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Communication for Immunization and Polio Eradication in Nigeria: A joint case study by NPI, WHO, USAID/BASICS and USAID/JHU-PCS

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Acronyms

AFP	acute flaccid paralysis
BASICS	Basic Support for Institutionalizing Child Survival
BCC	behaviour, change and communication
CHANGE	The Change Project
CPH	Community Partners for Health
DPT	diphtheria, pertussis and tetanus
EPI	expanded programme on immunization
FMOH	Federal Ministry of Health
HECTIC	Health Education, Communication, Training and Information Committee
ICC	Interagency Coordinating Committee
IEC	information, education and communication
JHU/PCS	Johns Hopkins University/Population Communication Services
KAP	knowledge, attitudes and practices
LGA	local government area
MOU	Memorandum of Understanding
NGO	non-governmental organizations
NIDs	National Immunization Days
NPI	National Programme on Immunization
OPV	oral polio vaccine
SMOH	State Ministry of Health
SNID	Sub-National Immunization Day
SMC	Social Mobilization Committee
UCI	universal childhood immunization
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WHO/AFRO	World Health Organization/Regional Office for Africa

Executive summary

The expanded programme on immunization (EPI) was launched in Nigeria in 1979, and attainment of universal child immunization (UCI) target coverage of 80 per cent was reported by 1990. The years after 1990 witnessed major decline in vaccination coverage in Nigeria, due in part to problems of inadequate service delivery, low political will and social support, inadequate service funding, poor community involvement and participation, and ad hoc approach to national and local mobilization efforts. However, polio eradication campaigns through National Immunization Days (NIDs) have brought about positive changes, including increased oral polio vaccine (OPV) coverage nationwide and improvement to cold chain and immunization systems. One component that has contributed to this achievement is the social mobilization and advocacy aspect of the campaign.

In order to provide information for the improvement of information, education and communication (IEC) activities in the African region, an interagency study team comprising the World Health Organization (WHO), USAID/BASICS and JHU/PCS and National Programme on Immunization (NPI) was constituted to study communication and social mobilization support for polio eradication and routine immunization in Nigeria and lessons learned as part of a five-nation African study. The main purpose of the study was to identify, examine and document major challenges to social mobilization and communication in support of immunization goals. Between 14-28 November 1999, the team visited five states (Lagos, Kano, Niger, Imo and Delta) and the Federal Capital territory, Abuja, conducting in-depth interviews with relevant stakeholders – ministers and commissioners for health, directors of primary health care (PHC), NPI coordinators, Social Mobilization Committee members, traditional leaders, women leaders and groups, local government chairmen, advertising agencies, some members of the Interagency Coordinating Committee (ICC), etc. – and reviewing available documents.

For the NIDs programme, planning for the social mobilization at the national level is handled by the social mobilization subcommittee of the Interagency Coordination Committee, whose membership is intersectoral and includes international funding agencies and non-governmental organizations (NGOs). In order to expand its activities and impact for routine immunization, the committee developed a five-year (1999-2003) Integrated Communication Plan (for NIDs, routine and surveillance) that serves as a comprehensive plan for national, state, local goverment area

(LGA) and district-level social mobilization/IEC activities. At the state and LGA levels, there is a Social Mobilization Committee/task force, which is charged with the responsibility of managing social mobilization/IEC activities at the state and LGA levels but functions primarily for NIDs. The Health Education Officers and the NPI Officers at the state and LGA levels coordinate the social mobilization activities. The mass media (radio, television, newspapers, posters, leaflets, outdoor billboards, stickers, etc.) is being engaged extensively for the campaigns, both at the national and state levels. Some LGAs have also designed and produced their own IEC materials, primarily print and other materials like pens, arm bands, etc. Advocacy meetings and activities have also been conducted at the various levels to build community awareness and support, such as rallies and events like the Challenge Cup (Caring Understanding Partners) competition involving three leading club sides in three states.

The study found that advocacy for NIDs has been done at all levels (e.g. 'flag off' ceremonies by the President at the federal level, Governors at the state levels and Chairmen at LGA levels) and that these efforts have yielded positive results in terms of increasing OPV coverage for NIDs. Advocacy and social mobilization were also found to be successful for the house-to-house Sub-National Immunizations Days (SNIDs) and NIDs held in 1999. The mobilization efforts have reported extensive use of mass media as well as traditional methods and channels of communication. Information on the NIDs was sent out by the ICC and its partners to radio and TV stations, newspapers, religious and traditional heads (Obas, Emirs, Obis and women traditional leaders), who in turn pass this information to their constituents through the appropriate channels. The traditional leaders and members of their councils, for example, use town criers to disseminate information down to the family units and individuals. In addition, through letters and visits by ICC representatives and/or partners, religious and NGO structures are used at the various levels to disseminate information and messages on NIDs and routine immunization.

Major constraints against effective social mobilization and advocacy were determined to be: lack of adequate funding, which does not enable the Social Mobilization Committees to be sustained, especially at lower levels; the need for additional governmental and donor support (resource, human, technical, logistic, etc.) to strengthen and sustain social mobilization and IEC efforts for NIDs, routine immunization and surveillance; and coordination and collaboration between partners and organizations at all levels on integrated social mobilization and communication planning, implementation and evaluation for immunization.

Introduction

Background on the study

From 14-28 November 1999, a five-person team consisting of two representatives from the NPI, one WHO consultant, one JHU-PCS/Lagos staff member and one BASICS/Washington staff member reviewed communication and social mobilization support and activities for polio eradication and routine immunization in Nigeria. This was one of five national studies (including the Democratic Republic of the Congo, Mali, Mozambique and Zambia) jointly planned and carried out by UNICEF, WHO/AFRO and USAID (CHANGE and BASICS). Nigeria was proposed for the study, given its social mobilization for NIDs and house-to-house experiences. The findings and recommendations will be used to improve immunization IEC activities within these countries and throughout the Africa region. Results of these studies will be shared with the WHO-sponsored Africa Regional Task Force for Immunization and the Social Mobilization Advisory Group meetings in Harare in November/December 1999.

The focus of the studies is to document successful and/or innovative IEC and social mobilization ideas and strategies that have been implemented in these countries, particularly in regard to a number of challenges that most African EPI programmes face:

- effectively and efficiently utilizing mass media and person-to-person communication to advocate and provide IEC for immunization activities;
- achieving an appropriate balance in social marketing/communication support for NIDs campaigns and for routine immunization;
- undertaking an inclusive planning process to produce, implement and evaluate a communications plan that integrates support for NIDs, routine immunization and surveillance for acute flaccid paralysis (AFP) and other diseases;
- understanding the reasons why some groups are hard to convince and using that understanding to develop effective strategies and activities to increase their participation in immunization;

- providing strong national immunization communications leadership (strategies, guidelines, training, resources) while encouraging and supporting local activities appropriate to local conditions;
- building dedicated staff and institutional support for NPI social marketing and communications; and
- building capabilities to respond effectively to rumors and urgent service problems.

Objectives and methodology

Objectives

- To identify, examine and document major challenges to social mobilization/communication in support of immunization goals
- To assess the planning processes and methodologies used in social mobilization for immunization
- To identify the key methods used to communicate immunization messages to communities at grass-roots levels
- To identify the human, technical and financial resources needed to improve communication support for EPI and NIDs
- To make appropriate recommendations as relevant to the findings

Approach

A team of five persons was organized to conduct the assessment and report on the findings. Two members were foreign nationals representing external partners (WHO/AFRO and USAID/BASICS headquarters). The other three team members were nationals representing USAID/JHU-PCS/Lagos and the NPI (Surveillance, Monitoring and Evaluation Officer and the Technical Officer for Social Mobilization).

Preparation

The national Social Mobilization Committee (SMC) discussed and agreed to the purpose, objectives and organization of the assessment and presented this to the ICC for approval. Once ICC approval was obtained, the NPI was charged with organizing the itinerary for the team and made the necessary appointments and arrangements for the interviews and travel. WHO provided primary logistical support, with contributions from USAID, JHU/PCS, BASICS and UNICEF.

Sample selection for the study and fieldwork

The selection of states and LGAs to be visited was made on the basis of regional representation and differentiation, availability of transport within the specified time-frame allotted and whether there was high or low immunization coverage. A total of six states were visited over a period of 10 days. Travelling between the states was primarily by air and by road. The states visited included: Lagos State, Kano State, Niger State, Imo State, Delta State and the Federal Territory of Abuja.

Methodology

In-depth interviews (with individuals and/or in group discussions) and documentary reviews were carried out in each state that was visited. The main areas addressed in the collection of information included: immunization coverage and programme status; surveillance; human resources for social mobilization and communication; social mobilization and communication planning and implementation; rapid response capabilities; advocacy activities for immunization; social mobilization and programme communication activities for routine immunization, NIDs and surveillance at all levels; and communication and outreach strategies for house-to-house, hard-to-reach and conflict areas.

Characteristics of persons interviewed

Respondents represented a cross-section of personnel and community members involved in the immunization programme and activities, including the Federal Minister of State for Health, State Health Commissioners, Directors of Primary Health Care, Chairpersons of SMCs, NPI Coordinators, representatives from international agencies and NGOs, Health Education Officers, LGA committee leaders and members, traditional and religious leaders, women's groups and community members. (See annex 1 for a full list of contacts.)

Country profile

Nigeria is the most populous country in Africa, with a projected 1999 population of 112.4 million within a land space of 923,768 square kilometers, based on the 1991 census figure and an intercensal annual growth rate of 2.83 per cent. For 1999, the estimated target populations are:

0-23 months (8%)	8,992,720
0-59 months (20%)	22,481,801
under 15 years (48%)	53,956,324
women of reproductive age (22%)	24,729,980

The Federal Republic of Nigeria is situated along the west coast of Africa between latitude 40°N and 140°N of the equator and longitude 30°E and 140° E of the Greenwich Meridian. The climatic conditions divide the country into mangrove swamps and rain forest in the south to savannah in the middle belt and desert in the far north. Nigeria has many ethnic groups and numerous minority languages. The three major languages are Hausa, Ibo and Yoruba. English is the official language.

Nigeria has a federal system of three tiers of government, consisting of a central administration at Abuja and 36 states with their administrative headquarters and local government administration. Each state is comprised of numerous LGAs (local government areas), with 774 LGAs throughout the country. The LGAs are further divided into districts. The country is divided geopolitically into six zones, namely, north-west, north-east, north-central, south-west, south-south and south-east. Since 29 May 1999, Nigeria has been administered through a democratic form of government.

Crude oil is the main source of revenue in Nigeria. Additional revenue sources include agriculture, coal and other solid minerals. The adult literacy level in 1996 was 51 per cent (males, 62 per cent and females, 39 per cent). Education is now compulsory up to 15 years of age. All the states have radio and television network (public and private), as well as public and private print media. Radio listenership is above 80 per cent nationally, while newspaper readership is 23 per cent nationally (ranging between 19 per cent in the north-east to 28 per cent in the south-east).

In Nigeria, provision of health services is the joint responsibility of the three levels of government (federal, state and LGAs) and the private sector. The Federal Ministry of Health (FMOH) has the statutory responsibility for the formulation of national health policies, implementation of national health programmes, and effective coordination, evaluation and monitoring of these health policies and programmes throughout the country.

EPI in Nigeria

The EPI was launched in Nigeria in 1979 and revised in 1984 due to low national immunization coverage and consequent minimal impact on the target diseases. In 1988, the FMOH, with the support of United Nations, international and national agencies, introduced the concept of mass campaigns as an effort to boost immunization coverage nationwide. Nigeria reported immunization coverage of 60 per cent by 1989, and the attainment of universal child immunization (UCI) target coverage of 80 per cent by 1990. This achievement was credited to government and health personnel commitment, intensive social mobilization, involvement of the private sector, and intersectoral collaboration (with armed forces, police forces, and Ministries of Agriculture, Education and Information).

In the 1990s, however, immunization coverage reports show a decline (see Table 1), which can be attributed to shortages in vaccines, unavailability of syringes and needles, and centralization of vaccine storage leading to poor distribution. Recognizing that sustaining high immunization coverage is an important disease control strategy, the federal government established the National Programme on Immunization (NPI) as a parastatal of the FMOH in August 1997 with the mandate to effectively control, through immunization and the provision of vaccines, the occurrence of the following deadly diseases: tuberculosis, poliomyelitis, diphtheria, pertussis (whooping cough), tetanus and measles. In addition to the standard six antigens, yellow fever vaccination has been added to the routine vaccination schedule. Hepatitis B vaccines have also been distributed to high-risk areas through tertiary hospitals.

Table 1: National summary of routine immunization coverage, Nigeria (1993-1998)

	Immunization coverage by year (per cent)					
Vaccine	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**
BCG	43	46	42	36	29	27
DPT3	25	40	32	20	21	21
OPV3	26	34	29	21	25	22
Measles	29	41	41	32	37	26

Yellow fever	1	0	0	0	0	no data
TT2+	21	38	34	38	23	29

Source: FMOH/NPI, 1998.

Since the establishment of the NPI, numerous steps have been taken to strengthen immunization activities in Nigeria:

1) NPI headquarters were established in Abuja to provide management control for the routine vaccination programme in Nigeria. The current democratic administration has mandated that the supervision of NPI parastatals be entirely under the federal Ministry of Health and is currently implementing this policy. The NPI also interacts with partners and donor agencies through a functional Interagency Coordinating Committee.

2) The central NPI orders and receives vaccines for routine immunization, which are then distributed to six zonal cold stores (see Table 2) to cover the six geographical zones of the country. The states are authorized to collect vaccines from these zonal cold stores. The zonal offices are to ensure that vaccines are available closer to where they are to be used, reduce logistics problems hitherto encountered by the states and afford effective programme monitoring and evaluation.

Table 2: Zonal offices and locations

S/N	ZONES	**LOCATIONS**
1.	North-central	Minna, Niger State
2.	North-west	Kano, Kano State
3.	North-east	Bauchi,* Bauchi State
4.	South-west	Oshodi, Lagos State
5.	South-south	Benin,* Edo State
6.	South-east	Owerri,* Imo State

*Temporary cold stores

3) Planning for routine immunization has been conducted, including production of the following reports: Five-year National Strategic Plan, 1999 Annual Plan of Action and a Biennial Plan of Action. Training of NPI staff is being implemented as a continuous process throughout the

country. In addition, cold chain inventory has been carried out nationwide, in collaboration with WHO. A databank has also been obtained on consultants used by the NPI at federal, state and LGA levels.

4) A system of surveillance for polio is being implemented, involving active case finding and reporting, stool collection and laboratory investigation. The national laboratories are located in Ibadan and Maiduguri. A system of monthly updating of surveillance reports has been devised, including the establishment of a data surveillance forum.

5) The Nigeria Immunization Fund is being put into place, as allowed under Decree no. 12 of 1997, in order to:

a) encourage the citizenry to commit to the concept of immunization;
b) allow the ordinary Nigerian to answer the clarion call of the federal government to provide private sector contribution;
c) institute sustainability into immunization service delivery by providing additional finance.

Polio eradication

In addition to providing routine immunization services, NIDs for polio eradication have been conducted in Nigeria from 1996 to 1999, with coverage improving each year (as noted in Table 3), and a reported national NIDs OPV coverage of over 100 per cent. In 1999, Nigeria was the first country in western Africa to carry out the house-to-house NIDs strategy for polio eradication.

Table 3: National Immunization Days (NIDs), 1996-1998

NIDs rounds	**National OPV vaccination coverage of children aged 0-59 months by year (per cent)**		
	1996	**1997**	**1998**
Round I	47	72	100
Round II	75	95	108

Source: FMOH/NPI, 1998.

Despite these achievements, wild polio virus continues to circulate throughout Nigeria, resulting in the decision by the ICC to conduct house-to-house SNIDs in April and May 1999 to reach an estimated target population of 13 million children aged 0-59 months in 15 selected states considered to be at the greatest risk of harboring wild polio virus. The purpose of the house-to-house strategy is for health workers or volunteers to vaccinate all children aged 0-59 months with OPV at their home, regardless of prior vaccination status. The houses visited, number of children 0-59 months immunized with OPV in each round, number of children who had never before received OPV, number of children vaccinated above five years of age and cases of AFP in children less than 15 years are recorded in the daily vaccination team, district summary, LGA summary and state summary NIDs reporting forms. The coverage results of the April/May 1999 SNIDs are presented by state in Table 4 below.

Table 4: Total number of children aged 0-59 months immunized during SNIDs (April-May 1999)

State	Target population	1st round	2nd round
Abia	511,639	706,796	844,289
Akwa Ibom	745,072	957,875	1,211,635
Anambra	721,403	840,323	1,001,904
Bauchi	700,927	1,082,660	1,267,833
Bayelsa	280,905	365,245	413,816
Cross River	530,911	639,345	736,461
Delta	691,367	849,457	1,136,891
Imo	728,882	1,095,981	1,441,835
Kaduna	1,316,771	1,544,174	1,812,973
Kano	1,418,637	2,947,485	3,185,749
Katsina	976,999	1,428,333	1,754,192
Kebbi	611,256	817,985	827,430
Lagos	2,059,268	2,266,650	2,625,305
Oyo	882,165	1,217,509	1,529,608
Rivers	832,998	943,956	1,096,330
Total	**13,009,200**	**17,703,774**	**20,886,251**

Source: 1999 Nigeria SNIDs report, June 1999, National Programme on Immunization.

Effective and creative strategies and interventions

Integrated planning process (NIDs, routine and surveillance)

Integrated communication plan (for NIDs, routine and surveillance)

Under the leadership of the NPI and the national SMC, a five-year (1999-2003) integrated advocacy and communication plan for polio eradication, routine immunization and surveillance in Nigeria was approved by the ICC in October 1999. Implementation of the plan is now beginning as part of the national SMC's activities for the year 2000, through funding by the ICC members. The integrated plan is comprehensive and a good model on communication for immunization for other countries in Africa and Asia. The objectives are clear, and activities and indicators to implement social mobilization, programme communication and advocacy for immunization at national, state and LGA levels are included. Key behavioural problems, identification of target groups, relevant channels and messages and related communication materials, strategies and activities are identified that combine communication approaches and seek participatory community involvement and action. In addition, time-frames, responsible agencies/contacts and budgets have been developed and included in the plan. The integrated plan was jointly designed by the NPI, FMOH and the ICC partners, involving some state and LGA input, at a national workshop in Ota, Ogun State in August 1999 through technical assistance and resource leadership by UNICEF/Nigeria, USAID/JHU and WHO/Nigeria. This workshop was a follow-up to the regional training workshop conducted by WHO/AFRO, UNICEF and USAID/BASICS in Nairobi, Kenya in October 1998 and attended by five Nigerian representatives.

Social mobilization planning process for NIDs

Social mobilization has been a critical component, along with logistics, service delivery, supervision and evaluation, in ensuring turn-out for NIDs at all levels. Social Mobilization Committees have been formed at the national and state levels and are also active in many LGAs and districts. In the social mobilization planning and implementation process, key collaborating partners with the MOH at the national and state levels are government officials (the President and his wife, Governors, etc.); the Ministries of Education, Information and Culture, and Women Affairs and Social Development; donor partners (WHO, UNICEF, USAID, JHU/PCS, Rotary International, Red Cross, etc.); national and state television, radio and print media; traditional and religious leaders from the various ethnicities and religions; and numerous NGOs and private sector companies and associations. Many of these partners have also collaborated on social mobilization for NIDs at LGA, district and community levels, along with local traditional and religious groups, women's groups, scouts and girl guides, market women and other local NGOs and community groups.

As part of the NIDs planning, particularly for the 1999 house-to-house SNIDs and NIDs, social mobilization steps and activities to be conducted have been outlined for states, LGAs and districts.

Training in social mobilization has also been included with the house-to-house NIDs training curriculum. The *1999 NIDs Field Guide*, further revised from the 1998 *Guide*, is a useful and comprehensive tool for NIDs planning on logistics, house-to-house strategy, supervision, evaluation and social mobilization. Appendix 2 and Section 2 on "Implementation Guidelines – Organizing Social Mobilization Activities" address social mobilization for house to house NIDs through the triple A approach: assessment, analysis and action. (Refer to annex 5 for a copy of this section from the *Field Guide*.) Key messages and the organization of social mobilization activities are outlined in the document. As part of the microplanning, social mobilization training for supervisors and vaccination teams is provided at the central, state and LGA levels. The supervisory checklist in Appendix 8 includes a section on social mobilization to identify whether there is a Social Mobilization Committee at the level being supervised; if advocacy efforts have been conducted; whether radio, TV and/or posters have been utilized; and health worker and general public knowledge of the NIDs and target age group for NIDs.

Advocacy

Political advocacy and high-level commitment for the NIDs and SNIDs has been obtained at federal, state and LGA levels, by the ICCs and SMCs. The President and his wife, as well as the Vice-President and various Ministers, have been involved in national flag-off ceremonies. At state and LGA levels, Governors and other political leaders, as well as traditional chiefs and religious leaders (Christian, Islamic, etc.) have also been engaged. Zonal advocacy meetings were held by the technical and social mobilization subcommittees of the ICC in August 1999 to increase awareness, knowledge and commitment (both political and resources) of politicians and decision makers in the states and LGAs on the global and national polio eradication goal; to sensitize partners on the need for and importance of the house-to-house vaccination as well as the revitalization of sustainable routine immunization services; and to motivate implementers to use the 1999 SNIDs results and experience to increase planning, social mobilization and support for the 1999 NIDs. In hard-to-reach and/or conflict areas, as well as with elite refusers, Rotary has provided social mobilization and advocacy assistance (including meetings with health workers who were on strike, letters to elites, assistance to teams in areas refusing national government programs, etc.) to explain the importance of polio eradication to communities and to encourage participation in vaccination services. Other private sector partners, like the Community Partners for Health

(CPH) and local businesses in the LGAs, have advocated for the NIDs among communities in their areas, working with the SMCs and NIDs Task Forces.

Awareness building

Challenge Cup Initiative

The Polio Eradication Challenge Cup Initiative was introduced by JHU/PCS into the 1998 NIDS as a strategy to get Nigerian men, especially fathers, to appreciate their responsibility as Caring Understanding Partners (CUP) who would love to see their children polio-free. The strategy was pilot tested in three states to determine its effectiveness, because of the realization that even though African men play an important role in decision-making about the number of children a family should have, the care and nurturing of the children are often regarded as the sole responsibility of the woman. The Polio Eradication Challenge Cup contest was a six-match format competition among three leading club sides in Nigeria, namely, Shooting Stars of Ibadan, Oyo State, Kano Pillars of Kano State and Rangers International of Enugu State.

The intervention made use of the following methods: radio and television spots in the three main Nigerian languages, posters, leaflets, pamphlets, football tickets, billboards, t-shirts, etc. The television and radio jingles also featured three role models, known as Goodwill Ambassadors, chosen from the three popular club sides selected to participate in the Challenge Cup competition.

The intervention served as a strong advocacy strategy. The Governors of the three States were personally involved in the competition and led members of their cabinet to watch the matches. They also spoke favourably for the campaign, and their messages were aired on the radio and television stations and printed in newspapers. An exit interview conducted among 884 respondents in the three cities indicated that people heard the message and took positive action (i.e., took their children for vaccination). The most popular sources of information were the radio and television. It is clear from this study that men’s participation in child health initiatives is still at a low level when the records of women and men at the immunization centers are compared. More efforts should be made to encourage men to directly support and be involved in immunization programmes.

Other events

Rallies using local music and dancers have also been used in some LGAs and states to mobilize the population. Public address systems and vehicles have been provided for social mobilization activities; however, in some areas, the vehicles have been provided in an ad hoc manner and/or need to be repaired. Football matches, fanfares and 'flag off' ceremonies have been utilized during NIDs in many states and have included partners from various organizations and strata of society to raise awareness on the campaigns, the goal of polio eradication and the need to vaccinate against polio and other diseases.

Participation at various levels

Social mobilization committees

At the national level, membership of the Social Mobilization Committee is drawn from Federal Ministry of Health, Health Education Unit, Federal Ministries of Education, Women Affairs, Local Government and Information, National Programme on Immunization, National Primary Health Care Development Agency, UNICEF, Rotary Polio Plus, USAID, WHO, JHU/PCS, the Red Cross and others. A number of committees in each state and LGA are overseeing particular social mobilization activities for immunization and other health interventions. In some states, SMCs for NIDs exist, while in others task forces have been established to oversee implementation of NIDs. A few of the states have SMCs that manage the implementation of all social mobilization activities. No matter the form, the committees are intersectoral. At the state level, membership is drawn from Ministries of Health (PHC Department and Health Education Unit), Women Affairs and Education, Rotary Polio Plus, Red Cross, Boy Scouts and representatives of the media. At the LGA level, where these committees exist, members include staff such as the PHC Coordinator, the Information Officer, representatives of religious and traditional institutions, representative of NGOs active in the area and other opinion leaders. At the state and LGA levels, the Health Education and Information Officers play the coordinating role. The SMCs are expected to create awareness, generate demand, build support at all levels and mobilize community participation.

The ICC has been a key partner in the implementation of the NIDs and polio eradication activities. A Memorandum of Understanding (MOU) was signed in 1998, which included social mobilization and stressed the need for SMCs at state and LGA levels. NPI social mobilization representatives are now based at the state and LGA levels and a framework for social mobilization for NIDs has been put into place. This framework is currently being expanded to address IEC, advocacy and social mobilization for routine immunization, in addition to polio, through the national SMC.

To assist with financing for immunization activities, including NIDs, the Nigeria Immunization Fund was implemented in October 1999, in collaboration with First Bank. Although this fund is in the early stages of implementation, the goal is to generate money for immunization from private companies and partners who will donate to the fund and enable NPI to utilize these funds at state and LGA levels. An Immunization Board, with representatives from the ICC and key ministries, has also been established to monitor this fund. It is anticipated that this fund will be utilized for various immunization activities, including social mobilization and IEC at state and LGA levels.

Structures for delivering IEC and social mobilization services for health exist throughout Nigeria. A good example is the Health Education, Training and Information Committee (HECTIC) in Kano State. HECTIC was established in 1992, in collaboration with UNICEF, to train health educators and provide health education services to 10 states (and 213 LGAs) in the north. The organization has six specialists (Masters in Health Education) on staff and has been working the last few years with the University of Ibadan to design a standardized training curriculum on health IEC (communication skills, developing IEC materials, conducting and implementing research, monitoring and evaluation, etc.) for health professionals. Immunization is one of the health areas covered as part of this curriculum. HECTIC has also been working closely with the SMOH (particularly the NIDs Task Force and the state emergency and epidemic diseases response unit) and state SMC (HECTIC is the secretariat for the SMC) to do outreach to the public and private sectors for the polio eradication activities as well as during outbreaks (e.g. for the measles outbreak in Kano State in March/April 1999). HECTIC's facilities are in Kano, including the training centre and a production unit that is used for print and electronic media. HECTIC and the SMOH acknowledge that they have not been able to conduct many activities with routine immunization over the last year, largely due to lack of funds and a rupture in stock of all routine antigens. They plan to conduct more training workshops and seminars, particularly on capacity building, and immunization review meetings in the states and LGAs in 2000 and 2001. UNICEF is assisting with these trainings, which will involve educated health workers and information officers as participants, but additional support is needed for the implementation and follow-up to these trainings.

Media (print and electronic)

Contractingytsourcing

Prima Garnet was contracted through JHU/PCS as an advertising agency to assist with design and production of television and radio spots on NIDs for the national campaign for private and state stations. JHU/PCS is a partner on the national SMC. The spots were one minute in length in English, Hausa, Yoruba, Ibo and Pidgin English and provided information on the NIDs, goal of polio eradication, safety of polio vaccine, target age groups and the need to come for routine immunization services. The spots were aired on national, state and private stations throughout the country. The spots are standardized to enable them to be used for subsequent years, with the dates updated. Prima Garnet's involvement enabled quality production and ease of connections with media services. Some national and state air time was donated; however, JHU/PCS paid for the airing on all state radio stations and a few private radio stations, as commercialization of stations has reduced free airtime and necessitated that all advertising, including government and social services (often at a reduced rate), pay for airtime. Some states also made their own productions in local languages, utilizing and adapting the same information as was produced at the national level. With JHU financing, Prima Garnet also assisted with the development of press releases, posters, stickers and outdoor billboards (two per state in 20 states for one year) that were used for NIDs. It is planned that the billboards will subsequently be used to post routine immunization and other health messages throughout the year. Although the lead time for the television spots was too short (just two days to produce and only one week to distribute), the SMC provided input on the design. The spots and the print materials were pretested with local IEC consultants before the final production, and the spots were aired at national and state levels at least five days before the NIDs and throughout each round of the NIDs.

Mass media (electronic and print)

According to the Nigerian-owned Research and Marketing Services' annual media survey conducted in 1997 (published in February 1998), radio listenership throughout Nigeria was 81 per cent for 1997 and TV viewership throughout Nigeria was 62 per cent for 1997. This survey also determined that at least 50 per cent of Nigerians own at least one television set. These are therefore popular mediums for transmitting information, including health messages. These channels have been utilized for the NIDs, and findings from the social mobilization checklists from the SNIDs indicate that they are effective in reaching about half of the population. State and local newspapers have also been used to advertise for the NIDs and to provide coverage on the campaigns. As noted above, the advertising agency Prima Garnet has assisted the SMC and ICC in producing electronic and print media, including press releases and billboards, for the NIDs. Banners, smocks and t-shirts have also been produced and funded by the ICC through Rotary and UNICEF, predominately at the national level with donor financing, and distributed to the states and LGAs for the NIDs; however, these often arrive late and do not get distributed to lower levels. Many states and LGAs, with local and/or Rotary financing, have also produced their own newspaper articles, t-shirts, posters, hats and stickers, as well as radio jingles and public service announcements (PSAs), in local languages for the NIDs. Given the size and diversity of the population in Nigeria, it is not possible to standardize the social mobilization materials and evaluate the messages and cost-effectiveness of the materials produced. The impact of the various mass media channels has not been sufficiently monitored. However, SNIDs findings from interviews conducted in 13 states using the social mobilization checklists indicate that interpersonal channels (town criers, community leaders and health workers) are more effective. For this reason, a combined approach of mass media and increased advocacy and participation by local leaders and community channels is being used for the 1999 NIDs. To increase impact, it has been recommended that any social mobilization funds or materials from the national level for NIDs be made available well in advance to the states to enable them to produce and distribute materials to the LGAs and/or utilize interpersonal channels that are most culturally and linguistically appropriate to their regions.

The Nigerian Television Authority

The Nigerian Television Authority (NTA) is the coordinating body for all television networks in the country. The networks are estimated to be as many as 28, and these are located in various states. Each state owns its own network(s) and also has private stations. The NTA carried out a viewer access study that indicated that at least 60 million Nigerians watch television during the main news time every day. This prime-time viewing provides a good opportunity for advertising and transmission of important information to the nation.

In the past, NTA has participated in the transmission of health information in programmes such as the ‘series on your health’ and ‘question and answer on health’ and activities have always been funded by the government. NTA also took part in creating awareness and covering events such as ‘flag off’ for the SNIDs and the first round of the NIDs, which took place in October 1999. NTA has now been privatized, and a prime goal is to maximize profit; therefore, its participation in social marketing for health issues, and NIDs in particular, will to a large extent depend on the available funding.

Interpersonal communication and local-level communication

The use of town criers is a traditional practice to attract attention and participation in activities by the people in the community. The crier goes throughout the community by foot or vehicle to inform about events, announce births or deaths or call meetings. Volunteer criers have been used for the NIDs at state, LGA, district and community levels to inform the communities about the NID dates, target age group and vaccination sites or door-to-door strategy. For the 1999 SNIDs and NIDs, some criers and vaccination teams at the LGA levels have been equipped with megaphones (provided by the ICC and Rotary) to increase their outreach. There is the need to ensure that LGAs are effectively equipped to enable them to establish, manage and implement Social Mobilization Committees and activities.

The results from the evaluation of social mobilization activities during the SNIDs revealed that interpersonal communication, particularly through local traditional and religious leaders, neighbours and criers, was more effective in reaching the population than posters and other print media. Given these findings, additional megaphones are to be provided by Rotary and the ICC and use of these interpersonal communication channels are being stressed for the 1999 and future NIDs.

The importance and advantage of community-level, interpersonal communication mechanisms were stressed by most states and LGAs, and further involvement of these channels was encouraged. In northern areas like Niger and Kano states, a traditional and Muslim leader, known as the Emir, and his council have played a key role in influencing populations, including potential refusers (such as traditional families where women seldom leave their compound), to participate in NIDs, including house-to-house. The Emir is approached by the SMC to provide messages on the NIDs, which he, in turn, passes on to his traditional council. The impact is strong, as the Emir’s word is considered to be powerful and his council members solicit criers, Imams, traditional healers and members in all wards and neighbourhoods to pass the information along to the communities. With specific messages, such as reporting AFP, the information is passed in a similar manner, but specific groups, like traditional healers, will be targeted, in order to encourage them to play a more central role.

Traditional and religious leaders have been used throughout Nigeria to assist with mobilization and advocacy for the NIDs. In similar ways to the Emirs in the northern areas, traditional chiefs, known as Ezes (also known as Obas) and Omus/Obis, have been involved in the southern areas. The Ezes and Obis, male chiefs, work through their traditional councils and networks, including criers and society groups, to inform communities about the event and pass on the basic NIDs messages. Omus, female chiefs, have a similar system; however, their impact is more direct on women, including respected elder women, market women, women's groups and traditional birth attendants.

House-to-house communication strategies and activities

With 13 months to the target date of polio eradication, Nigeria remains one of the major reservoirs of wild polio virus. To intensify its efforts, Nigeria conducted house-to-house SNIDs in April and May 1999 and house-to-house NIDs in October and November 1999. House-to-house for the NIDs has been beneficial in increasing the immunization programme's reach with OPV and in tracking children who have not been coming to the facilities for health services. In Kano State, the SMOH noted the limitations, however, of house-to-house and fear that, particularly with the zero-dose children, there would be confusion that all immunization services would now be provided by house-to-house rather than through the facility-based services. In the states visited, it was reported that messages are provided by criers and vaccinators during house-to-house visits for caregivers to continue to come to the facilities for immunization services, and there has been strong demand for immunization, particularly measles, expressed to NIDs vaccinators. NIDs have provided resources and enabled rapid mobilization, but this has not been able to be sustained for routine immunization, largely due to lack of funds and interruptions in vaccine supplies. Until the service delivery for the routine antigens is re-established, it is probable that campaign and outreach strategies like the house-to-house will need to be utilized in Kano to vaccinate as quickly as possible with the antigens as they become available.

Programme needs for more effective social mobilization and IEC

Increase focus on IEC and basic health education on immunization

Since 1996, much success in Nigeria has been achieved in mobilizing the population to attend NIDs; however, efforts in IEC and addressing knowledge, attitudes and practices (KAP) and behaviour of the public to demand and continue to utilize routine immunization have lagged. Some demotivation of health workers, in large part due to lack of funds and shortages of vaccines for routine immunization, is also a difficulty. Health workers have also not received consistent and standardized training and supervision that stresses the importance of IEC with caregivers and the community when providing health services. Through the gradual expansion of the activities of the national and state SMCs, increased attention is now being given to IEC and integrated communication planning to address programme communication and advocacy at all levels, in addition to social mobilization. These efforts need to be further implemented at state and LGA levels and integrated with service delivery and training, particularly of health staff, to create and meet demand. The SMCs need to be continued beyond NIDs and, where possible, utilize existing health committee structures and members rather than creating separate or parallel committees for NIDs and/or routine immunization.

NIDs

The *1999 Field Guide for NIDs* is appropriate for social mobilization activities for NIDs and AFP surveillance, but does not adequately address IEC. Some further refinement for the 2000 version is recommended to assess the types of media that are most acceptable and effective and to provide some qualitative information on the messages and KAP of caregivers and health workers. A detailed, separate NIDs Supervisory Checklist for Social Mobilization has been created and was utilized during the SNIDs to determine the most effective NIDs social mobilization channels. To be effectively utilized in the field, the key questions from the NIDs Supervisory Checklist for Social Mobilization should be incorporated into the overall Supervisory Checklist for the *2000 NIDs Field Guide*. (See annex 4 for additional lessons learned and recommendations from the NIDs for subsequent NIDs.)

Hard-to-convince

Nigeria is a secular state that is also multiethnic and multilingual. This diversity results in differences in perception, beliefs and attitudes. During the study, the reasons for hard to convince were indicated as religion, misconceptions and attitudes. Continuing outreach and IEC approaches need to be developed, tested and implemented with these hard-to-convince groups and their leaders in order to improve immunization coverage for NIDs and routine among these populations.

Religion

Catholics in some areas were said to believe that the polio vaccine contains family planning medication that may result in birth control. The Faith Tabernacle followers believe that it is not necessary to receive any type of medication. Social mobilization committees have held meetings with religious leaders to provide correct information on the nature and benefits of immunization. In some cases posters showing a lame child have been used to convince parents on the necessity of immunization and this has resulted in positive results.

Social status

In some states it was reported that parents in the high social economic status did not allow vaccinators entrance into their houses and refused to allow their children to be immunized. The reason given for the refusal is that their children are vaccinated by their own private doctors. Communication with landlords through schools, churches and mosques has been provided to further convince the elite group to have children immunized with extra doses of polio vaccine, regardless of their immunization status.

Harmonizing IEC/social mobilization and service delivery

The national SMC functions as a subcommittee of the ICC and has been effective in implementing NIDs social mobilization activities. As the ICC is expanding its focus on routine immunization and surveillance, the SMC and its members are a critical link to encourage demand creation and sustain demand, as well as acceptance and compliance by the general public for immunization services. The success of the IEC approaches is reliant upon – and therefore must be implemented in collaboration and coordination with – the public and private service-delivery system. The Five-Year Integrated Plan is an important step in this direction and should be implemented and evaluated as a key component of the ICC and NPI’s immunization activities. The ICC partners should be further encouraged to work with the NPI, particularly at the state, LGA and district levels, as possible, through the NPI managers and health educators to ensure that IEC and social mobilization efforts for routine immunization and NIDs are implemented in tandem with improvements to vaccination service delivery. As the national-level NPI is working to improve its immunization system nationwide, interim measures by the ICC and SMCs may need to be utilized at state and LGA levels to deliver vaccination services and provide IEC and social mobilization for campaigns and/or special vaccination efforts for routine immunization as vaccines become available.

For an immunization programme to be successful, immunization service delivery efforts must include plans, mechanisms and funding to encourage demand, foster acceptance and satisfy expectations for immunization services among the caregivers and the community. This is particularly important in hard-to-reach areas with consistently low routine vaccination, where logistics are crucial to physically reaching the population and IEC is necessary to raise awareness and understanding and convince the population to accept the services. In terms of creating demand, many of the polio eradication efforts in Nigeria have focused on social mobilization and advocacy. The SMCs need to look at whether KAP are being affected and behaviour change is occurring, not just the logistics of mobilizing the populations and reaching the hard to reach (i.e. using boats, having vaccination teams travel to remote areas, etc). From a communication perspective, it is important to assess what messages and IEC these hard-to-reach and/or hard-to-convince groups are receiving, not just whether they are being physically reached through the service delivery system. Vaccination teams should be trained in IEC skills, particularly interpersonal communication, to improve the demand and acceptance of immunization services by these populations.

Integrated communication planning at state, LGA and district levels

Each state and LGA is expected to have a SMC and Social Mobilization and Information Officers assigned by the NPI. It is unclear, however, how active and engaged these SMCs and social mobilization representatives have been in all states and LGAs, particularly given the lack of supervision and evaluation of social mobilization. It would be useful for the state SMCs and the national SMC to have lists of the SMCs, their members and addresses/contact information for all of the LGAs, to enter this into a database that would enable contact and information sharing. At national, state and LGA levels, there is a need to make the SMCs sustainable for polio and routine immunization, which may require that the SMCs utilize existing health education committees, programs and/or partnerships that may have broader mandates than immunization (such as water and sanitation committees, the National Orientation Agency, CPHs, Epidemic Response Units, UNICEF-sponsored committees, etc). Terms of reference, including roles, responsibilities and membership, should be defined and incorporated at all levels. Assurance of a separate budget and secure and consistent funding for social mobilization and IEC activities should also be institutionalized.

Through the ICC partners, as outlined in the integrated plan, training for the SMCs at state and LGA levels should be conducted in the next two years to sensitize these SMCs on advocacy, programme IEC and social mobilization for routine immunization, surveillance and further polio eradication activities. The guide developed is to be used at state, LGA and district levels to assist in planning communication activities for health, utilizing immunization as the example. Key trainers are to be identified and trained to work at the state and LGA levels with communication planning meetings to be held in the six zones in the year 2000. Where possible, existing structures, like SMCs and/or water and sanitation or community outreach teams, should be streamlined and utilized to prevent overlap in programs and to promote sustainability of the communication teams and activities. Under UCI, collaboration on social mobilization for immunization existed across sectors (public, private, NGOs, military, business, etc.) and throughout the country. It is hoped to revitalize and reinforce this structure and link the SMCs at LGA, state and national levels. The integrated communication planning process, if effectively and sustainably implemented, could be a useful tool and model for this effort, using immunization as a potential launching point.

Monitoring and evaluation

There is a need to build a monitoring and evaluation (M&E) system into the social mobilization component of the National Programme on Immunization. The M&E system should include indicators to assess knowledge, attitude, practice and behaviour of health workers and caregivers. The existing supervisory checklist on social mobilization should be expanded to include these specific indicators that can be used as an evaluation tool by all agencies.

Monitoring and evaluation of behavioural change communication campaign for NIDS

Monitoring of NIDs campaigns has been planned and executed at all levels. Educational and promotional materials are designed at federal level. These are distributed through the Central (federal) facilitators. The facilitators at different levels monitor the distribution, utilization and effectiveness of the promotional materials through use of forms. Although the forms are designed to capture the effectiveness of all the methods used, the method of data collection has not been properly implemented to ensure that the data collection and findings are reliable. The media plans are only monitored in a few states, due to lack of funds, but the state facilitators are encouraged to monitor the broadcasts in their states.

To evaluate the impact of social mobilization for the NIDs, JHU/PCS contracted with a private company called Research and Marketing Services, which conducted Omnibus surveys among about 5,000 respondents randomly chosen from the 36 states and Abuja Federal Capital Territory in October and December 1998. The findings indicated an increase in NIDS awareness levels by 25 per cent overall between the two rounds of the NIDs in 1998. Of interest are the differences in increased awareness levels of the NIDs between the sexes (females by 38 per cent, compared with 15 per cent among males) and by geographic locations (rural by 31 per cent, compared with 20 per cent among urban dwellers).

The single most important source of information mentioned during the October 1998 survey was the radio jingle (56 per cent) while the TV jingle was a distant second (27 per cent). Other important sources included health workers (17 per cent), posters/billboard (11 per cent), radio drama (6 per cent), spouse/partners (6 per cent), TV drama (4 per cent) and newspapers. Close to 7 in every 10 respondents who saw or heard of NIDs took action, of which the most significant action was to take children for immunization.

It is noteworthy that a negligible proportion of respondents mentioned the traditional ruler or town crier as a source of information; whereas the current assessment indicated that they are very significant and credible source of information. There is therefore a need to do a further study to ascertain the true situation and the impact of these interpersonal channels.

Resource needs

The resource needs for social mobilization can be estimated from the programmatic requirements. Essentially, there is a need to carry out social mobilization and IEC activities for routine immunization, supplemental immunization and surveillance. For each of these, it is essential to carry out advocacy activities, social mobilization activities and programme communication activities. Advocacy activities include advocacy visits, lobbying, meetings and workshops.

Programme communication activities include production of radio jingles in the main languages of Hausa, Ibo, Yoruba, English and Pidgin, airing of the jingles, conducting health education sessions within communities, training health workers and staff in IEC, and production of communication materials for households and communities. For social mobilization, comprehensive training of officers is needed at all levels. This is to be followed by regular supervisory visits of those officers to the communities. In order for social mobilization and IEC for immunization to be effective and sustained, consistent and reliable funding is needed each year, with a budget line item and funding specifically for social mobilization and IEC (salaries, activities, materials, transport, etc.) included in overall ICC and/or immunization programme budgets.

Capacity building

Some universities and other higher education institutions run health education programmes. Institutions such as University of Nigeria, Nsukka, Ahmadu Bello University and University of Ibadan, and African Regional Health Education Centre (ARHEC) have degree and/or diploma programmes. Most of the universities' faculties of education have a separate curriculum for health education.

Summary of constraints and recommendations

Constraints

- Non-existence and/or non-functioning of standing SMCs to carry out year-round social mobilization and IEC activities at all levels.
- Inadequate funding for social mobilization and communication activities and programme needs for NIDs, routine immunization and surveillance.

- Late commencement of planning for social mobilization and communication activities.
- Insufficient collaboration to achieve and implement a common social mobilization/IEC framework by all agencies and partners at all levels.
- Vaccine stock-outs, especially with routine vaccines, resulting in dissatisfaction and waning demand and utilization of immunization services.
- Insufficient research/statistics on social mobilization/IEC activities nationwide, and need to conduct and utilize formative and qualitative research activities to better identify and define behavioural obstacles to improved coverage and effectiveness of messages, materials, and media.

Recommendations

- The ICC should prioritize social mobilization/IEC as a major component for boosting and sustaining immunization activities and not as a secondary consideration after other components, such as provision of vaccines or logistics.
- Provision of adequate funds at all levels is needed to plan, conduct, monitor, and evaluate advocacy, social mobilization and communication activities.
- Motivation of Social Mobilization Committee members is needed, especially at lower levels, through secure salaries or stipends/per diems to support their work and transport costs and sustain year-round activities of the committees.
- Integration of the activities of the SMCs already existing in some states and sponsored by different partner agencies for different programmes. These activities, committees and partners need to be harmonized to support social mobilization/IEC for routine and supplemental immunization and prevent parallel or conflicting systems.
- Additional advocacy is needed, particularly with the private sector (including medical/health organizations that invariably attend to the needs of a major segment of the population) to support and participate in routine and supplemental immunization and surveillance.
- Strategies and activities should be planned, implemented and evaluated at all levels in Nigeria as outlined and documented in the Five-Year Integrated Communication Plan for Social Mobilization/IEC.
- Training (and retraining) on social mobilization/IEC for immunization is needed at all levels for members of the SMCs.

- Formative, operational and qualitative research is needed on advocacy, social mobilization and communication for immunization to better define, develop and implement cost-effective strategies to overcome behavioural obstacles to higher coverage throughout the country.

Annex A: Contact list

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Annex B: Documents reviewed

NPI Field Guide for 1999 NIDs (house-to-house strategy).

NPI Report on Nigeria Sub-National Immunization Days (house-to-house strategy), June 1999.

"Nigeria SNIDs House-to-House Strategy, Report on Social Mobilization Activities for 1999 SNIDs," Sola Kabamba, Adviser WHO/AFRO, in collaboration with the NPI Social Mobilization Committee, April-May 1999.

"NPI Five-Year Integrated Advocacy and Communication Plan for Polio Eradication, Routine Immunization and Surveillance in the Federal Republic of Nigeria (1999-2003)."

"1999 Plan of Action, National Level, NPI, May 1999."

"Five-Year National Strategic Plan, NPI (1999-2003)."

Zonal Advocacy/Briefing Meeting Notes (for 1999 NIDs), 3 August 1999 (Edo, Bauchi, Niger states).

"Polio Update," November 1999, Rotary International Polio Plus.

Imo State 1999 1st Round NIDs Report, October 1999.

Borno State 1999 1st Round NIDs Report, October 1999.

"Child Survival Protection and Development (CSPD) in Nigeria – Key Social Statistics," April 1998, National Planning Commission and UNICEF.

Briefing of Central Facilitators, NPI Report, May 1999.

Annex C: Definition of terms

Advocacy: Activities implemented for the purpose of gaining political and social leadership and acceptance in order to gain support for programme implementation.

Communication: The process of transmitting information between sender and receiver using verbal or nonverbal communication through the sense of touch, smell, sight, hearing and/or feeling.

Emir: A male traditional and religious (Muslim) leader commonly found in the northern part of Nigeria who is traditionally respected and revered by the community members within his jurisdiction and/or culture.

Eze (Oba): A male traditional leader commonly found in the southern part of Nigeria who is traditionally respected and revered by the community members within his jurisdiction and/or culture.

Omu: A female traditional leader who is often a widow and presides over a women's council to provide guidance and discipline among the women in the community within her jurisdiction and/or culture.

Social mobilization: A process of soliciting support and involvement of all feasible partners, allies and communities so as to encourage programme participation.

Town crier: A person who is instructed and sent by the traditional leader and/or his or her council to deliver an important message in the community using a drum, megaphone or other tool to attract attention and inform the community about an issue or event.

Annex D: Lessons learned and specific recommendations for NIDs

Recommendations

The planning process for the 1999 NIDs is based on the triple A approach: assessment, analysis and action. It is not clear, however, how the assessment of needs for social mobilization/IEC is carried out and how the data from the analysis is used to plan for the action and evaluation. This should be clarified in the document and/or in the training on social mobilization/IEC that is provided for the vaccination teams.

To be effectively utilized in the field, the key questions from the NIDs Supervisory Checklist for Social Mobilization (notably numbers 1, 6, 7 and 8) should be incorporated into the overall Supervisory Checklist for the NIDs, particularly to evaluate the effectivenes of the materials and their distribution.

Revision of the Supervisory Checklist could include: (1) Question 3 should be modified to ask caregivers how they heard about the NIDs, with the supervisor being able to check radio, television, posters, criers/mobile megaphones, health workers, traditional leaders, religious leaders or other (write-in) as categories; (2) Question 16 should be asked of the general public, not health workers, and should include a bullet on identification of the symptoms of polio. If possible, the supervisor should note yes or no for each respondent, not generalize all five responses; (3) A question should be added to assess the training that health workers have received on the NIDs, including social mobilization and IEC (particurlarly interpersonal communication at the health facility and door-to-door) with caregivers to encourage caregiver attendance and acceptance of immunization during NIDs and for routine immunization.

In Appendix 2, the key message on AFP should note the importance of bringing the child to the health worker or facility as soon as possible (i.e. within 14 days) of the sign of limpness or weakness in the arms or legs. Under “Act” in Appendix 2 and in Section 2.I. of the Implementation Guidelines, lines should be added to note the importance of ensuring that megaphones are in place and that local leaders have been contacted and are providing messages on the NIDs and routine immunization.

Example from Lagos State

In Lagos, the state SMC meets for planning and implementation of social mobilization activities for the NIDs. Advocacy has been done with high political-level policy makers (Governor, local member of Parliament, NGO and private sector leaders), with increased efforts for the 1999 NIDs, as local health workers were on strike prior to the second round. Within the state MOH, there is a Health Education Unit that has been assisting with the NIDs. There are five university-trained Health Educators (University of Lagos has a Health Education Department) who train the LGA-level health educators on communication and social mobilization.

Within Lagos State, there are 20 LGAs that each are reported to have community development associations. These associations, which in some districts include private organizations known as Community Partnerships for Health, are included in the SMCs of the LGAs and are utilized to sensitize and mobilize church leaders, tradition leaders, district heads and the schools through letters and visits. For the house-to-house strategy, interpersonal communication activities have improved, through the use of megaphones and with health educators as part of the vaccination teams to explain why vaccinators are coming to their door and to stress the importance of polio and routine vaccination. For the SNIDs, the door-to-door approach has demonstrated a marked increase in awareness and coverage for polio eradication in Lagos State, based on the findings from the social mobilization checklist and the SNIDs coverage figures.

Hard-to-reach areas have been identified in the LGAs and these populations are being targeted for the 1999 SNIDs and NIDs. For the hard-to-reach in the urban densely populated areas, sites are established at markets and common areas and more door-to-door teams have been used to increase delivery of OPV. Mass media and traditional channels, such as town criers, are utilized to inform and encourage the community to participate. Low-density areas have also been identified in Lagos, particularly among the elites on Victoria Island. The elites in Lagos predominantly accept immunization services, but they utilize private practitioners and are not able to stay at home for door-to-door teams. The strategy for the elites in the 1999 NIDs is to utilize megaphones in the elite areas announcing the campaign and to vaccinate these children at the schools, with letters from the Ministries of Information and Education sent to the schools to inform them and enable the teams to come to vaccinate. Through the schools, parents are to be notified about the NIDs vaccination. Private practitioners are also being encouraged to support the NIDs, but their involvement has been ad hoc. It was recommended to the LGAs to increase efforts to gain the support and cooperation of the private practitioners for the 2000 NIDs through advocacy efforts by medical associations and the Ministry of Health.