checklist of the items to be observed. An observer may be a participant observer (participating in the situation he/she is observing) or a hidden observer (concealed where the people being observed are unaware of his/her presence). Some activities (such as toilet habits of adults) may not be easy to observe. In other instances, observation alone may not be able to explain some occurrences. Observation is, therefore, commonly used in combination with other research methods.

Documents and records review

Review analysis and decision-taking on the basis of project documents are a form of research that takes place on projects all the time. The documents reviewed may include communication plans, memoranda, minutes of meetings, monitoring reports, supervision reports, letters, epidemiological data, etc. Documents and records research is particularly useful when developing new project activities.

Participatory rapid appraisal (PRA)

PRA is also referred to as participatory learning method (PLM) or rapid rural appraisal (RRA). It is an intensive, systematic, semi-structured research design carried out in a community by a multidisciplinary team that includes community members. The other members of the team may be health workers and researchers. The rationale for the composition of the team is that the different categories of stakeholders tend to see issues differently and should, therefore, come together to debate the issues and appreciate the complexities involved. The study method has a strong emphasis on community participation: the different categories of participants learn from one another; the method facilitates data collection, analysis and decision-taking at the same time; it is flexible; it takes a short time to come up with results; it is a low- to medium-cost method and often uses visuals such as diagrams, ranking, mapping, direct observation and time trends, thereby allowing even illiterate subjects to participate.

The current trend is to integrate "beneficiaries" as part of the research process. In this environment, the health worker, the researcher and the "beneficiaries" learn from one another and the decisions they arrive at are more relevant. In the process, the "beneficiary" gains a better understanding of his/her situation and claims increasing ownership of the intervention. PRA research methods are becoming increasingly favoured over other kinds of methods.

Case studies

Preparation of case studies is a form of research that draws information from a variety of sources. During preparation of case studies, the factors that have contributed to the situation are closely analysed and "best practices" identified as a guide to similar activities in the future.

Triangulation

Triangulation is the name given to using different research methods to countercheck findings. Use of three different study methods is advised when qualitative study methods are used, hence the use of the word *triangulation,* in reference to three.

9.1.4 Choosing a research method

A research method to use is determined mainly on the basis of the information required and the kind of questions that need to be asked. Research questions may include: What is happening? Who is doing it? Why? How? How many? How much? What are people's perceptions about a given practice? The following grid will help researchers and programme managers discuss and reach consensus on the research method (or a combination of methods) to use.

Research methods for different questions

Information needed	*Specific research method*
Questions about **why**	FGDs In-depth interviews Rapid ethnographic techniques
Questions about **what is happening**	Epidemiology or other survey KAPB survey Observation study
Questions about **who**	Literature/records review Observation study Demographic health survey KAPB survey Rapid ethnographic techniques
Questions about **how**	Observation study KAPB survey In-depth interview PRA FGDs
Questions about **how many** or **how much**	Sample survey KAPB survey
Questions about **perceived needs** and **problems**	Observation KAPB survey PRA FGDs

9.1.5 Minimum research package

What minimum package of research is needed in a communication programme?
A programme implementing research-driven communication needs to carry out the following minimum package of research activities:

- A quantitative KAPB survey to establish a baseline in areas of interest against which to measure future programme achievements.
- Formative qualitative research carried out before or early in the planning process to probe knowledge levels, attitudes, practices, motives and other relevant areas. The data should help in strategy and message design.

- Pretesting of educational materials with target audience to ensure that the materials are understood, relevant and can communicate intended messages effectively.
- Small-scale qualitative studies (such as limited FGDs and intercept or exit interviews) to monitor aspects of an ongoing communication programme.
- Constant monitoring to establish how planned activities are being implemented and to identify issues and problems that may need to be addressed and corrected.
- Periodic process evaluation studies (see 9.4) to determine whether the changes in knowledge, attitudes, practices and behaviour have occurred. Evaluation should also look at the performance of strategies and processes used.
- A post-test impact and/or outcome evaluation to compare results of the intervention with the baseline and determine if program goals and objectives have been met.

Who should be the study subjects?
Study subjects should be mainly identified primary and secondary target audiences (see 3.9).

9.1.6 Who should conduct research?

It is not necessary for EPI departments to have in-house capacity to carry out all the needed research. This would be too costly and even counterproductive. Even EPI programmes with research departments of their own are sometimes forced to contract out research work because the research needed may be too big, the department may lack in-house skills or facilities to carry out the particular type of research or the study may need an external perspective.

It is cost-effective to conduct research through collaborative research institutions. But note that some of the institutions may not be accustomed to developmental research and may need orientation to produce focused, relevant research data that programme officers can use with ease.

Involve district teams and community members in the research process. This should help build research capacity and increase appreciation of the role of research. It may also help give health workers, volunteers and members of the community an opportunity to interact firsthand with pertinent issues on the ground, increase understanding of the issues and claim ownership of both research findings and the programme as a whole.

9.1.7 Disseminating research findings

Summarize research findings and their implications for EPI planning and share results with the community and partners nationally and at lower levels. A half-day research dissemination meeting with national partners would be ideal. During the meeting, distribute a summary of the findings and discuss the relevance of the findings to programme development.

9.2 Review and pretesting of educational materials

Materials should be developed on the basis of formative research results. The materials should be reviewed by experts and pretested to ensure that they are technically correct, understood and acceptable to key target audiences and the agents expected to use them to educate others.

What process is used in pretesting?
The grid below shows aspects of educational materials that should be pretested.

Print	*Audio*	*Video*
Concepts	Key concepts, phrases	Script
Raw text	Imagery and story line	Story board
Revised text	Script	First run of video
Illustrations	Sound	
Text and illustrations		

- It is advisable to develop educational materials with the help of a committee or reference group comprising communication professionals, technical experts and other stakeholders. This may be the CC (or its subcommittee). The committee playing this role should review and provide continuing guidance throughout the material development process.
- The raw draft of material (text or script) should be thoroughly reviewed by the reference group (and content experts) to ensure that the content is technically correct. Several reviews and revisions may be necessary.
- When written scripts have been reviewed and finalized, material developers work on concepts, imagery, illustrations (print materials), story line (audio) and story board (video). Print material concepts may be in the form of several alternative illustrations (e.g. a series of images summarizing the concept that immunization provides protection against diseases). A radio producer may develop examples and a story line, while the video producer works on a story board (a series of illustrations that give some idea of the shots to be taken).

These products should be reviewed by the reference group. They should also be pretested first on a limited number of people representing a cross section of the target audience or during FGDs to establish whether they can be understood and are culturally appropriate. As a result of pretesting, the products are revised and the concepts/ideas refined further.

Revised text, illustrations and audio and video tapes are then pretested with more representatives of the target audience using appropriate methods. They are then revised again before the next round of pretesting and revision.

What methods are used to pretest?
One or a combination of the qualitative research methods listed above may be used to pretest educational materials. FGDs and one-on-one in-depth interviews are the methods most commonly used in pretesting.

How many times should educational materials be pretested?
Educational materials should be pretested and revised as many times as will make them understood and accepted by most members of the key target audience. Where time and funding are limited, each piece of educational material should still be pretested and revised at least two times.

What questions are asked during pretesting?
Text, illustrations and a combination of text and illustrations each have a special role to play in educational materials. The different components should be pretested as (1) text only, (2) illustrations only and (3) text and illustrations combined. During each round, different key questions will need to be asked. Extensive notes should be taken during pretesting to ensure that materials are appropriately revised.

Some questions to ask when pretesting text only
Have respondents read the text aloud and note any word they may find difficult to read. Ask respondents:

- Can you state in your own words what you have just read?
- What is the text telling you?
- Is there any word that you do not understand?
- If yes, please explain. What substitute word(s) do you recommend?

Illustrations only
Ask respondents:

- What do you see here?
- What message is the illustration trying to give?
- What do you think about the message?
- Do you think this message is appropriate?
- Do you think this message can be implemented/adopted?
- Is there anything you like or dislike about the message?
- What do you think about the illustration(s)?
- The illustration is trying to… (tell the client the intended message). What improvement can be made to make the illustration communicate that message better?

Illustrations and text or captions
Some of the questions above are repeated. In addition, ask respondents:

- Do the text and illustration complement each other well?
- What changes can be made to improve the message?

9.3 Monitoring

Communication activities should be monitored continuously throughout the life of a programme to track implementation of planned activities and assess how messages, educational materials and other inputs are being received.

Methods that may be used to monitor programme implementation include the following:

- Periodic review of programme documents (such as work plans, monthly/quarterly reports, etc.).
- Regular audits of materials at representative distribution points to find out quantities of materials issued, who gets the materials, the purpose to which the materials are put and the comments users make on the materials, if any.

- Spot checks at public places and places where members of the target audiences are found to see if audiences remember hearing or seeing messages in the media, on notice boards, etc.
- Central location intercept interviews to ask about target audiences' perceptions of campaign slogans or tag lines.
- Regular field trips to demonstration sites to check on availability of products or supplies.
- Observations at service points, points of sale and in counselling or training sessions. Key areas and activities to monitor in communication include the following:

9.3.1 Monitoring implementation schedules

This activity is undertaken to answer the following questions:

- Are planned programme activities being implemented according to set schedules?
- If no, why not?
- Are materials distributed and used as planned?

Methods that can be used to monitor this programme area include:

- Regular progress reports from the field.
- Regular audits of materials at representative points.
- Observation (especially supervision visits) to find out how materials are used.

9.3.2 Monitoring electronic media broadcasts and materials in print media

This answers the following questions:

- Are planned media broadcasts and print material schedules being met?
- What other related materials have been broadcast or published as a result of the EPI/NIDs publicity?

Monitoring mass media broadcasts and print material schedules is a challenging activity. Staff working on EPI/NIDs are not always at home to listen to radio and TV, nor do they always buy all the many newspapers and magazines in which EPI/NIDs materials could appear.

Options for collecting the necessary information include the following:

- Relying on the joint effort of EPI staff who may hear the materials (this is unscientific and unreliable, but a commonly used method in many programmes).
- Assigning a person (or persons) to listen to all important radio/TV stations and make press cuttings (a little more reliable, but unlikely to catch all materials).
- Recruiting volunteers to monitor key media channels.
- Hiring a media monitoring company to monitor, collect and analyse materials. Such companies exist in some countries. Steadman and Associates in Kenya is an example of one such company.

Using the services of a media monitoring company is by far the most reliable monitoring method. In addition, subscribing to a media monitoring service has other advantages. Steadman and Associates, for example, provides regular information on audience stratification and characteristics. Subscribing to the services of a media monitoring company may be expensive, but it is nevertheless worthwhile.

9.3.3 Monitoring the quality of interpersonal communication

Monitoring interpersonal communication activities seeks to answer the following questions:

- Are interpersonal communication activities being carried out at the different points (such as service delivery points) as planned?
- How is the quality of interpersonal communication between clients and workers (such as information disseminators, immunizers)? Are clients satisfied and interacting well?
- Are clients receiving the key information that they should receive during interpersonal interactions?
- How is the quality of interpersonal communication between communication trainers and trainees?

Methods that can be used to obtain the needed information include:

- Observation at points of interpersonal interaction (immunization points, during home visits, etc.).
- Exit interviews at immunization centers.
- Group discussion with appropriate audience categories.

9.3.4 Monitoring indigenous/traditional media

It is important to find out the following about indigenous or local media:

- How many local groups are involved in disseminating EPI/NIDs information?
- Are there other groups that could be involved in disseminating information?
- What types of groups are they?
- What areas do they serve?
- How are they managed?
- How are they viewed and received in the community?
- What is the interim impact of the messages they disseminate?

Methods to obtain the needed information include:

- Discussion with other EPI/NIDs programme facilitators at the national level and in the regions.
- Visits to observe performances.
- Small group discussions with sections of the audience after performances.
- Intercept interviews with the people leaving performances.

9.3.5 Monitoring interim effects of programme interventions

As communication activities continue, programme managers will be anxious to have answers to questions such as following:

- What do people think about the messages they are getting from the programme?
  - Do they understand the messages?
  - Do they accept or reject the messages?
  - Do they find it possible or impossible to implement the action being proposed in the messages?
  - Do they find it easy or difficult to implement the messages? If difficult, what help/support can help them to act positively on the messages?
- Are any changes taking place in knowledge, attitudes or behaviour among the target audiences?
- If yes, what kind of changes are taking place? Are they negative or positive?
- Are our interventions making any gains?

Methods that may be used to elicit the needed information include:

- Central location intercept interviews seeking people's perception of programme slogans.
- FGDs to investigate the impact of messages and detect possible confusion or negative reactions.
- Observation at service delivery points and other suitable points.

9.4 Evaluation

Evaluation helps communication managers to account for the investment made, refine strategies and identify and correct flaws in programme implementation. This section discusses three commonly used types of **evaluation**: process, impact and outcome.

Process evaluation focuses on short-term achievements of a programme, programme activities and the performance of programme processes and administrative and logistical arrangements. These indicators deal with the following questions: Were activities implemented as planned? How efficiently? How well did administrative and logistical arrangements work? Process evaluation usually uses qualitative research methods.

Impact evaluation assesses medium-term effects of the programme. Impact evaluation usually uses quantitative research methods and provides information on the extent to which programme objectives have been achieved. The evaluation answers questions such as: Did any change take place? Was the change brought about by the intervention or by other causes?

Outcome evaluation provides information on the long-term effects of programme interventions. In health programmes, outcome indicators are concerned with change in morbidity, mortality, health status and quality of life. Outcome evaluation uses quantitative research methods.

The grid below summarizes the key features that distinguish the different types of evaluation.

9.4.1 Types of evaluation

Process evaluation	*Impact evaluation*	*Outcome evaluation*
Provides feedback on the activities and processes used in the activities. This includes: • Extent and quality of programme activities. • Efficiency of administrative arrangements and work process. • Reactions to programme activities. • Staff performance and competence. • Programme procedures and processes. • Consequences of programme activities. • Why and how programme changes were achieved. • Interaction between programme interventions and other factors in the environment. • Interaction between the various players on the programme and how the interaction affects programme achievements. Mainly uses qualitative study methods, such as document/record review, FGDs, observation, etc.	Studies short- or medium-term achievements and effects of a programme. It answers questions such as: • Is there change (e.g. in KAPB)? • Was change caused by the intervention? Impact evaluation focuses on the immediate effects of a programme and the environmental factors that affect programme achievements, such as resources, social support, policy, availability of skills, etc. Impact evaluation is usually statistical and usually uses time series research design (which compares the situation before and after the intervention or compares behaviour/results at a given clinic during the same time period before, during and after the intervention).	In many ways, outcome evaluation is similar to impact evaluation and uses similar statistical research methods. Major differences are that outcome evaluation: • Studies long-term effects of a programme, such as change in mortality and morbidity, change in health status, change in quality of life, change in hunger and unemployment, etc. • Uses comparative designs (which compare the situation before and use controls as well).

9.4.2 Steps in carrying out an evaluation

(i) Establish evaluation indicators

Evaluation indicators are derived from communication objectives. Ideally, evaluation indicators should be established during initial programme planning (see 3.13). The following could form evaluation indicators on an EPI/NIDs programme:

Knowledge

- Percentage of target audiences reached by messages.
- Proportion of target audiences who know the national immunization schedule.
- Percentage of target audiences who can give two correct reasons why NIDs are conducted.
- Percentage of target audiences who know the linkage between routine immunization and NIDs.
- Percentage of target audiences who can correctly define AFP.

- Percentage of target audiences who can correctly state why community members should report cases of AFP.
- Percentage of target audiences who can correctly describe the process of reporting AFP.

Attitude

- Percentage of target audiences who believe that children should be immunized.
- Percentage of target audiences who believe that the immunization given during routine immunization and that given during NIDs is:
  - The same
  - Both safe
  - Both necessary

Behaviour

- Percentage of children under five receiving OPV3 and NIDs immunizations.
- Percentage of immunizers giving caretakers key immunization messages at immunization points.
- Partners and organizations participating actively in NID activities, e.g. by attending at least 80 per cent of committee meetings in between NIDs or volunteering time to carry out EPI duties.
- Percentage of people reporting AFP cases.
- Number of AFP cases reported.

Sustainability

- Level of political and leadership support.
- Level of funding by government and other sources.
- Structures established to support communication at the different levels: national, district and community.
- Level of institutionalization of research-based communication processes.
- Quality of long-range communication programmes developed.
- Level of community involvement in planning, funding, implementation, monitoring and evaluation of communication activities.
- Level of decentralization of resource allocation and programme management.

(ii) Establish evaluation objectives

Based on evaluation indicators, and other concerns for the project, develop evaluation objectives. The following questions should help in the development of evaluation objectives:

- How do we want to use the findings of the evaluation?
- What decisions do we want the information from the evaluation to help us make?
- What must we measure to get the information we need?
- How much funding do we have for the evaluation? (Tailor your evaluation size and complexity to the funding available.)

(iii) Determine design and methods

Choose a combination of research methods and sample size in line with the information sought in the objectives.

(iv) Collect data

The data collection format used will depend on the research design (see 9.1.4).

(v) Analyse data

Analyse data to indicate changes in knowledge, attitude and practices.

(vi) Utilize research data

Generally, research and evaluation data to guide focused planning is lacking in EPI programmes. It is also true that sometimes research materials are available, but they are not used. A common reason for this failure is that programme planners feel overwhelmed and would rather wait for another day "when there is time to read and systemize research data."

To facilitate use of data collected during research and evaluation:

- Develop a summarized version of key findings and their implications for planning.
- Disseminate the findings to EPI team members and collaborating agencies. A good forum for dissemination may be the ICC meeting or a special dissemination meeting.
- Use the findings to develop improved strategies.
- Guided by research, monitoring and evaluation findings, move on to the next phase of programme development.

Annexes

ANNEX 1 Follow-up activities

The Harare Consultative Workshop for EPI Communication recommended that the following activities be implemented to operationalize the present guidelines:

WHO Africa Regional Office

WHO Africa Regional Office should:

- Seek a resolution of the Regional Committee promoting the role of communication in the EPI/polio eradication programme in general and these guidelines in particular.
- Send out these guidelines to all African ministers of health, Rotarians, UNICEF, USAID missions, BASICS and other partners over the signature of appropriate agency directors. The directors' letter should recommend the need for research-based communication in EPI programmes and highlight the elements that need to be modified or emphasized in EPI communication.
- Support national programmes to improve integration and harmonize work between the different EPI departments: clinical, supply, surveillance, communication, monitoring and evaluation.
- Collect and distribute available communication manuals for the guidance of communication staff.
- Identify, in collaboration with UNICEF, a pool of communication resource persons in the region that national programmes can call upon, and provide funding to facilitate utilization of these experts.
- Provide additional funding for communication activities.
- Mobilize donors to support integrated surveillance.
- Evaluate implementation of these guidelines within a year of use.

National level:

- Launch these guidelines at appropriate seminars and public events.
- Distribute the guidelines widely.
- Encourage EPI programmes to adapt the guidelines for ease of use at lower levels.
- Initiate and institutionalize research-based communication in national programmes.
- Build capacity for research-driven communication planning and implementation at the national, subnational and lower levels.
- Carry out advocacy for improved integration and harmonization of work relations between the different EPI departments: clinical, supply, surveillance, communication, monitoring and evaluation.
- Hold meetings and special briefings on these guidelines for key individuals.
- Integrate communication in EPI, NIDs and surveillance in order to upgrade communication skills of the various cadres that come in contact with clients.

ANNEX 2 Relative strengths and weaknesses of communication media and channels

Media/channel	*Strengths*	*Weaknesses*
Mass media Such as radio, TV and newspapers	These are strong in: Creating a general awareness Increasing information Giving basic facts Giving information a sense of importance and legitimacy Reaching many people at the same time Popularizing messages and making them less stigmatized Reinforcing messages Creating a bandwagon effect that can encourage and pressure people to join in	Because interaction with the audience is limited, these media are weak in: Providing detailed explanations Responding to questions of a personal nature Personalized persuasion Supporting targets through behaviour change steps Flexibility Responding to audience feedback
Group Such as group discussions, seminars, workshops, etc.	Group media/channels are interactive and bring people together to share ideas. They are strong in: Explaining details and responding to questions and doubts Legitimizing messages Building consensus Providing support for change of attitude and behaviour Providing support for sustenance of new behaviour Addressing rumours and misinformation	Group media/channels are weak in: Ensuring uniformity of message content Responding to questions of a personal nature Reaching large sections of the population at the same time Flexibility (sometimes it is difficult to gather many people together) Some people may not be courageous enough to speak out or ask questions Group settings may lead to bias, unfair pressure Group environment may not favour certain views or categories (such as minority groups)

Media/channel	*Strengths*	*Weaknesses*
One-on-one Such as individual counselling	These channels are strong in: Responding to questions and needs of a personal nature Identifying and filling information gaps Flexibility Persuasion Supporting the behaviour change process Bringing about attitude and behaviour change Legitimizing, reinforcing and sustaining new knowledge, attitudes and behaviour	Interpersonal contacts are weak because they: Require time and staff, so they can be labour intensive Can only reach a few people at a time Can distort messages or omit them as messages are repeated to one person or a couple of people at a time Can introduce the communicator's bias into communication May communicate inaccurate messages if the communicator is not well versed in the content

ANNEX 3 Some communication activities and materials used in EPI programmes

The table below presents a list of activities and educational materials that have been used in EPI programmes throughout Africa. It is recommended that the list be used by communication officers for reference during communication planning. But, of course, the choice of the specific activities and materials has to be based on a country-specific context, research results, priority behaviours identified, messages and target audiences.

Activities	*Educational materials*
Mass media	
Launch of NIDs by celebrities, use of goodwill ambassadors, ceremonial immunization by celebrities, national address by presidents and other high-level officials, press conferences/statements, announcements via megaphones.	Development and use of logos, leaders' statements, posters, newspapers, radio and TV programmes, mass media interviews with: leaders, satisfied caretakers, experts, success stories, spot announcements, footage/interviews from other countries, different radio/TV programme formats (phone-in, talk shows, guest of the week, press conferences, panel discussions), advertisements, public service announcements, newspaper editorials, event promotion by radio/TV continuity announcers, on-location promotion/announcements, drama, news coverage, calendars, banners, billboards.
Large groups	
Announcements in places of worship, rallies and processions, public meetings. Message dissemination at religious events, traditional ceremonies, sports events. Announcements via megaphones at exhibitions, trade fairs, travelling/community theatre, traditional music and dance.	Booklets, newsletters, flyers, drama, printed T-shirts and other textiles, films, videos.

Activities	*Educational materials*
Group media/channels	
Briefing meetings/seminars/group discussion with key partners and line ministries, planning meetings with staff/partners/community/special interest groups.	Cabinet memos, drama/plays, fact books, programme briefs for key allies (such as members of parliament), teaching materials (such as flip charts), demonstrations, case studies, role plays, slides, film strips, flannel graphs.
One-on-one channels	
Visits and discussions with key allies, lobbying individual allies, use of ICC members to lobby for the programme, telephone contact, inviting WHO regional director to confer with national leaders, counselling at health facilities, discussions with family members during home visits or house-to-house visits, child-to-parent educational activities, telephone hotline contact to report AFP.	Pocket fact books, counselling cards, stories and examples, pictorial booklets and pamphlets used for teaching before giving target audiences to take away, photographs used to stimulate discussion.

ANNEX 4 Routine EPI, NIDs and surveillance sample messages

This list presents a sample of messages that have been used in different countries of the Africa region. The listing includes messages for a wide variety of audiences and are not necessarily recommended for use in their present form. The messages may be selected, adapted, refined, pretested and used as appropriate.

Routine immunization

Infants, particularly when they stop breastfeeding, have a weak and vulnerable immune system and are therefore vulnerable to many diseases. Take your child for immunizations. Immunization protects your child from certain diseases like polio and measles. Ensure that your child completes all the immunizations needed by the first birthday.

Your child needs to have the following immunizations... (list antigens on the national immunization calendar).

Make sure your child gets all the immunizations. In addition, take your child for NIDs immunization. Immunizations given during NIDs provide the child with extra protection and will help to eradicate polio from our country.

NIDs

Polio is an infectious disease. It is a dangerous disease that can cripple or kill your child.

Polio vaccine protects your child from polio. It is safe, free and effective.

Bring all children up to five years of age for immunization at the nearest immunization point on... (day and date). The vaccine will protect your child from polio. The vaccine is given free of charge.

The polio vaccine administered during NIDs is the same as that used during routine immunization. It is safe.

Remember NIDs are on… with a repeat dose on…. All children under five years of age should be brought for immunization on both days.

The extra doses given during NIDs will increase the child's resistance to polio and will help to eradicate polio.

Polio can be eradicated. The immunizations the child receives on NIDs are extra to those received during routine immunization and will help eradicate polio from… (country). Help eradicate polio from… (country) by encouraging your relatives, friends and neighbours to take their children for immunization on... (date). All children under five years of age (or 59 months) should come to be immunized, even those who already have been immunized in previous NIDs or during routine immunization services.

NIDs are a strategy to eradicate polio. Many other countries of the world (including all African countries) are implementing NIDs to eradicate polio. Help eradicate polio in our

country. Bring your children for immunization. Encourage neighbours and friends to bring children for immunization. All children under five years should come, even those who have been immunized.

A child immunized during previous NIDs should still receive the polio immunization on… (date). It is very safe. The extra doses will not harm the child. Even children who missed the first round of immunization should still come for immunization on… (date).

OPV doses given during NIDs are extra doses that supplement, not replace, the doses received during the usual schedule.

Play your role in polio eradication:

- Ensure that all children are protected against polio. Take your child to your local health centre for polio drops.
- Ensure that all children below the age of five years receive extra doses of OPV during NIDs and other polio vaccination activities.
- Encourage neighbours and friends to participate in all immunization activities.
- Additional polio vaccination increases the child's protection against polio. Giving polio immunization to all children at the same time will interrupt circulation of the polio virus and eradicate polio.

Programmes combining polio with vitamin A distribution

Children require vitamin A for growth and development.

Vitamin A prevents night blindness and can improve your child's vision.

Vitamin A protects the body from infections, especially measles and diarrhoea.

All children over six months and under five years of age will receive vitamin A during the second round of NIDs on… (date). Bring all children under five years for polio immunization and children between six months and five years for vitamin A capsules.

Disease surveillance

Polio causes weaknesses in the limbs of a child. Inform a health worker of any child under 15 years old who loses strength in the limbs. The child could be suffering from polio. If health workers are informed early, they can help to minimize the harm to the child. Prompt reporting could protect other children from contracting the disease.

A child with a sudden onset of paralysis should immediately be reported and examined by a health worker so that he/she can be given appropriate care to minimize the harm that can be caused by the condition.

Inform the nearest health facility, nurse, teacher, village community worker… (names of others that can be informed) immediately about any child with sudden weakness in the limbs.

A child with sudden weakness in the limbs may have polio. Take the child to the health facility or inform health workers so that they can perform tests.

Actively look for children with weakness in the limbs and refer them to the nearest health facility. Report all cases irrespective of the religion, colour or social status of victims. Advise neighbours and friends in areas where a child with AFP has been reported to bring their children under five years of age to be vaccinated against polio, even if they were vaccinated before.

Avoid delays while consulting traditional healers; it is important to refer the child imme-

diately before others are infected. Give the health worker the full address to help him/her find the child. The address should include... (specify according to country).

Follow up on all children with AFP discharged from the hospital. These children should be examined by a health worker two months after the onset of the paralysis to find out whether or not the child is still paralysed.

WHO has indicated that for… (country) to be certified polio-free, at least… (number) of children with sudden onset of paralysis should be reported every year.

(Country)… will be certified polio-free only if more than… (number) cases of suspected polio are reported over a three-year period, investigated every year and found negative.

ANNEX 5 Disease surveillance experiences from the region and elsewhere

Zimbabwe

Zimbabwe launched its surveillance programme alongside the first NIDs in 1996. To facilitate this programme component, surveillance guidelines for health workers were developed and health workers trained at the national and regional levels. Health workers, in turn, trained traditional healers and community health workers and identified community leaders.

Surveillance messages were also disseminated in the media and from health facilities.

During the development of this Handbook, the country was developing surveillance guidelines for community members.

Reported cases of sudden paralysis eventually reach nurses who inform clinicians. In turn, clinicians investigate the cases and make their reports known higher up the ladder.

The following messages were developed to support surveillance:

- Inform the nearest health centre, nurse, environmental health technician, teacher, counsellor, community health worker, etc. about any child with sudden weakness in the limbs.
- Actively look for other similar children in the same area and refer them to the nearest health centre.
- Report all cases irrespective of the religion, colour or social status of the child.
- Advise neighbours and friends in areas where a child with AFP has been reported to take their children under five years of age to be vaccinated, even if those children have been vaccinated before.
- Avoid delays while consulting traditional healers; refer the child immediately so that other children do not get infected.
- Follow up on all children with AFP discharged from the hospital. These children should be examined by a health worker two months after the paralysis has started to find out whether or not the child is still paralysed.

The bottleneck in the programme at the moment is failure of examining clinicians to make their findings known to the next level.

Uganda

Uganda is preparing to launch a community-based surveillance system and has sensitized the national, district and subcounty NIDs planning teams to the idea. The technical surveillance guidelines were developed some time back, but proved to be too technical for lower-level health staff expected to use them, so they are now under revision.

The communication section is waiting for the revision to be completed so that they can extract messages from the final technical draft.

In the meantime, the government of Uganda has published a two-volume *Community information handbook* (comprised of a community and trainers guide) to sensitize the public on the need to collect data for planning and problem-solving. The booklets (developed through collaborative efforts of a number of government ministries with UNICEF support) teach community data collection skills and can be readily adapted to suit AFP reporting needs.

Zambia

Efforts towards establishing a polio surveillance system in Zambia started with the training of laboratory and medical officers. A subsequent evaluation found that arrangements for delivering specimens from point to point were inadequate and this bogged down the process. As a result of the findings, a national plan to address deficiencies was developed, together with a technical case definition of AFP.

The next step will be orientation training for health facility and community-based health workers and development of a lay case definition of AFP.

South Africa

The vaccinators' manual of the Expanded Programme on Immunization published in South Africa by the EPI programme in 1995 gives a lay case definition of AFP as ***sudden weakness or paralysis in the leg(s) and/or arm(s) not caused by injury***.

South Africa is already implementing an AFP surveillance system. Surveillance guidelines and lay and technical case definitions have been developed, and orientation training for various cadres is under way.

The programme has mounted intensive media publicity for surveillance. Toll-free numbers for reporting AFP cases are publicized in the mass media, on posters and in booklets.

Bangladesh

As elsewhere in the world, Bangladesh has had a disease surveillance system for a long time. But when polio became an emphasized disease, it became clear that the facility-based system the country was implementing was inadequate. The facility-based system:

- Emphasized polio and not AFP reporting.
- Was not timely, in that polio cases were not reported promptly.
- Had low sensitivity to finding and reporting polio cases.
- Did not conduct active polio surveillance.
- 76 per cent of AFP cases in the community sought help outside health facilities.

To fill up these gaps, a community-based surveillance system covering polio, neonatal tetanus (NT) and measles was designed based on the following strategies:

- Active weekly AFP surveillance visits to major hospitals by local surveillance officers.
- Immediate reporting of all cases of suspected AFP seen at health facilities.

- Immediate reporting of AFP cases from the community. To facilitate community reporting:
  - Volunteer key informants (5 per outreach site and 40 per ward) were appointed to report AFP cases to district surveillance officers through local fieldworkers.
  - Primary and secondary school students were trained to report AFP cases to district surveillance officers through their teachers.

Responsibilities of fieldworkers:

The responsibilities of fieldworkers were to:

- Identify and immediately report any child under 15 years who has AFP to the district surveillance officers.
- Identify and immediately report live NT cases to supervisors (including various supervisors of MOH, EPI supervisor, sanitary inspector, NGO supervisor, etc.).
- Report any deaths occurring in babies 3–28 days old to supervisors every week.
- Report measles cases or outbreaks to supervisors.
- Identify potential key informants (KIs) to help in the identification and reporting of suspected cases of AFP, NT and measles outbreaks.
- Maintain regular weekly communication with the KIs and supervisors.
- Educate and motivate the community through meetings (e.g. during Friday prayers) or individual contact on the importance of immediate reporting of suspected cases of AFP or NT to KIs or fieldworkers.
- Assist the medical officer (when needed) to identify the houses of suspected cases when there is need to investigate cases and conduct outbreak response immunization.

Qualifications of key informants (KIs)

- Literate
- Willing to volunteer
- Respected in the community

KIs recruited included local healers, village health workers, NIDs volunteers, outreach site caretakers, oral rehydration solution depot holder, contraceptive depot holders, kabiraj, homeopaths, pharmacists, traditional birth attendants, imams, union council members, ward commissioners, social club of group members, members of income-generating groups, students, teachers, chowkidar, dafadar, ansar, general practitioners.

Responsibilities of KIs

- Understand how to identify AFP, NT and measles.
- Immediately report any case of suspected AFP or NT (including all cases of babies who die when 3–28 days old) or outbreak of measles to the fieldworker. If possible, AFP cases should be reported directly to the district surveillance officers. Data to report on AFP and NT cases should include case name, age, sex, date of symptom onset, if case has died, if case is now in the hospital, father's name and address.

- Tell community members through individual contact or group meetings that to prevent additional cases of polio and NT in the community, any case of suspected AFP or NT (including any baby who dies when 3–28 days old) must be immediately reported to you so that you may inform the appropriate health officials so that action can be taken to protect other children.
- Tell parents that paralysed limbs can regain some (but not full) strength if exercises begin early after the onset of paralysis.
- Tell parents to bring children with AFP or NT to the Thana Health Complex or hospital for proper diagnosis and treatment.
- Identify and train additional KIs.

KIs training strategies

- Two- to three-hour orientation sessions at union level, 40 KIs at a time.
- Orientation sessions conducted by local surveillance officers and the district surveillance officers.
- Instruction of KIs who fail to attend the course by fieldworkers on a later date.

Training content included

- Why reporting of AFP and NT is important.
- Case definitions for AFP and NT.
- Emphasizing immediate reporting.
- Information on whom to report to.
- Data to be reported.
- Need to communicate the importance of reporting AFP and NT cases.
- Need to encourage parents to take children with AFP to health facilities to minimize disability.

Role of teachers in case notification

- Understand how to identify AFP, NT and measles.
- Teach students how to identify AFP and NT (including the death of children 3–28 days old) and immediately report to a fieldworker, the teacher or any other health worker.
- Report cases of suspected AFP to the disease surveillance focal point immediately. Report cases of suspected NT (including deaths in babies 3–28 days old) to the fieldworker (or his/her supervisor) within a week.
- Teach students that children with polio can be helped by proper positioning and moving of the affected limbs if this begins soon after the onset of paralysis.
- Teach students that any child with recent onset of AFP or NT should be brought to the Thana Health Complex or hospital for positive diagnosis and treatment.
- Ask students to share with family and friends what they have learned about AFP and NT at school.

Experience from the Guinea worm disease eradication initiative

In 1990, WHO designated dracunculiasis (Guinea worm disease) as the next disease in line for eradication (by 1995) after smallpox. This set in motion processes and activities similar to the ones now taking place in polio eradication. India, Pakistan and 17 African countries with endemic Guinea worm disease (including Ghana, Nigeria and Cameroon) were involved in the initiative. As in polio, surveillance is key to certifying countries Guinea worm disease-free.

Three kinds of surveillance were used in the Guinea worm disease programme:

- Village-by-village search
- Village-based surveillance
- Surveillance for case containment

Village-by-village search

Health workers, NGO staff, workers of other agencies and volunteers were mobilized to go village by village in search of Guinea worm disease patients. One to four weeks were spent to cover all villages in a given country, as working longer would have made it difficult for agencies to release staff for the work. This approach was used during the latter stages of smallpox eradication and was justified on the grounds that it was necessary to ascertain quickly the full extent of the disease distribution.

Through this operation, villages with endemic Guinea worm disease were identified and watched more closely.

Village-based surveillance

One or more individuals from endemic villages were identified and assigned the responsibility of reporting monthly on cases of Guinea worm disease. The individuals were selected by the villagers or designated by village leader(s). If there was a village health worker in the village, he/she was assigned the responsibility. The individuals either worked voluntarily or for a small fee.

The village reporters were trained on how to conduct household visits monthly, record cases in the village register, report the information to a health outreach team that may visit the village periodically, or report directly to the nearest primary health care outpost.

Cameroon, Ghana, Nigeria and Pakistan pioneered village-based Guinea worm disease reporting.

Surveillance for case containment

This method is considered appropriate when Guinea worm disease cases are few and disease elimination is imminent. It is also considered appropriate where cases have been imported into areas that have not had endemic Guinea worm disease. The method was first used in Pakistan in 1990, but has since been used in Cameroon and India.

The important consideration in this method is to detect cases as soon as possible to prevent any further transmission. Quantifiable time reporting standards are set (e.g. report the case within 24 hours), and anyone who meets the standard gets a reward.

Cash rewards have been used in Pakistan and India. The rewards may be given to a health worker, villager or Guinea worm disease patient who reports within the specified time limits.

ANNEX 6 Interpersonal communication

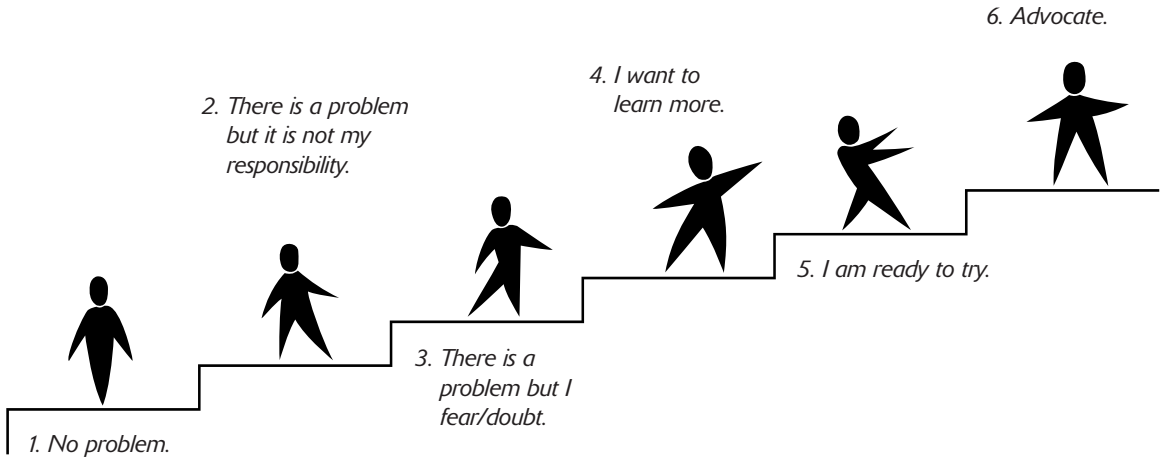
As noted elsewhere, one of the major weaknesses with communication in EPI programmes is the tendency to use mass communication and mass events while underutilizing interpersonal communication. Mass events are seen as attractive because they bring together many people and are instantly judged a success. Dissemination of information through mass media is further favoured because the technologies and materials used (such as radio, television and glossy paper) are sophisticated and give prestige to the programme. Besides, messages disseminated through mass media may reach many people at a time, and this is often equated with being effective in achieving programme goals.

These assumptions are unfortunately not always true.

The goal of communication for development is to bring about behaviour change. In an EPI programme, this involves encouraging caretakers to bring their children for immunization repeatedly, until they get all the immunizations they need. This goal is rarely achieved by merely disseminating messages in the media.

Behaviour change process

A caretaker does not necessarily change his/her behaviour because he/she has heard a message in the media or seen a poster. Often, the caretaker thinks about the message to see how it fits in with his/her other beliefs. He/she may check out the message with other people he/she trusts. If these people approve of the message, he/she may give it more attention; if they do not approve, he/she may disregard the message. The process of thinking about the message and counterchecking it may go on for some time before a final decision to drop or act positively on the message is taken. The steps below summarize the attitudinal changes that the caretaker may undergo before he/she decides to act positively on the message.



Communication for behaviour change involves not only disseminating information, but also supporting target audiences to comprehend messages, develop favourable attitudes towards the messages and undergo attitude changes that will encourage target audiences to adopt the recommended new behaviour. Even after they adopt the new behaviour, target audiences still need support to maintain the new behaviour long enough to reap the full benefits of that behaviour.

Used alone, mass media and mass events are not strong in providing the support needed to help target audiences to adopt and sustain recommended health behaviours. Annex Two discusses the relative strengths and weaknesses of the various communication media.

Interpersonal communication

Interpersonal communication may be described as face-to-face communication. It may occur between two people or in a group in which the people involved have eye-to-eye contact with each other. Interpersonal communication settings involve people relating in close proximity. The people involved maintain eye contact, hear each other, observe and respond to each other's non-verbal reactions and exchange ideas, views and experiences at quite a deep level. The interactive nature of interpersonal communication gives it many advantages.

Strengths of interpersonal communication

Interpersonal communication is strong in supporting the behaviour change process. In particular, it is strong in:

- Explaining in detail, responding to questions and doubts, persuading and convincing target audiences about the value of the proposed behaviour.
- Legitimizing programme ideas.
- Building consensus, bringing about behaviour change and providing support for continuation of the new behaviour.
- Addressing rumours and dealing with counter-rumours campaigns.
- Responding to issues, problems and questions of a personal nature.

Opportunities for interpersonal communication in EPI programmes

Interpersonal communication occurs in almost all areas of the EPI programme, but is particularly important:

- During advocacy efforts (e.g. between EPI managers and senior policy makers).
- Between EPI managers and partners.
- Between health workers providing immunization and caretakers bringing in children for immunization.
- Between motivators and caretakers.

Interpersonal communication is particularly important in the last two situations.

Characteristics of effective interpersonal communication

According to the Quality Assurance Project of USAID, an interpersonal communication encounter is effective when (1) the patient discloses enough information about illness to lead to accurate diagnosis; (2) the provider, in consultation with the client, selects a medically appropriate treatment acceptable to the client; (3) the client understands his or her condition and the prescribed treatment regime; (4) the provider and the client establish a positive rapport; (5) the client and provider are both committed to fulfilling their responsibilities during treatment and follow-up care.

Effective interpersonal communication, therefore, assumes establishment of a good rapport, exchange of pertinent information and mutual commitment to follow-up steps. In EPI, this translates to:

- The caretaker telling the health worker about the immunization status of the child.
- The caretaker allowing the health worker to provide the needed immunization.
- The caretaker getting to know the immunization the child has received and why.
- The health worker telling the caretaker about the next (or future) immunization(s) that the child will need.
- Both the health worker and the caretaker committing themselves to ensuring that the child gets the next (or future) immunizations.

Skills for engaging in effective interpersonal communication

Skills for engaging in effective interpersonal communication may be divided into three categories:

- Skills for caring communication
- Skills for problem-solving
- Skills for counselling

(i) Skills for caring communication

This refers to skills needed to make the client feel welcome and appreciated. They include skills for:

- Welcoming the client
- Empathizing with the client
- Praising and encouraging the client

Welcoming skills include the capacity to greet a client warmly, offer them a seat and carry out other preliminaries as the culture may demand. These preliminaries are important, especially at the health facility, and are helpful in establishing a rapport and making the client feel at home.

Empathizing with the client: Empathy refers to the ability to step into the shoes of the other person in order to see issues from his/her perspective. When you **see** issues from the other person's perspective, you will be able to understand them from the other person's perspective and show more sympathy towards the views of the other person.

Praise and encouragement: Caretakers need to be praised for the little they know and the efforts they make to keep immunization cards and bring in children for immunization. Praise and encouragement increases caretakers' resolve to continue the practice.

(ii) Skills for problem-solving

Apart from making clients feel at home and appreciated, health workers carrying out interpersonal communication need to effectively use the skills of asking and listening.

The two skills will not only lead to understanding clients better, but they will also facilitate identification and solution of issues that may hinder positive response to the recommended health behaviour.

Asking: Asking skills help individuals engaged in a conversation to verify information, observations and impressions. Asking skills also help people to find out how much has been understood and appreciated or rejected during a conversation. By asking, the communicator gets to know the difficulties the target audiences may be having with the messages and the help that may be needed to help target audiences act positively on messages. To promote a smooth conversation, questions are asked in the following order:

- Start with short, general, easy-to-answer questions such as: What is your name? What is the name of your child? What is your husband's name? Where do you live?
- Follow with questions that need some explanations, such as: How is the child feeling today? Does the child eat well? Why have you not brought the child to the health facility for the last six months?
- Then ask probing questions if needed. These include questions such as: Why do you say that sick children cannot be immunized?
- End with checking questions: What do you think about the conversation we have just had? How does immunization help the child? When will your child need to come back for the next immunization?

When asking, encourage the other party to give more information. Avoid interruptions or premature diagnosis.

Listening: Listening is a crucial skill in a conversation. Practice active listening to encourage the person you are communicating with to volunteer more information. In active listening, the people engaged in a conversation give gestures that show that they are listening and are following what is being said. These include hand or head movements and remarks such as "yes," "I am listening" and "good."

(iii) Skills for counselling

Counselling skills include the following:

- Speaking simply and directly
- Explaining logically and systematically
- Exploring clients' beliefs
- Correcting misconceptions
- Using visual aids

- Motivating clients and discussing concrete behaviour change
- Summarizing key information
- Checking for understanding
- Giving clients a chance to ask questions
- Confirming follow-up steps

Speaking simply and directly: People need to explain things in a simple, clear and direct manner. Use familiar words and imagery. Ask checking questions and repeat the explanation if the other person has difficulties understanding.

Explaining logically and systematically: People understand things better when they are explained things in a logical and systematic way. Illogical explanations confuse people and make understanding difficult.

Exploring clients' beliefs: Beliefs stand in the way of acceptance of a message and positive action. It is, therefore, important to understand what the client believes about the message. When his/her beliefs are known, they can then be discussed with a view to leading the client to a decision. The client's beliefs may be known through careful use of the skill of asking.

Correcting misconceptions: A client may refuse to bring his/her child for immunization because he/she believed that vaccines have family planning pills in them. The health worker should establish misconceptions such as these and find a skilful way of correcting them. Good listening and asking skills should help the communicator to become aware of such misconceptions.

Using visual aids: Health workers should learn how to use teaching aids effectively in order to improve communication with clients (see Chapter Four for the benefits of teaching aids).

Motivating clients and discussing concrete behaviour change: The ultimate purpose of communication for development is to bring about behaviour change. A caretaker will (1) need to be convinced that immunization is good for his/her child and (2) take a decision to take his/her child for immunization before taking the step of (3) taking the child for immunization. During conversations, health workers and other motivators should, therefore, motivate caretakers to take a definite decision to act (e.g. take the child for the next immunization).

Summarizing key information: Summarizing skills help a person engaged in a conversation to find out if he/she understood what the other person said. Summarizing also helps people engaged in a conversation to check and confirm areas of agreement and disagreement.

Checking for understanding: It is important to check from time to time to find out if the person you are in a conversation with is understanding you or not. From time to time, ask questions such as: Do you understand what I am saying?

Giving clients a chance to ask questions: At appropriate moments in the conversation, give the client an opportunity to ask any questions he/she may have so that you can respond to them and help the client to understand better.

Confirming follow-up steps: State and explain the next steps; what needs to be done and when. It could be helpful to give the client a memory aid with simple and easy-to-understand instructions. Memory aid with figures and images could be developed for illiterate clients.

ANNEX 7 Sample communication supervision checklist items

Planning and scheduling communication activities

- Cadres involved in communication and their specific roles.
- Do the roles cover all important programme areas (advocacy, social mobilization, programme communication, surveillance)?
- Are the target audiences covered?
- What messages are disseminated?
- How are communication sessions planned (group, interpersonal)?
- Are teaching aids available?

Public meeting activities and skills

- What preparations do motivators make before addressing public meetings?
- How are sessions conducted? How is the audience involved in discussions?
- Use of teaching aids.

Group communication activities and skills

- What preparations do motivators make before addressing public meetings?
- How are sessions conducted? How are participants involved in discussions?
- Use of teaching aids.

IPC activities and skills

How are the following IPC skills used during interactions:

- ***Skills for caring communication:*** Welcoming clients appropriately, appropriate non-verbal signals, soliciting feelings, respect, friendliness, recognizing clients' experience, empathizing with clients, expressing support and partnership, reassuring clients.
- ***Counselling skills:*** Exploring clients' understanding, correcting misunderstandings or misinformation, using appropriate vocabulary, presenting information in a way clients can easily remember, using visual aids well, checking for understanding, summarizing as appropriate, recommending concrete behaviours, motivating clients to continue with routine immunization and NID activities, reminding clients about follow-up action.
- ***Problem-solving skills*:** Listening actively and attentively, encouraging dialogue, asking clients about their opinions, avoiding interruption, avoiding premature diagnosis, probing.

Public reaction and client satisfaction

- Messages disseminated to clients.
- Messages remembered by clients.
- What clients think about messages: Are messages acceptable? Can messages be implemented?
- Client perception of communication and social mobilization (CSM) services.
- Client suggestions for improvement.

Staff deployment and relations

- Qualifications and other training received by staff carrying out CSM activities.
- Staff strengths and weaknesses.
- Teamwork and working relations among staff.

Community reactions and participation

- Role being played by the community in planning and delivery of health/EPI activities.
- Community volunteer/motivator structures and activities.
- How community role can be strengthened.

ANNEX 8A Inter-agency coordinating committee

Terms of reference

1 Background and rationale

The first meeting of the Task Force on Immunization (TFI) in Africa took place 15 and 16 November, 1993, in Lusaka (Zambia), convened by WHO/AFRO. In the early days, the Task Force's mandate included the need to identify resources for countries in AFRO, coordinate their distribution and provide recommendations on next steps. The following year, 1994, in Cape Town, a regional inter-agency coordinating committee (ICC) was formed and began to voice aspirations for a positive movement and progress in Africa for the strengthening and sustainability of EPI. A number of important strategies have been suggested, such as strengthening EPI management at the district level and through decentralization, implementing EPI through an epidemiological approach, etc.

The polio eradication initiative has brought to attention the indispensable role of the ICC.

Of the 36 countries in the Africa region that have conducted NIDs, so far about 90 per cent have used an ICC to varying degrees to support the polio eradication initiative. The ICC offers an invaluable and critical strategy for coordinating resources within the country. This can be extended to strengthen routine EPI and to maximize the benefits of immunization and other health services.

A number of countries in Africa have embarked on health sector reforms in an attempt to improve health systems. The impact of health sector reform on EPI is yet to be determined, although we now know that planning, management and budgeting have improved where radical reform has been in process for some years. The ICC adds to the benefit of health sector reform.

2 Terms of reference for the national ICC

2.1 Conceptual framework

- The ICC has emerged as a strong force in support of polio eradication. It is clear that there is a place for its continued role, to strengthen various aspects of routine immunization services and other child health concerns.
- The ICC is critical in providing support to the national immunization programme and in overseeing commitment and support for immunization services in the country.

- It is important for the national EPI programme to work with an organized committee, but this committee should not be seen as a structure that is an end unto itself, but a **strategy** to strengthen immunization services.
- The structure of the ICC should be complementary to the needs expressed by the EPI team. In this case, the ICC rallies around the EPI team to support and strengthen the priorities that have been identified at the national level.
- Where EPI leadership is new or not assertive enough, the ICC could serve as an advisory board and clearing house for matters related to EPI and other child health issues, in effect supporting the ministry of health with its leadership role. However, it is more desirable for ownership to clearly belong to the national programme.
- Even with experienced EPI managers in place, the ICC has a role to provide moral, technical, political and other support that urges the EPI team to continue producing good results.
- Because of his/her contact with the highest level in the ministry of health during the ICC meetings, the EPI manager's authority is strengthened. Support is more forthcoming when the deputy or minister of health is seen as an integral part of the ICC.
- It is advisable that the chair of the ICC be placed at a higher level than that of the EPI manager, so as to retain the confidence of all interested partners and to free the EPI manager to participate in these meetings objectively.

2.2 Functions of the ICC

It is important for the ICC to remain a single multipurpose body, whose functions vary with the priorities set by the EPI programme to meet the needs of the country. The functions and outputs of the ICC should be far more significant than its organizational structure.

- The main functions of the ICC are to foster solid partnerships by coordinating all inputs and resources available from inside and outside the country in order to maximize resources for the good of the child. The ICC partnership has proved itself a positive force in supporting NIDs and can be extended to routine EPI.
- The ICC should support the national level to review and endorse work plans, such as the NIDs plans of action, EPI annual plans, EPI five-year plans, surveillance plans, etc.
- The ICC should support the EPI programme to mobilize resources, both within the country and externally, for use in the programme.
- While resource mobilization is important, the ICC may assist the EPI programme in enhancing transparency and accountability by reviewing use of funds and other resources, together with the EPI programme, at regular intervals. This should be a process that enhances and motivates both the ICC and the government to continue resource mobilization for EPI.
- The ICC needs to ensure that the programme manager receives both technical and political support that helps to validate his or her authority on issues pertaining to EPI.
- The ICC needs to support and encourage as much information-sharing and feedback as possible, not only at the national level, but also with the implementing levels within the country and interested partners outside the country.

- A number of technical issues will continue to arise. The ICC needs to be geared to address these issues. Current examples include the need to strengthen immunization services, the introduction of new antigens such as hepatitis B, etc.

2.3 Membership of the ICC

2.3.1 Technical subcommittee

The most significant experience with the ICC has been with the polio eradication exercise. For the NIDs, many countries opted for three subcommittees addressing social mobilization, logistics for the operations and implementation of NIDs and surveillance. The subcommittees meet with their own leadership and report back to the main ICC. Prominent and respected technical experts concerned with the welfare of the child offer their expertise on a voluntary basis if incentives are not available. The technical committee could co-opt technical experts from supporting agencies, such as Rotary International, UNICEF, WHO, USAID, DANIDA, etc. Other bodies such as the National Quality Control Authority, experts in cold chain, etc. should be co-opted as required.

2.3.2 High-level support

In order to help operationalize technical concepts, influential persons, such as politicians and representatives of international agencies, need to be co-opted onto the ICC. Given the seniority of the persons who sit on the ICC, it is advisable that the permanent secretary, or his/her designate, provide leadership for the ICC. The minister and/or deputy minister of health may be called upon when very important matters arise, thereby endorsing the importance of EPI as an anchor of child health.

2.4 Frequency of meetings

Meetings should be held a minimum of four times per year. Where the need is greater, they can be held as often as once per week. The agenda needs to be circulated prior to the meetings in order to encourage regular attendance. Minutes of the meeting should be as brief and as action oriented as possible. They should be distributed to all interested partners and stakeholders by all means possible, including email (Ethiopia reaches AFRO/EPI in this manner).

2.5 Issues for discussion in the ICC

The major issue for the ICC is resource mobilization. However, any of the following might be topical during ICC meetings: policy, advocacy, the role of social mobilization, quality of care, population concerns, resource mobilization, accountability, sustainability, planning, health sector reform, logistics, vaccine supply, cold chain, monitoring, surveillance and certification.

2.6 Implementation of the ICC recommendations within the country and mechanisms of feedback

It is important that all partners and implementing levels adhere to the recommendations coming out of the ICC meetings. The province, district and community already have multi-sectoral coordinating mechanisms in use for other activities. These can be exploited to ensure that recommendations of the ICC are being implemented effectively.

A focal person for information sharing and feedback should be identified at each level. This person could be the secretary of each committee and will be responsible for minute-taking and circulation. WHO/AFRO appreciates receiving minutes of the national ICC.

2.7 Monitoring activities of the ICC

In order for EPI programmes to gauge how well they are doing with their ICC, here are some indicators that can be used at the country level:

- Regular attendance of meetings, with active participation by members.
- Regular meetings, with minutes and relevant information circulated.
- Chairmanship of the ICC by higher level than EPI manager.
- Locally sourced funds and other resources available for EPI.
- National plan of action endorsed and supported by the ICC.
- Presence of three or four supporting agencies in the ICC.
- Relevant linkages made and feedback maintained.

Other indicators may, of course, be added to those suggested above.

ANNEX 8B National communication committee

Terms of reference

The role of the national communication committee is to plan, coordinate and ensure successful implementation and management of communication activities for routine EPI, supplemental immunization and disease surveillance. The tasks of the committee are to:

- Develop national communication plans for routine EPI, supplemental immunization and disease surveillance.
- Participate in identifying issues and problems relating to communication action.
- Participate in planning and management of communication research activities in collaboration with EPI staff and other resource persons; use research findings to develop strategies and plans for addressing identified issues in the EPI programme.
- Oversee implementation of communication for routine EPI, supplemental immunization and disease surveillance.
- Plan and supervise supplemental or major communication initiatives, such as NIDs.
- Mobilize resources for EPI/supplemental immunization/disease surveillance communication internationally, nationally and within local communities.
- Facilitate formation of national and lower-level committees and other structures to support EPI communication.
- Develop and implement training and other capacity-building activities that will strengthen EPI communication at all levels.
- Supervise and coordinate EPI communication activities throughout the country.
- Facilitate monitoring, evaluation and utilization of data collected to improve planning of EPI communication activities at all levels.
- Ensure that the EPI/supplemental immunization/disease surveillance communication programme is managed efficiently and effectively.

Membership

The national communication committee should be multidisciplinary in nature, with broad membership, to enable mobilization of community support and resources from a wide base. The committee should include representatives of:

- EPI management
- Ministry of health (EPI unit, health facilities, evaluation unit, etc.)
- Ministry of information
- Ministry of social services

- Ministry of education
- Ministry of local government
- Local and international NGOs working in health
- Provincial administration
- Political leaders
- Religious leaders
- Religious organizations
- UNICEF
- WHO
- BASICS
- Local Rotary Club
- Manufacturers association
- Chamber of commerce and industry

Lower/sub levels

Lower/sub-level communication committees (CCs) should draw members from similar organizations operating at their level. Functions will be similar to those of the national-level committees, with the difference that they are operating and supporting EPI activities at a lower level.

ANNEX 9 Subcontracting and managing communication contracts

Communication is a wide and complex profession that calls for many skills. These include:

- Quantitative and qualitative research skills.
- Planning skills.
- Training skills.
- Skills for developing a wide range of electronic, print and other kinds of educational materials.
- Skills to accomplish a wide range of communication activities, such as writing and performing drama plays, information gathering and packaging, etc.
- Coordination, supervision and management of communication activities.

These are specialized skills, and no EPI programme can be self-sufficient in all of them. To bridge the gap between what can be done in-house and what needs to be done outside, development programmes routinely subcontract work.

What are the benefits of subcontracting?

- Frees paid staff to concentrate on other duties.
- Helps programmes to get more work done.
- Gives a programme access to specialized skills and resources.
- Gives a programme high-quality products that its own staff may not have the expertise, experience or capacity to produce.

What aspects of work should be subcontracted?

Almost any aspect of communication can be subcontracted. It is cost-effective, however, to subcontract specialized, discrete activities such as research, material development, training or evaluation. Subcontracting priority should be given to tasks that the programme has no in-house capacity to carry out.

How does a programme determine what work to subcontract?

A decision on what work to subcontract is best taken during initial planning. It becomes additionally clear what work to subcontract after the plan of action has been developed (see 2.4). From the list of activities on the plan, tasks that cannot be performed in-house are identified. A decision to subcontract can also be taken later, as programme needs emerge during implementation.

How is communication work subcontracted?

To subcontract communication work:

- Determine the work you wish to subcontract.
- Quantify the work and estimate the time needed to do it.
- Research who could carry it out, who has the professional expertise and the experience, possibly nationally and, if needed, regionally and even internationally.
- Develop a written contract to be signed between the programme and the subcontractor. The contract should have the following details:
  - A brief description of the project (not more than a couple of paragraphs), with a reason for the work.
  - A description of the work to be done.
  - The process/procedures for doing the work.
  - The responsibility/contribution of the programme: content, personnel, transport, etc., as applicable.
  - The responsibilities/tasks of the contractor.
  - Time-frame for getting the work done.
  - Stages by which the work will be done and outcomes expected at each stage.
  - The review or pretest process, as applicable.
  - Payment schedule. The schedule is usually linked to stages of performance contingent upon successful completion of work (or stages of work) to the satisfaction of the commissioning agency.

  Most contracts also specify the conditions under which the contract can be terminated.

What else does a communication officer need to know about subcontracting?

Communication officers need to know that there are competent and incompetent contractors, honest and dishonest ones. It is important that communication officers be on guard to safeguard the interests of the programme. The interests are best safeguarded when communication officers understand the work well enough to:

- Write a clear contract.
- Review and discuss the work with the contractor knowledgeably.
- Know when good- or bad-quality work has been done.

Communication officers should, therefore, acquaint themselves with both the needs of the programme and the communication processes in order to work effectively with contractors.

ANNEX 10 Polio eradication in Africa: questions and answers

NIDs are a relatively new activity in Africa, and many people have asked questions about them. Some of the questions are answered below.

1. What is the Polio Eradication Initiative and why is Africa involved in it?

Eradication of polio means that there will be no paralysis from the wild polio virus and that there will be no wild polio virus circulating anywhere in the world. When this is achieved we can stop immunizing against polio, just as we were able to stop immunizing against smallpox when it was eradicated 18 years ago.

In 1988, at the annual World Health Assembly (WHA), ministers of health from all member countries of the World Health Organization (WHO) unanimously endorsed the goal to eradicate polio by the year 2000. In 1995, at the WHO African Regional Committee meeting, African health ministers reaffirmed their commitment to this goal and to the strategies to achieve it. Also, in 1996, the heads of state at the Organization of African Unity (OAU) summit committed themselves to this goal.

In 1988, it was estimated that 350,000 children became permanently paralysed from polio in that year alone. In 1996, the estimate was down to 40,000. This improvement is a result of improving routine immunization programmes and NIDs.

2. What are NIDs?

NIDs are part of supplemental immunization activities, one of the three strategies being used to free the world from polio. The other two strategies are routine immunization and disease surveillance.

Achieving and maintaining high levels of immunization coverage (over 80 per cent of all infants) through **routine immunization** makes the NIDs more effective. This means immunizing as many infants under one year of age as possible, with at least three doses of oral polio vaccine (OPV), preferably starting at birth. High routine coverage reduces the occurrence of polio to low levels and forms the basis for the Polio Eradication Initiative. It also makes any other additional immunization activities more effective and prevents the reintroduction of the wild polio virus into areas that have become polio-free. The proportion of children in Africa immunized each year with at least three doses of OPV is approximately 80 per cent.

Supplementing routine immunization with additional activities, such as **NIDs**, is done to interrupt the transmission of the wild polio virus. Even with high routine coverage, there are still enough unimmunized children to support the continued circulation of the polio virus. NIDs are special days when extra doses of OPV are given to **all** children under five years of age. Two rounds yearly, four to six weeks apart, for three consecutive years are generally needed to interrupt the transmission of the polio virus.

NIDs are for **all** children under five years of age, regardless of their immunization status. Even fully immunized children should receive a supplemental dose of OPV during each round. If a child missed the first round, it is still important for him/her to attend the second round. Even one supplemental dose can still help to eradicate polio.

High-quality **surveillance** to detect and investigate all cases of AFP is essential to identify areas where the wild polio virus is still circulating and ultimately to prove to ourselves and the world that Africa is polio-free. Stool samples must be collected from all suspected AFP cases and shipped to polio laboratories to determine if the cause of the AFP is the wild polio virus.

The fact that new cases of polio are now uncommon in many African countries does not mean it doesn't exist. We must actively look for it in order to prove that it is not there. You can help by ensuring that every child under 15 years of age and with sudden onset of weakness or paralysis of one or more limbs is seen at a health centre or hospital within 14 days of onset, so that two stool specimens can be collected and tested to confirm whether or not the child has polio.

As part of supplemental immunization activities, **mop-up immunization** uses surveillance data to plan and carry out localized immunization campaigns, targeting districts or areas where the last few cases of polio have occurred, in an effort to eliminate the wild polio virus from the last remaining pockets of infection.

These strategies have been successful in making the Americas and large parts of Asia and Europe polio-free. There has been no transmission of the wild polio virus in the Americas since 1991.

3. Why NIDs?

As the level of routine immunization coverage increases, the circulation of the wild polio virus is reduced but does not stop altogether. When the goal is to eradicate rather than control the disease, a more aggressive strategy is needed, as described above. Organizing NIDs to supplement routine immunization is part of this aggressive strategy.

The whole world is involved in the campaign to eradicate polio, and Africa is part of this global campaign. Forty-two countries have conducted NIDs between January 1997 and early March 1998, including many countries in difficult circumstances, such as Angola and the Democratic Republic of the Congo. Blocks of countries, such as Tanzania, Uganda and Kenya, are cooperating to conduct NIDs within one week of each other. This increases the likelihood of eradicating the virus from large contiguous parts of Africa. Immunizing a high percentage of young children over a short period of time has been shown to be the most effective strategy for the purpose of interrupting the circulation of the wild polio virus.

4. Why do fully immunized children need to be vaccinated during NIDs?

This is the most commonly asked question and indeed one which has caused suspicion and resistance from some groups and individuals in many countries. The OPV doses given during NIDs are extra and are given for the following reasons:

(i) To induce immunity in unprotected children. About 58 per cent of all children under one year of age receive all their OPV doses during routine immunization. After four doses of OPV, about 10 per cent of children (about 15 per cent after three doses) still

may not have acquired immunity or protection because of vaccine failure, which is still not fully understood. Therefore, over the years, there is a build-up of susceptible (non-protected) children, comprised of those who either did not receive any or the full routine polio immunization and those who were vaccinated but did not acquire protection. By providing additional OPV doses to all children under five at the same time during NIDs, most of the susceptible in the community become protected.

(ii) To boost intestinal immunity in all children, even those previously vaccinated, so that the transmission of the wild polio virus is interrupted. Polio virus is shed from stools. By using OPV during NIDs, the intestinal immunity blocks entry of the wild polio virus into the intestines of the child and subsequently reduces transmission in the community.

Doses given during NIDs are not only for the protection of the individual child but are intended to get rid of the polio virus in the community and thus lead to the eradication of the disease.

5. Why do we only immunize children under five years?

Children under five are most vulnerable and most likely to catch and spread any diseases, including polio, as they have underdeveloped immune systems and are unable to practise good hygiene.

6. Why so many doses? Will they not be harmful?

The doses of OPV are administered repeatedly because the more doses, the higher the level of immunity conferred on the child. The repeated doses will not harm the child. Booster doses are normal in immunization.

7. Is the NIDs polio vaccine different from the routine vaccine? Is it safe?

The vaccine used for the NIDs is the same as that used for routine polio immunization. The vaccine is safe and it is effective. The vaccine manufacturers are all licensed, approved and monitored by WHO and UNICEF to ensure that the vaccine is both safe and effective.

The vaccine for NIDs is manufactured by three different manufacturers, in France, Belgium and Germany. Each of these countries has a national control authority to ensure that any vaccines produced in their countries are of the highest quality. Any rumours that the NIDs OPV is contaminated with HIV and/or contraceptives are completely untrue.

8. How long will Africa have to implement NIDs?

NIDs are carried out as long as a country has the wild polio virus in circulation or as long as the national surveillance system for polio is not effective enough to prove that the country is either polio-free or has only focal areas of transmission. In the countries where there is an excellent programme for routine immunization, it is expected that only three years of NIDs will be sufficient to make most, if not all, of the countries polio-free. Some countries with low immunization coverage may have to carry on NIDs for a longer period. The disease surveillance systems needed to determine whether or not the wild polio is still in circulation are being put into place now.

After the NIDs, it will be extremely important to achieve and maintain high coverage of

all children with at least three doses of OPV through routine immunization. This will ensure that if polio is imported from outside the country, there will not be enough susceptible to sustain its transmission.

9. Why are so much effort and so many resources being put into fighting polio when other diseases such a malaria and measles kill more children?

Many people have asked: Why polio? What about all the other diseases that claim so many lives? Why all the emphasis on polio—a disease that paralyses but rarely kills and that we rarely see in many countries nowadays?

The reason is that polio is one of the few diseases that cannot only be prevented but can be eradicated, and we have the know-how to do so. We need to ask ourselves whether we can continue to tolerate polio, which causes untold suffering and permanent disability, when we have the technical expertise to get rid of it. Many other diseases can be controlled through immunization or good hygiene, but the germs that cause them are proving too difficult to completely destroy or eradicate. We will continue to control these diseases even as the war for the eradication of polio goes on. The decision to eradicate polio was made when paralytic polio was a big public health problem, and it is only with improved immunization that the cases of polio have been reduced in recent years. However, cases of polio still occur, and unless the virus is eradicated, it could be reintroduced into polio-free areas, re-establishing the disease and putting the world back to where it was before the eradication goal was set in 1988.

In 1979, the world eradicated smallpox, a disease that had plagued humans for centuries. Now we have the same opportunity with polio. We can make the world free of the polio virus so that no one will ever again become paralysed and permanently disabled from polio. Once eradicated, we will also be able to stop immunizing against polio, thus saving millions of dollars each year in vaccine costs alone.

Other benefits of eradicating polio are:

- It boosts the immunization of the other childhood diseases by raising community awareness and reaching children never immunized before.
- The war against polio provides valuable experience and builds infrastructure (such as laboratory networks and logistics) and systems (such as community-based surveillance) for the fight against other infectious diseases.
- The eradication of polio will provide motivation to the medical world and the world at large for the eradication of other diseases.

We are also in a sense "suffering" from the success of immunization programmes. The number of cases of polio in many countries in Africa has dropped dramatically in the last 10 years because of the success of routine immunization, making the disease look insignificant. This is the problem with any successful prevention programme. At some point, the number of new cases of the disease drops so low that it no longer appears to be a problem, making it less visible and therefore less likely than other diseases to be taken seriously. With a few more years of work, however, we will have the opportunity to rid the world completely of polio and to stop immunizing against it altogether. The resources now going into the purchase of polio vaccine can then be redirected to the prevention, control and treatment of other important diseases.

10. Who is involved in the war against polio?

The global war against polio is an international campaign of remarkable public/private partnerships: African governments, led by their ministries of health, have truly created partnerships at all levels. **The war against polio is the responsibility of all.** This has been demonstrated by the support that has been accorded to the initiative at all levels.

International partners: Donor nations, development banks and aid agencies provide funds. WHO provides technical leadership and training. UNICEF assists with vaccines, cold chain, programme development and social mobilization. USAID has provided funding and technical support. Experts from the U.S. Centers for Disease Control and Prevention give laboratory and technical support. Grass-roots support comes from Rotary International: the 1.2 million Rotarians worldwide have committed nearly US$400 million in private funds to purchase polio vaccine and support the operational costs of delivering the vaccine.

National partners include the following and many others: Medical professionals, including health workers in the health system, medical associations and NGOs in health; non-medical professionals, including other ministries and departments; the media; the business community; pharmaceutical companies; and religious institutions. These provide support in transportation and sponsorship of other activities, as well as in the planning and mobilization of the communities. Parents provide valued support in bringing children to the NIDs and mobilizing other parents. Community support is also provided in the form of volunteers for the vaccination posts and in community mobilization.

11. How will we know that polio has been eradicated?

When there are no more cases of polio reported in any country in Africa, concomitant with an adequate AFP surveillance system.

12. After polio, what?

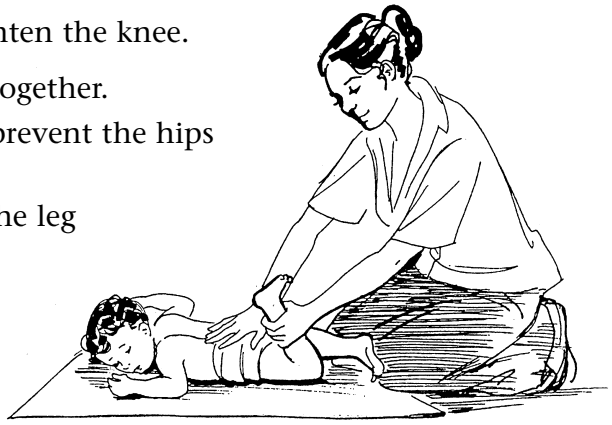
It is now being observed that supplemental immunization is greatly reducing deaths and ill health due to measles, as well as the number of new cases of measles. Even before polio is eradicated, the lessons learned from polio eradication strategies are being applied towards the control and possible elimination of measles, as well as the elimination of NT, two of the deadliest vaccine-immunizable diseases against which a war can be waged.

ANNEX 11 Exercises to improve strength of paralysed limbs[1]

Exercises to do with the child lying on the stomach

Exercise 1. Bend the child's knee.

This exercise stretches the muscles that straighten the knee.

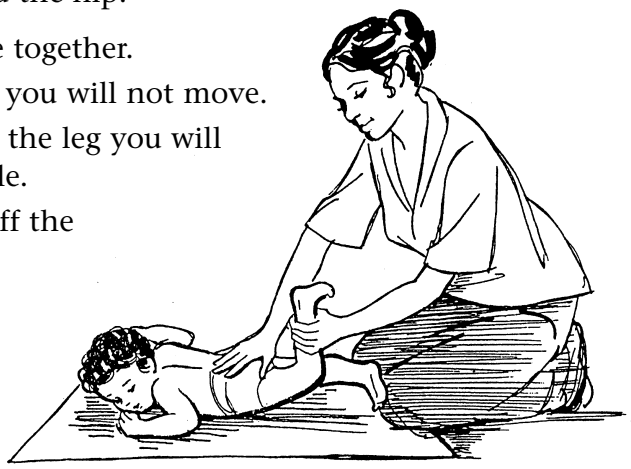


Begin with the child's legs straight and close together.

- Put one hand on the child's buttocks to prevent the hips from moving.
- With the other hand, hold the ankle of the leg you will move.
- Gently bend the knee, then straighten it. If the knee has full movement when it bends, the foot will touch the buttock.
- Repeat the movements of bending and straightening the knee 6 times.
- If the other leg is weak, do this exercise for the other leg.

Exercise 2. Straighten the hip by moving the leg backwards.

This exercise stretches the muscles that bend the hip.



Begin with the child's legs straight and close together.

- Put one hand on the buttock of the leg you will not move.
- With the other hand, hold the ankle of the leg you will move and bend the knee to a right angle.
- Gently lift the leg so that the thigh is off the ground. Then lower the thigh to the ground.
- Repeat the movements of lifting and lowering the thigh 6 times.
- If the other leg is weak, do this exercise for the other leg.

[1] Reproduced from the National Plan for AFP and EPI Disease Surveillance—Field Guide (1997). Ministry of Health and Family Welfare, Directorate General of Health Services (EPI). Government of the People's Republic of Bangladesh.

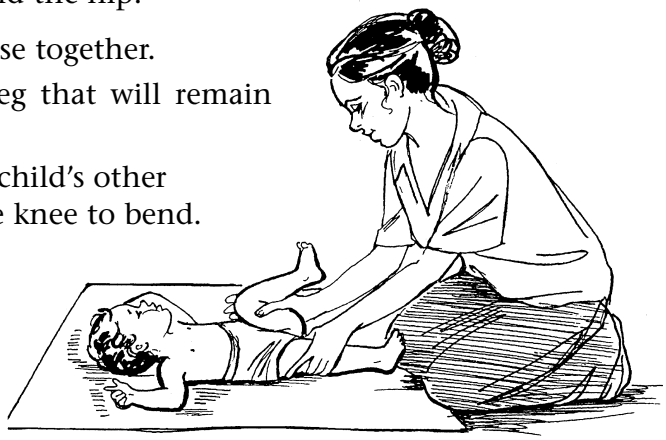
Exercises to do with the child lying on the back

Exercise 3. Bend the child's hip with the knee bent.

This exercise stretches two muscle groups. On the leg that is moved, this exercise stretches the muscles that straighten the hip. On the leg that remains straight down on the ground, this exercise stretches the muscles that bend the hip.

Begin with the child's legs straight and close together.

- Put one hand on the thigh of the leg that will remain straight on the ground.
- With your other hand, gently lift the child's other thigh up towards the trunk. Allow the knee to bend.
- Then lower the thigh and straighten the leg.
- Repeat the movements of lifting and bending, then lowering and straightening, the leg 6 times.
- Repeat the exercise with the other leg, as it helps both legs.



Exercise 4. Bend the child's hip with the knee straight.

This exercise stretches the muscles that bend the knee.

Begin with the child's legs straight and close together.

- Put one hand on the thigh of the leg that will remain straight on the ground.
- With your other hand, hold the child's other knee straight and gently lift the leg up. If the muscles that bend the knee are not shortened, the leg will be able to form a right angle with the trunk.
- Then lower the leg.
- Repeat the movements of lifting and lowering the leg 6 times.
- If the other leg is weak, do this exercise for the other leg.

Exercise 5. Move the child's legs together, away from each other, and together again.

This exercise stretches the muscles that move the child's legs apart and the muscles that move the child's legs together.

Begin with the child's legs straight.

- Put your hands around the child's knees and thighs.
- Gently move the legs together and cross the right thigh under the left one. Keep the knees straight. Do not turn the legs. Keep the legs as close to the ground as possible.
- Then move the child's legs apart.
- Then move the legs together and cross the left thigh under the right one.
- Repeat these movements of the legs coming together and crossing under each other and then moving apart 6 times.

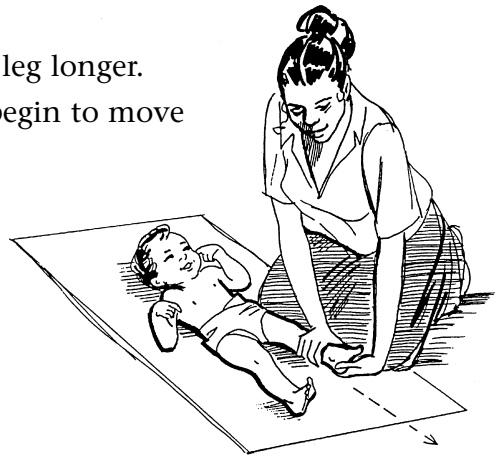
Exercise 6. Move the child's foot upward.

This exercise stretches the muscles that pull the foot down and in.

There are two movements for this exercise. First pull the heel (the back of the foot), then move the front of the foot upward.

Begin with the child's legs straight.

- Put one hand just above the child's ankle to hold the leg straight down on the ground.
- With your other hand, grasp the heel of the child's foot. The heel should rest between your thumb and fingers.
- Gently pull the heel as if you were trying to make the leg longer.
- Keep pulling with your thumb and fingers, and then begin to move the palm of your hand up to the child's foot.
- Hold the foot up while you count from 1 to 5.
- Release the push of your hand and then the pull.
- Repeat the movements of pulling the heel and moving the foot up 6 times.
- If the other leg is weak, do this exercise for the other heel and foot.

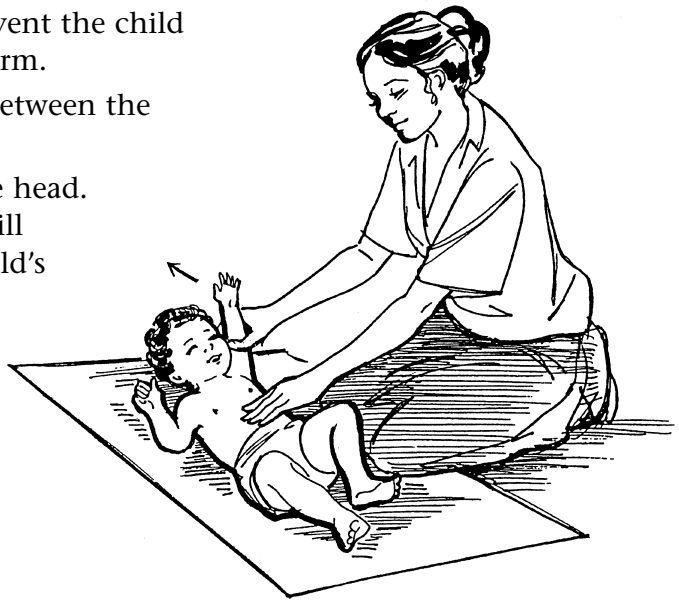


Exercise 7. Lift the child's arm up over the head.

This exercise stretches the muscles that pull the arm down.

Begin with the child's arm straight beside the trunk.

- Put one hand on the child's trunk to prevent the child from turning while you are moving the arm.
- Put your other hand on the child's arm between the shoulder and the elbow.
- Gently lift the child's arm up towards the head. If the arm has full movement, the arm will move up near the ear. Then bring the child's arm down to the side of the trunk.
- Repeat the movement of lifting and lowering the arm 6 times.
- If the other arm is weak, do this exercise for the other arm.

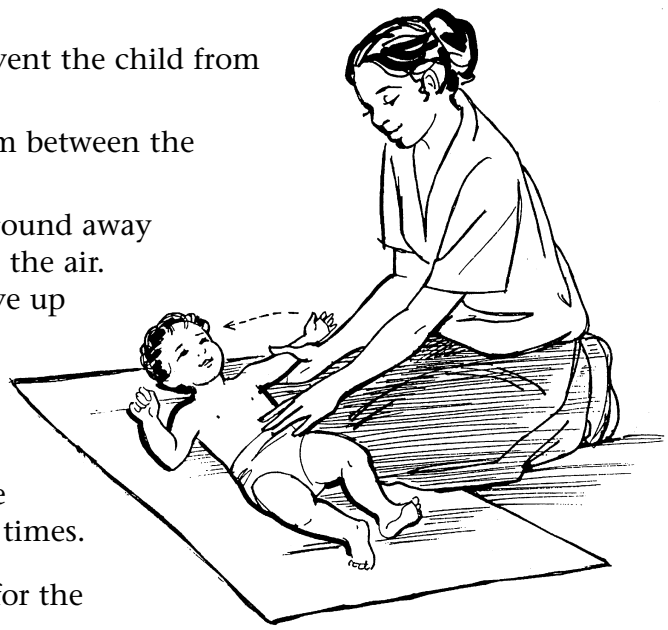


Exercise 8. Move the child's arm away from the body by moving it to the side.

This exercise stretches the muscles that pull the arm down close to the trunk.

Begin with the child's arm straight beside the trunk, palm of the hand turned up.

- Put one hand on the child's trunk to prevent the child from turning while you are moving the arm.
- Put your other hand under the child's arm between the shoulder and the elbow.
- Gently move the child's arm along the ground away from the trunk. Do not lift the arm up in the air. If the arm has full movement, it will move up towards the head near the ear. Then move the arm back down to the trunk by moving it along the ground.
- Repeat the movements of the arm away from the side of the trunk up towards the head and then back down to the trunk 6 times.
- If the other arm is weak, do this exercise for the other arm.



Exercise 9. Straighten the elbow…and bend the elbow.

Straightening the elbow stretches the muscles that bend the elbow. Bending the elbow stretches the muscles that straighten elbow.

Begin with the child's upper arm beside the trunk.

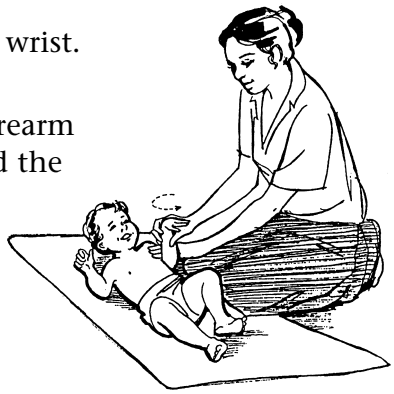
- Put one hand on the child's arm near the shoulder to prevent the upper part of the arm from moving.
- With your other hand, gently straighten and bend the child's elbow.
- When you straighten the elbow, the palm of the child's hand should be turned up so that the back of the child's hand touches the ground when the elbow is straight. Most children who have weakness in the arm have more difficulty straightening the elbow than bending it. Do the movement gently and straighten the elbow as much as possible.
- When you bend the elbow, the child's hand will touch the shoulder.
- Repeat the movements of bending and straightening the elbow 6 times.
- If the other arm is weak, do this exercise for the other arm.

Exercise 10. Turn the child's forearm so that the palm of the hand and the fingers are turned towards the child's face…and then away from the face.

Turning the child's forearm stretches the muscles that allow the forearm and hand to turn.

Begin with the child's upper arm beside the trunk, elbow bent to a right angle.

- Put one hand on the child's upper arm to prevent it from moving.
- With your other hand, hold the child's forearm near the wrist. Do not put your hand on the child's hand.
- Use your fingers and thumb to gently turn the child's forearm so that the palm of the hand and the fingers turn toward the child's face…and then away from the face.
- Repeat the turning movements 6 times in each direction.
- If the other arm is weak, do this exercise for the other arm.



Exercise 11. Move the child's wrist so that the hand bends forward… and then backward.

This exercise stretches the muscles that move the hand forward and backward.

Begin with the child's upper arm near the trunk, elbow bent to a right angle.

- Put one hand on the child's forearm, between the elbow and the wrist, to prevent this part of the arm from moving.
- Use the fingers of your other hand to move the child's hand. Do not move the child's fingers.
- Gently move the child's hand so that the palm of the hand bends forward…and then backward.
- Repeat the movements of the hand 6 times in each direction.
- If the other arm and hand are weak, do this exercise for the other arm and hand.

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